

# Physician Organization In California: Crisis And Opportunity

The backlash against capitation and integration cannot lead America back to a future of solo fee-for-service practice.

by James C. Robinson

**ABSTRACT:** Many of the 250 physician organizations that provide care to California's sixteen million health maintenance organization enrollees are in a state of crisis, squeezed between constrained revenues, rising practice costs, and consumer sentiment that favors unconstrained choice over integrated delivery. Medical groups and independent practice associations are retrenching to their core geographic areas, reducing capitation for drug benefits and hospital services, and abandoning dreams of displacing health plans. Consolidation is accelerating in some areas, as medical groups join with hospitals to extract higher payment rates from insurers and employers. The conjunction of consumerism and premium inflation creates new opportunities for organizations that truly can manage health care, but the challenges roiling California's medical groups may preclude meaningful efforts to seize the initiative.

CALIFORNIA MODEL

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PHYSICIAN ORGANIZATION HAS BEEN PROMOTED as the structural solution to health care's most intractable problems—a point of balance between solo practice and corporate medicine; a clinical partner to the hospital and contractual partner to the insurer; a bastion of professionalism against the insidious rot of financial incentives; and the foundation for patient-focused, population-based health care. In this dream of a physician-led future, California has served as the model and the mantra, the experiment to be replicated and example to be followed, the cauldron of competition and consolidation wherein sixteen million people obtain their insurance through health maintenance organizations (HMOs) and their care through one of 250 physician organizations. Medical groups in California have been paid on a capitated basis, delegated by insurers the managed care functions of network development, physician credentialing, claims payment, utilization management, and quality reporting. During the 1990s they pursued economies of scale and market power through mergers and acquisi-

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tions of solo practices, single-specialty networks, multispecialty clinics, and independent practice associations (IPAs). Then, on what appeared to be the eve of their triumph, when they seemed poised to displace insurers as the locus of financial control and the hospital as the locus of clinical control, came the crash.

The crisis has swept through every form of physician organization. Physician practice management (PPM) firms such as FPA and MedPartners went first, dumping their medical groups at fire-sale prices under pressure from disenchanted investors and aroused regulators. Hospitals have followed at a more deliberate pace, worried lest they lose patients as they spin off physician practices. Free-standing medical groups and IPAs have little to divest but are retrenching to their core geographic areas, sometimes breaking multispecialty organizations into specialty-specific components, and putting aside the rhetoric of disintermediating the health plans. All physician entities, regardless of structure or ownership, are pulling back from the strategies of yesteryear, reducing or renouncing capitation for hospital and pharmacy services, handing some aspects of utilization management back to insurers, and terminating the bottom-dollar contracts that brought patients but not profits. The vitriol, vituperation, and insolvency fears have propelled politicians to regulate everything that moves and bail out everything that doesn't.

Reality is never as exotic as perception. Even in their heyday, medical groups in California were not the panacea described by their protagonists. Today, at their nadir, they are not nearly as fragile as claimed by their antagonists. Yet without question the California model of physician-led managed care has been weakened by the financial challenge, organizational tumult, and regulatory backlash of the past three years. The outcome of the contemporary imbroglio will have important implications not only for the largest state in the Union but for the nation as a whole, since it will frame a generation of attitudes toward the role, if any, of physician organization in the health care delivery system. Different diagnoses will imply different prognoses. To the extent that the sources of failure are external to the medical groups and due more to implementation than to strategy, physician organizations in California will pass through a period of reevaluation and ultimately emerge humbler, wiser, but stronger. To the extent that the problems are internal and due to strategy as well as implementation, however, we have not yet seen the bottom.

## The Medical Group Model Of Managed Care

Managed care in California has always differed from that in other states by being firmly centered on physician organizations rather than insurer-developed networks of individual physicians. The medical group orientation derives from the example of the Kaiser Foundation Health Plan and its affiliated Permanente Medical Groups, which have sustained a successful contractual relationship for fifty years. When Kaiser's ever-growing market share provoked a competitive response by Blue Cross and some hospital systems in the 1970s, the nascent HMOs immediately sought multispecialty medical groups rather than solo practices as the foundation for their delivery systems.<sup>1</sup> Payment was and is on a prospective, per member per month basis for primary care and specialty physician services and, depending on the context, for all or part of hospital, pharmacy, and ancillary services. The medical groups were and are delegated responsibility for recruiting and credentialing new physicians, processing and paying claims to outside vendors, and monitoring and managing utilization.<sup>2</sup> The HMOs passed the core of managed care rights and responsibilities on to the physicians and focused their own efforts on marketing, reinsurance, regulatory compliance, and the performance improvement initiatives stipulated by the National Committee for Quality Assurance (NCQA).

The surge of enrollment in HMOs outstripped the capacity of the multispecialty clinics and spurred the growth of IPAs, which perform capitation contracting, credentialing, claims payment, and utilization management functions in a manner similar to the clinics but leave their physician members as the owners of their solo and small-group practices.<sup>3</sup> By 1990 the perceived benefits of growth induced a wave of amalgamation among medical groups and the rise of hospital systems and PPM firms, nonphysician entities that sought to capture the value of physician-led managed care by purchasing and combining multiple groups and IPAs.<sup>4</sup> The largest entities demanded and received capitation for hospital as well as physician services, and several obtained limited insurance licenses as a step toward direct contracting with Medicare and private employers.<sup>5</sup>

### Crisis And Retrenchment

The financial instability of physician organization in California has been subjected to considerable discussion and distortion. The media report that one-third of medical groups and IPAs have gone bankrupt, drawing on a highly publicized press release from the California Medical Association, itself a misinterpretation of an informal, unpublished consultant estimate.<sup>6</sup> In fact, California witnessed two

very large bankruptcies of PPM firms (FPA and the California unit of MedPartners) and the closure of several medical groups and IPAs. The impact of the FPA and MedPartners bankruptcies was severe for the downstream subcontractors, who never received full payment for the clinical services they rendered, and for the physician members of the affiliated medical groups, which went through considerable turmoil as they either regained their independence or were resold to a hospital system or other large entity. Moreover, the core of the erstwhile MedPartners network in southern California was resold to a relatively unknown entrepreneurial physician organization that merely prolonged the agony of overconsolidation before filing for bankruptcy in late 2000.

For the moment, despite apocalyptic predictions and some significant closures, the medical group and IPA structure is holding together. In a few areas, such as San Mateo County, the largest local IPAs have collapsed, and the HMOs are contracting with individual physicians rather than with physician organizations. Elsewhere the physician organizations are refocusing their activities on core markets, products, and functions. The future of the California model, in the short term, depends on whether this retrenchment, combined with higher payment rates from the HMOs, will allow the medical groups and IPAs to step back from the abyss or, on the contrary, whether it will prove to be too little and too late.

### External Challenges

All organizations are imprinted by the environmental context that prevailed when they first were formed and must struggle to modify their vision and strategy as the world changes. The prepaid physician organizations in California were for the most part born in the 1980s, an era of rapidly rising health care costs and extensive public debate over excess capacity, overspecialization, and inappropriate services. The environment challenged them to reduce cost growth through a primary care focus, integrated provider panels, prepayment, and utilization management. At the same time, however, the environment continued to tie capitation payments indirectly to the inflating indemnity premiums, allowing the medical groups to enjoy the best of both worlds: cost control and revenue expansion.<sup>7</sup>

By the late 1990s the external environment had changed dramatically. Economic prosperity had created a consumer demand for broad provider panels and unimpeded access to specialty services, while sophisticated purchasers and vigorous price competition unlinked HMO premiums from indemnity rates and choked off the annual increases in per member per month payments to which the medical groups had become accustomed. Now medical groups face

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the worst of both worlds: inflating costs and constrained revenues. The external challenge to the medical groups contains three principal components: the level of payment itself, the rise of consumerism, and the transformation of the health plans.

■ **Payment rates.** The U.S. health care system has inherited a resplendent infrastructure of hospitals, clinical technology, and physician specialists from the era of open-ended federal subsidies, indemnity insurance, and cost-plus reimbursement. In most industries excess capacity leads to declines in payment rates and then in unit costs as producers compete for customers on the basis of price. The peculiar economic and political institutions of health care long impeded this re-equilibration, allowing underemployed providers to raise rates and yet stimulate more, rather than less, use and spending. The managed care revolution in California imposed a more conventional economic logic. Excess capacity lay at the root of the collapse in payment rates for medical groups and their many subcontractors in the 1990s. Confusion, chaos, and greed played important roles, but the fundamental fact is that medical groups accepted low rates because they wanted to attract patients from competing organizations. The metropolitan areas in California were too large, the purchasers too sophisticated, the regulators too supportive of market principles, and the hospitals too fragmented for the physicians to sustain the strategy of anticompetitive collusion that has upheld payment levels in most U.S. communities.

Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties afflicting medical groups and IPAs in California. Payments are just now regaining the levels prevalent five years ago, before the tsunami of reductions began with the purchasers, swept through the HMOs, and then crashed upon the medical groups and their hapless physician members. But the correlation between low payment and organizational turmoil is complex and inconsistent. Physician organizations in states such as New York receive much higher rates than their California counterparts do but have suffered even worse organizational fates, while payment rates are comparable or lower in Minnesota, where physicians have avoided the extremes of financial insolvency. Within California the organizational turmoil is worse in Los Angeles, which enjoys high Medicare HMO payments, than in San Francisco, with lower rates. While no physician organization is

fat and happy, some in every region earn modest operating profits while their neighbors are awash in red ink.

■ **Consumerism.** Prepaid group practice certainly is not incompatible with a consumer-driven health care system. Advocates of managed competition, from Alain Enthoven to Hillary Rodham Clinton, have interpreted informed and cost-conscious choice among physician-led delivery systems as the foundation of consumer sovereignty. Just as auto manufacturers assemble vehicles from individual components and universities assemble curricula from individual professors, medical groups can add value to consumer choice by structuring the delivery system into clinically and economically meaningful units that can be monitored, measured, and subjected to performance incentives.

One of the incontrovertible failures of physician organization in California and elsewhere, however, has been the relatively late and reluctant acknowledgment of the primacy of consumer preference, as opposed to professional judgment, as the core principle for allocating resources. Despite ritualistic genuflections, most medical groups were taken unaware by the speed and intensity of the changing consumer focus from cost control to choice and access. In some ways medical groups were victims of their own success, since the five-year stability in HMO premium rates stemmed from the reductions in hospital use engineered by the physicians. The spectacular boom in the California economy, which spurs consumers to demand whatever they want whenever they want it, also has been stimulated by the stability of fringe-benefit costs. Either way, medical groups now find themselves on the wrong side of history, seeking to promote primary care to patients who prefer specialty services, channel patients who do not want to be channeled, prescribe generic drugs in the face of direct-to-consumer brand advertising, and, generally, interpret health care as a scarce resource in need of priority setting rather than as a mood-enhancing basic human right.

The unwillingness of public and private purchasers to create mechanisms for structuring consumer choice is a major cause of the failure of integrated delivery systems and, by extension, of the lack of market reward to medical groups for cost-reduction initiatives. But medical groups and IPAs also suffer from a deeper structural mismatch with the unstoppable trend toward ever more heterogeneous, service-oriented, quality-conscious, and price-sensitive consumer demand. The essence of the prepaid group practice is the principle that the consumer will choose the medical group at time of open enrollment, usually based on the number and characteristics of its primary care physicians, and then acquiesce, when a serious illness or injury occurs, to treatment by whichever specialists those

primary care physicians have brought into the group.

Seen from the perspective of the larger economy, this is not an unusual principle. Most prospective students select a university before knowing all of their interests and then move among the faculty hired by that university rather than self-refer across independent universities with the support of some open-panel, point-of-service, educational insurance product. In health care, however, consumers tend to wait until they receive a serious diagnosis before choosing, based on anecdote and Internet, a specialist, procedure, and facility. The organizational link between a specialist and a primary care physician is one factor, and in many cases a decisive one, but woe to the physician organization that replaces advice and referral with gatekeeping and formal authorization.

■ **Transformation of health plans.** Many medical groups and IPAs originally were formed as defensive responses to the rise of managed care, but their patient volume and revenues grew in tandem with the rising market penetration of network HMOs. A major contributor to the current crisis has been the unraveling of the sense of joint destiny and quasi-partnership that smoothed the rough edges of financial disputes in years past. Many medical groups and IPAs now perceive themselves as locked in a zero-sum game, where what is good for the physician is bad for the insurer, and as embroiled in a daily guerrilla war of bad faith and betrayal.

The envenoming of plan-physician relationships stems in part from the underpricing of the HMO products to corporate purchasers, which resulted in unsustainably low capitation rates' being passed along to the physician organizations, and in part from the change in Medicare payment policies, which changed elderly HMO patients from money makers to money losers from the physician perspective. At a deeper level, however, the shift from cooperation to conflict followed the evolution of American health care from a series of quasi-isolated regional sectors to one market populated by national carriers under surveillance by the national capital markets. As California-based health plans expanded eastward, the absence of indigenous physician organizations in those states forced them to develop products based on individual physician contracting and fee-for-service rather than group contracting and capitation.<sup>8</sup> Their organizational futures became ever less commingled with those of medical groups in California.

The national carriers first sought to compete with the low-cost California HMOs by building staff-model products or by contracting with the same set of medical groups, but they never perceived a joint destiny or invested in partnerships. As the tide moved away from capitation in eastern states, as a result of the collapse of inte-

grated delivery systems such as the Allegheny Health, Education, and Research Foundation (AHERF) and PPM firms such as FPA, the national carriers dismantled their clinics, pulled back from tentative efforts at relationship building, and prepared themselves for a reversion to individual physician contracting.<sup>9</sup> The oft-predicted demise of the medical group model in California has yet to occur, and plans that never built strong capitated products have been forced to abandon the state. But the investor-owned, multistate health plans that remain active in California now highlight in their quarterly reports how little they are dependent on capitation, delegation, and cooperation with physician organizations. Wall Street celebrates moves away from the medical group model and punishes with severe discounts those plans that retain a reliance on physician group contracting.<sup>10</sup>

At the most fundamental level, the conflict between health plans and medical groups in California reflects the weaknesses of "virtual integration," of interdependency among independent organizations.<sup>11</sup> While a small number of large physician organizations account for the vast majority of HMO enrollment in California, health plan executives rarely meet with leaders of these groups to discuss strategy, capacity, finances, or the future.<sup>12</sup> Health plans and physician organizations have delegated their relationships to the contracting staffs, who are rewarded for their ability to shift as great a fraction of the premium dollar as possible to their side of the table. Some physician organizations now identify as allies hospitals and pharmaceutical companies, for whom the agenda is to increase the costs of care (revenues to the providers), and identify as enemies insurers and employers, for whom the agenda is to reduce the costs of care (revenues to the providers).

The weaknesses of virtual integration in California highlight the comparative strengths of the two alternative forms of relationships between upstream and downstream firms. Vertical integration, by joint ownership or mutually exclusive contract, forces both players to recognize their interdependency and find a *modus vivendi*. Despite two years of financial losses caused by product underpricing, the Kaiser HMO did not slash payments to and bankrupt the Permanente Medical Group. The opposite end of relationship spectrum from vertical integration is spot contracting, the avoidance of organizational interdependencies between upstream purchasers and downstream providers. In California, spot contracting is embodied in preferred provider organization (PPO) products, which maintain a straightforward strategy of large deductibles for the consumer, sharply discounted fee-for-service for the doctors, and abandonment of the thankless task of coordinating the process of care.



## Internal Challenges To Physician Organization

■ **Diseconomies of scale.** A fundamental premise of group practice is that large organizations are able to spread the overhead expenses of running a practice over a broader financial base and thereby reduce the unit costs of care. Overhead expenses include clinical and nonclinical staff, supplies, and information technologies. More important, though, are less tangible administrative capabilities such as physician, patient, and process profiling; financial accounting, actuarial evaluation, and management; contract evaluation, negotiation, and implementation; compensation mechanisms for partners, employees, and vendors; claims processing, adjudication, and payment; utilization review; disease management; and quality improvement. Physician organizations in California have invested in infrastructure to an extent unheard of outside the largest multispecialty clinics in other states, and their leaders are routinely shocked when they travel east and discover that many physician practices cannot produce a list of their diabetic patients; must beg an insurer's authorization to admit a patient to a hospital; and sign managed care contracts without bothering to read, much less negotiate, the terms. But despite improvements, most physician organizations in California never built a physical, human, and data infrastructure adequate to manage the complex clinical and financial responsibilities that come with large scale. The most successful organizations are those that were founded earliest and had the time to build out their facilities, recruit and socialize their physicians, foster brand-name recognition in the community, and develop their managed care capabilities at a moderate and sustainable pace.

The efficiency gains achieved through medical group expansion have been partially or fully offset by the inefficiencies that attend large, complex organizations and especially those put together through mergers and acquisitions. The traditional solo physician practice often was run in a highly efficient manner because the doctor was the residual claimant to all practice profits and struggled continually against every form of on-the-job amenity that adversely affected the bottom line. Malingering and slack were less likely when doctors were managed by their wives. Small physician groups achieve comparable efficiencies through careful screening of potential new partners, continuous peer monitoring, and productivity-based payment. The medical groups in California that grew large in a short time brought together physicians who did not know or appreciate each other, who shared no common vision or culture, and who treated fewer patients per day than when self-employed. The attenuation of incentives and productivity has bedeviled large medi-

cal groups of all descriptions and underlies the dissolution of many staff-model HMOs, hospital-based delivery systems, equity-model practice management firms, and freestanding physician-led clinics. It extends beyond efficient use of the physician's own time to incentives for careful management of support staff, supplies, tests, and referrals. The large medical group is always threatened by the tragedy of the commons, where collectively physicians have the incentive to work hard and conserve resources but individually they face the stronger incentive to inquire as to the family well-being for each patient, not risk medical error by rushing through a workup, take full advantage of continuing medical education opportunities, and be out of the clinic parking lot by 5:05 P.M.

■ **Inadequate capitation risk spreading.** Medical groups in California were distinguished from physician organizations elsewhere by their early embrace of capitation payment. Pioneers in prepaid group practice recognized the potential for predictable, prospective payment to reduce the transaction costs of claims submission, processing, and contention; to stabilize practice revenues and facilitate long-term planning; and to reward cost-reducing changes in clinical practice. Outside California, capitation often suffers under the image of a payment mechanism that insurers force onto physicians. Inside California, prospective payment for an ever broader set of services has been until recently a mechanism demanded from insurers by physicians.

Capitation bundles together two analytically distinct elements of financial responsibility. Insurance or "incidence" risk encompasses the costs deriving from the likelihood that particular illnesses will occur for reasons outside the immediate control of the physician, while clinical or "technical" risk encompasses costs stemming from the efficiency or inefficiency of the treatment style used by the physician after the problem is manifest.<sup>13</sup> Having a large volume of patients is important for averaging out unpredictable fluctuations in both forms of risk, but the variation in cost is both greater and less subject to management for incidence than is the case for technical risk. Once they embraced incidence as well as technical risk, therefore, medical groups in California were ever more committed to growth in enrollment. Yet they never achieved the scale of operations and, more importantly, never built the analytic capabilities in actuarial evaluation, underwriting, and risk-based pricing that are essential components of insurance and quasi-insurance entities.

A major contributor to their financial problems has been the unwillingness to accumulate the financial reserves and tangible net equity that insurance risk bearing demands. To the extent that medical groups can adjust to fluctuations in epidemiological costs

by changing the payment rates paid to their physician members, they can reasonably argue that they are prepaid providers rather than insurers. But growth entails responsibility for payment of claims to subspecialists, ambulatory facilities, medical equipment distributors, and hospitals. These vendors are not prepared to accept payment at less-than-contracted rates just because the medical group enrolls a sicker-than-expected patient mix, and they are willing to pursue their claims through any dispute resolution mechanism up to and including bankruptcy court.

■ **The mirage of bargaining leverage.** Growth in physician membership and patient enrollment was conceptualized by physician organizations as a means for increasing the rates at which they are paid by insurance entities and for decreasing the rates they pay out to specialty, hospital, and ancillary subcontractors. The largest groups did enjoy some gains in bargaining leverage but have been dismayed to encounter ever more effective resistance both up- and downstream. The limits of leverage against health plans stem from the simple fact that health care is local, and even the largest medical groups never built anything approaching monopoly power in any particular submarket. Scale typically has been achieved through mergers with groups in adjacent communities, not by the absorption of all local competitors. The vast supply of physicians attracted to the California lifestyle and the lack of entry barriers to establishing practice produce an abundance of upstart IPAs, specialty carve-outs, and expansion-minded entrepreneurs always willing to undercut rate increases demanded by the local incumbents. Payment rates now have declined to levels that equilibrate supply and demand in the most brutal fashion, as enough specialists and subspecialists simply walk away from the table. The subcontractors are not going quietly but, rather, threaten vociferously to move from overserved communities along the beach to underserved communities in the U.S. hinterland unless granted union bargaining status, exemptions from antitrust enforcement, and direct governmental bailout.

The story is not over, however, with respect to physician organization and bargaining power. Although entry barriers are low and monopoly power against insurers is difficult for physicians acting alone, entry barriers are significant, horizontal merger is accelerating, and the ability to push back is growing for hospital systems that combine with physician organizations. California has witnessed major showdowns between insurers and physician-hospital organizations in recent years, and more can be expected. Physician leaders have come to understand that single-market depth, rather than multi-market breadth, is the route to bargaining power and that ownership by or partnership with hospital systems is one means to this end.

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The failure of most physician-hospital systems to achieve cost decreases does not preclude new alignments in pursuit of revenue increases. Historical tensions between physicians and hospitals remain strong, however, with many hospital systems and medical groups engaged in bitter disputes over unit prices and utilization management for inpatient and outpatient facility services.

■ **Diseconomies of scope.** The salient characteristic of the largest physician organizations in California has not been their scale but their scope—the heterogeneity of services and specialties brought together under the principle of coordinating the entire continuum of care. Most medical groups and IPAs in California combine the full range of specialties with a strong admixture of primary care physicians. Hospital-affiliated groups share ownership and governance linkages with facilities of every description. “Wraparound IPAs” that combine integrated medical groups and IPA networks mix the oil of salaried physician employees with the water of independent clinical practitioners. This diversification has been conceptualized in part as a means to achieve overall organizational growth but, more importantly, as the foundation for embarking on the quest for the Holy Grail: coordinated care from prevention through primary, specialty, hospital, postacute, and home and community care.

In principle, the aggregation of diverse but interdependent activities within one clinical organization can enhance cooperation and minimize conflict between self-interested individuals and otherwise independent entities. But amalgamation also can transfer inside the organization the diversity and disunity formerly coexisting under the principle that good fences make good neighbors. Multi-specialty medical groups are continually challenged by the imperative to mediate the financial and cultural tensions between primary care, which is a high-volume but low-margin business, with specialty care, where the opposite is true. Boundary conflicts among specialties and subspecialties can be numerous and nasty. Many physician organizations, especially IPAs, are faced with incipient rebellion from specialties that have come to understand the power of suborganizations to extort greater shares of the overall budget with threats of unified withdrawal. The technological, financial, regulatory, and cultural differences between professional and institutional services have disrupted many physician-hospital delivery systems. These disputes are magnified when physician organiza-

tions seek to expand geographically, since the practice of medicine varies in mysterious ways across even small subregions. The transfer pricing dilemma facing capitated provider organizations, which must decide how much to pay for a specialty consultation or extra hospital day when rates are determined by internal politics rather than open market competition, heightens internal tensions and can lead to a clinical war of all against all.

### **Crisis And Opportunity**

The medical group crisis is most evident in the state that embraced most fervently the doctrine of physician-led, prospectively paid, clinically integrated health care. But it extends to all states and all forms of physician organization. All health care organizations, not just those led by physicians, face constrained revenues, unconstrained costs, and escalating consumer expectations. But physician organizations face special cultural, governance, and leadership challenges that derive from the enduring features of medicine as a profession and the inherent difficulty of combining profession and organization.

Medical groups in the era of managed care are caught between the imperative for organizational growth and the virtues of practice intimacy. Consumers' demands for broad choice favor medical groups with many physicians over those with few. Pressure from purchasers and regulators for financial solvency and quality monitoring raise the overhead costs of administration and information systems. Capitation and other forms of prospective payment subject medical groups to the law of large numbers, encouraging enrollment gains to spread actuarial risk. The potential for monopoly power entices physicians to join with their fellows and force insurers and employers to fund the system at more generous levels. But the drive toward organizational growth threatens the collegiality, democratic governance, and informal leadership, to say nothing of the incentives and productivity, of traditional small-group practice.

Large scale inevitably brings a complexity of decision making, a bureaucratization of operations, and an attenuation of incentives to what traditionally has been a Mom-and-Pop business model. Large scale is at best a necessary, never a sufficient, condition for developing organizational capabilities and enhancing service quality. As they merged with erstwhile competitors, many medical groups retained a culture and structure of governance suited only for much smaller and more intimate settings. The failure to adjust culture and governance underlies the inability of many groups to invest in actuarial capabilities and management information systems, to develop clinical protocols and financial reserves, and to support physician

and nonphysician leaders willing to say no when necessary.

The current backlash against capitation and integrated health care cannot lead America back to a future of fee-for-service and solo practice, because of the inherently inflationary proclivities of traditional financing and delivery mechanisms. It is possible to envisage a delivery system without managed care but not one without continuing pressures to restrain cost growth. The most important short-run changes now are occurring on the demand side of the health care market, as governmental programs and private employers retreat from the paternalism of yesteryear and gradually shift responsibility for choice, use of quality data, and cost sharing onto beneficiaries and employees. Changes in demand inevitably will trigger changes in health care supply, however, as physicians and other providers encounter an ever more price-sensitive consumer.

**A** NEW HEALTH CARE SYSTEM is being forged in the crucible of managed care and the backlash against it. This new system will embrace a consumerism intermediate between cost-unconscious demand and top-down controls, will pay physicians through methods that blend elements of fee-for-service and capitation, will demand a medical professionalism that includes both individual responsibility and collective accountability, and will support entities that lie somewhere on the continuum between solo practice and vertical integration. Organizational innovations are sprouting up in all states, in all clinical sectors, and with every form of sponsor. Single-specialty practice management companies are regrouping and organizing individual specialties to compete with multi-specialty organizations. Hospital systems are structuring themselves internally along product lines, sharing equity and authority with selected specialists, and competing against ambulatory centers and short-stay facilities. Broad-panel insurance products are experimenting with networks within networks, carving in and carving out subsets of providers based on price, convenience, and consumer satisfaction. Internet entrepreneurs are developing episode-of-care pricing methods, health banking accounts, chat rooms and bulletin boards, and mechanisms that allow consumers to construct personal medical networks. California, the battered birthplace of physician-led managed care, is awash with venture capital, Internet start-ups, and clinical entrepreneurs looking for the new new thing. The question is whether the emerging health care system will be built on medical group foundations or, rather, seek to coordinate physicians individually, without the efficiency, fraternity, factionalism, and chaos of physician organization.

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## NOTES

1. For the early history of physician organization in California outside the Kaiser Permanente system, see L.P. Casalino and J.C. Robinson, *The Evolution of Medical Groups and Capitation in California* (Oakland: California HealthCare Foundation, 1997); and R. Gumbiner, *FHP: The Evolution of a Managed Care Health Maintenance Organization, 1955–82* (Berkeley: University of California Press, 1995). For a history of Kaiser Permanente, see J.G. Smiley, *Can Physicians Manage the Cost and Quality of Medical Care? The Story of the Permanente Medical Group* (New York: McGraw-Hill, 1991).
2. J.C. Robinson and L.P. Casalino, "The Growth of Medical Groups Paid through Capitation in California," *New England Journal of Medicine* 333, no. 25 (1995): 1684–1687; J.C. Robinson and L.P. Casalino, "Vertical Integration and Organizational Networks in Health Care," *Health Affairs* (Spring 1996): 7–22; M.J. Penner, *Capitation in California: A Study of Physician Organizations Managing Risk* (Chicago: Health Administration Press, 1984); and E.A. Kerr et al., "Managed Care and Capitation in California: How Do Physicians at Financial Risk Control Their Own Utilization?" *Annals of Internal Medicine* 123, no. 7 (1995): 500–504.
3. B. Shenkin, "The Independent Practice Association in Theory and Practice," *Journal of the American Medical Association* 273, no. 24 (1995): 1937–1942; and K. Grumbach et al., "Independent Practice Association Physician Groups in California," *Health Affairs* (May/June 1998): 227–237.

4. J.C. Robinson, "Consolidation of Medical Groups into Physician Practice Management Organizations," *Journal of the American Medical Association* 279, no. 2 (1998): 144-149.
5. Medical groups obtained global capitation under a variety of legal structures, including purchasing their own hospitals, being purchased by a hospital system, forming a dual-contract partnership with a hospital or hospital system, obtaining a limited ("Knox-Keene") insurance license, or negotiating with HMOs for a hospital services risk-sharing arrangement where up to 99 percent of the surplus went to the medical group rather than back to the insurer. For an extended comparison of the four core forms of physician organization (multispecialty clinics, IPAs, physician-hospital organizations, and practice management firms), with examples from California and other states, see J.C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Berkeley: University of California Press, 1999).
6. The consultant estimated that thirty medical groups per year were going bankrupt but used as its definition of "medical group" the conventional definition of three or more physicians practicing together. It never claimed that thirty groups and IPAs of the size adequate to contract with an HMO were going bankrupt, nor that thirty per year represented an increase in the normal rate of organizational turnover in a state with 70,000 physicians. Nevertheless, the thirty per year estimate, tripled to cover three years and then divided by the denominator of 250 large physician organizations, produced the erroneous though widely propagated allegation that one-third of California's medical groups had gone under.
7. Medicare explicitly linked its HMO payments to fee-for-service costs in each region, and the commercial HMOs shadow-priced more traditional carriers.
8. Blue Cross of California has always maintained a large book of indemnity and then PPO enrollment. For a decade (late 1970s to late 1980s), however, it placed great emphasis on building its capitated HMO product in the then common expectation that prepaid group practice was the delivery model of the future. It subsequently recognized the consumer preference for broad choice and the diseconomies of scale attendant to physician organization. WellPoint currently emphasizes open-access, noncapitated products in most states.
9. L.R. Burns et al., "The Fall of the House of AHERF: The Allegheny Bankruptcy," *Health Affairs* (Jan/Feb 2000): 7-41; and Robinson, *The Corporate Practice of Medicine*.
10. Innumerable examples could be cited as evidence of the investment community's skepticism concerning Medicare, capitation, and the medical group model of managed care. For example, see C.A. Boorady and N. Pyle, *Managed Care: Second Quarter Industry Preview and Model Book* (New York: Goldman Sachs Investment Research, 14 July 2000); G.E. Harris, M.J. Ripperger, and H.G.S. Horn, *Managed Care Industry* (New York: Warburg Dillon Reed, 15 December 1999); and L.C. Marsh, A.T. Feinstein, and J.R. Raskin, *Managed Care Industry Guidebook* (New York: Lehman Brothers, 27 October 1999).
11. For discussions of the strengths and limitations of virtual integration and relationship contracting, see O.E. Williamson, *The Economic Institutions of American Capitalism* (New York: Free Press, 1985); and H.W. Chesbrough and D.J. Teece, "When Is Virtual Virtuous? Organizing for Innovation," *Harvard Business Review* (Jan/Feb 1996): 65-73.
12. This statement obviously does not refer to the close and ongoing relationships between the Kaiser HMO and Permanente Medical Groups in northern and southern California.
13. D. Emery, *Global Fees for Episodes of Care* (New York: McGraw Hill/Healthcare Financial Management Association, 1999).