

Shifting Ground: Erosion of the Delegated Model in California

Introduction

California is unique in the extent to which health plans contract with medical groups and independent practice associations (IPAs) on a capitated—a fixed per-member, per-month—basis and delegate responsibilities, such as utilization management and credentialing, to these physician organizations. California physicians have embraced the reduction in health plan oversight and the opportunity for financial reward for efficient practice, while health plans believe these arrangements have helped to control costs and premium increases. Indeed, this “delegated model” may have significantly contributed to California’s relative success in containing health care costs over the past two decades.

However, the Center for Studying Health System Change’s (HSC) recent site visits to six California regions found that the delegated model is being threatened by three emerging market developments. The first involves a general enrollment shift from health maintenance organization (HMO) to preferred provider organization (PPO) products. While this is a national trend, more stringent regulation of HMOs and PPOs in California may be intensifying the shift. The second factor is a health plan market development whereby two leading California insurers are now being managed from out of state: PacifiCare, acquired by UnitedHealth Group, and Anthem Blue Cross of California, whose management has shifted to the Anthem corporate office in Indiana. These insurers reportedly are less interested in supporting a provider contracting model distinctive to

California. Third, there has been a sharp general increase over the current decade in provider leverage over health plans. Although many medical groups remain enthusiastic about the delegated model, some perceive opportunities in the current health care environment to achieve higher incomes by switching to fee-for-service payment.

The erosion of the delegated model in California may have important implications for health care spending trends in the state, and for federal efforts to develop new provider payment mechanisms that include elements of capitation. This issue brief, based on extensive interviews with stakeholders in six California market regions, examines both the success of the delegated model in California and pressures on the model in recent years.

Delegated Model Historically Entrenched in California

Long before the cost crisis of the late 1980s prompted broader interest in tightly controlled managed care products, HMOs flourished in California. Kaiser Permanente, the nation’s largest HMO, was founded in California in 1945 and has played a key role in shaping the state’s health care market ever since. In part because of the presence of Kaiser, with its exclusive physician group practice and ownership of hospitals and other facilities, and spurred by favorable changes in federal law in the 1970s, California insurers were in the vanguard of HMO product development.

HMOs other than Kaiser contracted nonexclusively with medical groups or IPAs to care for patients, usually on

HSC's Six-Community Market Study

In fall 2008, a team of researchers from the Center for Studying Health System Change (HSC) conducted site visits to six California communities to study those markets' local health care systems and to gain insights into regional characteristics in health care affordability, access, and quality. The six markets — Fresno, Los Angeles, San Francisco Bay Area, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions. Approximately 300 interviews were conducted between October and December 2008 in the six communities with representatives of hospitals, physician organizations, health plans, major employers, benefit consultants, insurance brokers, community health centers, state and local policymakers, and other stakeholder organizations.

The present issue brief is based primarily on interviews with health plans, physician group practices, IPAs, employers, and benefits consultants. A two-person research team conducted each interview, and notes were transcribed and jointly reviewed for quality and validation purposes. The interview responses were coded and analyzed using ATLAS.ti, a qualitative data management software tool.

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a capitated basis and with tight administrative controls on care use. Medical groups are financially integrated entities (typically partnerships of physicians), while IPAs contract with independent physicians, often taking over from insurers the financial risk of capitation while paying physicians on a fee-for-service basis, using administrative mechanisms to manage utilization. As physicians assumed financial risk for patients' care through capitation, they developed the infrastructure and expertise to also assume administrative and care management responsibilities otherwise retained by the insurers. Under this delegated model, which is used only in HMO products, insurers delegate certain responsibilities, such as provider credentialing, utilization management, and chronic disease management, to a group of physicians, most often a multi-specialty group practice or an IPA. PacifiCare, now part of UnitedHealth Group, pioneered the delegated

model, but all major California health plans contract with at least some physician organizations using this approach.

Usually, capitation contracts applied only to professional services, and to ancillary services such as laboratory testing, although hospitals also sometimes took per-capita risks for their services. Delegation of financial risk for prescription drugs, although initially common, was largely abandoned a decade ago when physicians recognized that drug utilization was not as predictable and controllable as they had believed.

Conditions in California have been much more favorable for the delegated model than elsewhere. The presence of large medical groups, some with close relationships to hospitals, made easier the development of the required practice-management infrastructure, and competition with Kaiser Permanente likely contributed to physician receptivity to this approach. Health plans outside of California often choose not to pursue this model because delivery systems elsewhere

are generally more fragmented and, therefore, less able to effectively manage utilization and costs.

The delegated model also took hold in California because physicians value the freedom it affords from utilization management by health plans. They also appreciate being financially rewarded for efficient care delivery, particularly for activities that they believe constitute good medical practice, such as actively managing chronic disease and avoiding unnecessary utilization. Health plans, for their part, support the model because they perceive that under many circumstances physician organizations are able to manage care more efficiently than they can.

Although not studied extensively, the delegated model may have played an important role in shaping health care delivery in California. Earlier site visits conducted by HSC as part of its Community Tracking Study found support for the assertion that the delegated model led to lower costs in HMOs and, consequently, to higher HMO enrollment in California compared to the rest of the country.¹ California has had lower cost trends than the rest of the country, declining from 100 percent of the national average in 1991 to 88 percent in 2004. Expansion of the delegated model may have contributed to this lower cost trend.² Also, some respondents attributed early adoption of the hospitalist model in California—in which hospitalized patients are managed by a hospital-based physician rather than by their community physician—to the delegated model because of physician organizations' incentives to contain costs.

The Diminishing Position of the Delegated Model in California

The delegated model has persisted in California because some physicians and health plans continue to see its value. But changing market conditions in the state suggest that use of the delegated model is declining. Three major factors have played a role in this. First, the health insurance market is shifting from HMO products to PPO products, and the delegated model is used only in HMOs, where provider

responsibility for an enrollee's medical care use can be clearly established. Second, national health plans have been standardizing their strategies across the country and are less inclined to invest in distinct strategies for California. This trend reportedly accelerated with PacifiCare's acquisition by UnitedHealth Group and with increasing centralization, in Indianapolis, of the management of Anthem Blue Cross. Third, some physicians' attitudes toward the delegated model have changed, in part because of overall increased physician leverage with health plans, and in part because of the diminishing share of enrollees covered by HMOs generally and the delegated model specifically.

MARKET SHIFT FROM HMOS TO PPOS

Nationally, the market for private insurance has been shifting from HMO to PPO products over time. For employer-based coverage, the proportion of those enrolled in HMO or HMO/point-of-service (POS) products declined from 45 percent in 2002 to 32 percent in 2008; California has long had much higher enrollment in HMO/POS products, but this has declined over the same period from 70 percent to 63 percent.³ Respondents in the present study indicated that the shift is stronger in northern California than it is in southern California. They suggested that commercial—private employer-sponsored and individual coverage—PPO enrollment in California has been gradually increasing at the expense of enrollment in non-Kaiser HMO products. In contrast, HMO enrollment among individuals obtaining commercial health insurance coverage from public employers has been relatively steady, likely because of these employers' continued commitment to comprehensive benefits with low patient cost-sharing.

Some of the shift from HMO to PPO products also reflects a national trend that began with the managed care backlash of the mid 1990s, when consumers demanded more freedom to choose their physicians and hospitals. PPOs provide this option for consumers (albeit at a higher price if care is sought from an out-of-network provider). Because

HMOs, PPOs, and Capitation

Although their descriptive titles both include the term organizations, HMOs and PPOs are different types of health insurance products. HMOs traditionally provide very comprehensive benefits that can be obtained only from network providers; the newer POS variant in the HMO product provides access to out-of-network providers but at higher cost to the patient. With HMO products, plans can contract with providers on either a capitated (fixed payment per enrollee, per month, for all services or only some types of services) or on a fee-for-service basis. The differences in these payment methods do not affect the consumer directly, but might have indirect effects as a result of the different incentives they present to providers.

PPO products, on the other hand, are adaptations of traditional health insurance in which network providers agree to a price schedule and patients pay specified cost-sharing, such as a deductible and coinsurance. Services by other providers are covered, but patients have higher cost-sharing for out-of-network care and are responsible for the differences between what these outside providers charge and what the plan allows. For PPO products, providers contract with health plans on a fee-for-service basis. Most large health plans offer both HMO and PPO products. Even Kaiser Permanente, widely known for its HMO products, now offers PPO products as well.

PPOs offer more freedom to enrollees in this respect, some employers see them as better suited to serve employees' desires for a more consumer-centric health care system.

One could view the decline in enrollment of non-Kaiser HMOs in California as both caused by and contributing to the erosion of the delegated model. In northern California, physicians and hospitals have more aggressively consolidated their market power through mergers and acquisitions, placing them in a better position to negotiate favorable contracts with non-Kaiser HMOs. In the past, HMOs periodically negotiated with providers with the understanding by both that the provider would be dropped from the HMO's network if a satisfactory agreement could not be reached. This was a credible threat, given that the

HMO business model did not rely on including all, or even most, local providers in plan networks, and other network providers would be available to serve member needs. Provider consolidation has reduced this threat, since dropping the consolidated provider organization could leave geographic gaps in an HMO's network and thus make the HMO product less attractive to employers and their employees. As a consequence, provider leverage with HMOs in price negotiations has increased, placing upward pressure on HMO premiums, thereby reducing the cost advantage that HMOs have traditionally enjoyed relative to PPOs. As this process has played out, PPOs have become more attractive to many employers and their employees, when compared to HMO products, and the delegated model has become increasingly difficult to sustain.

An important factor that now appears to be reinforcing this dynamic is the pressure that employers are placing on PPOs to lower their premiums by increasing patient cost-sharing. The PPO benefit structure lends itself to increased cost-sharing through higher deductibles and coinsurance and narrower covered benefits. In contrast, a competitive advantage of HMOs has been their ability to offer a competitively-priced product with comprehensive benefits and limited patient cost-sharing. Respondents reported that cost-sharing in HMOs has increased somewhat, but that HMOs have less room than PPOs to make such adjustments. As one respondent noted, "There aren't many plan design options that can be made, especially on an HMO non-self-funded platform." The results are now becoming evident in the marketplace. While HMOs have long been viewed as a low-cost option in the health insurance market, one insurer respondent reported that, according to their internal data, in only one quarter of the counties where it offers both a PPO and an HMO product do the HMOs have lower overall total cost of health care.

A second factor contributing to the decline of HMO enrollment and the use of the delegated model in provider contracts is the desire of some national employers to trim

administrative burden and costs by offering the same health benefits to all employees, irrespective of employee residence. Large national insurers can accommodate this employer demand by offering a standardized PPO product throughout the country. To the extent that this strategy has been implemented in California, there has been a reduction in the non-Kaiser HMO products offered to employees in the state, contributing to the overall HMO enrollment decline.

A third factor was highlighted by HMO executives as being significant in creating a competitive disadvantage for HMOs relative to PPOs, and as therefore accelerating the erosion of the delegated model in provider contracts: the lack of a level regulatory playing field between HMOs and PPOs in California. In California, regulatory oversight for HMOs and PPOs is provided by different state agencies: the Department of Managed Health Care (DMHC), which oversees all HMO products and most of the fully-insured PPO products provided by Anthem Blue Cross and California Blue Shield; and the Department of Insurance (CDI), which regulates the remainder of the PPOs and other insurance products. Self-insured employer plans are subject only to limited regulation by the U.S. Department of Labor, and most of these are PPOs.

Health plan respondents contended that DMHC's enforcement of consumer protection measures is overzealous, unnecessarily adding to HMO costs. They argued that contracting with efficient providers and eliminating inefficient providers from their HMO networks is essential to their ability to contain costs and compete with PPOs, which are not regulated by DMHC. For example, health plan respondents cite recent DMHC decisions, intended to protect enrollee access to providers, which make it more difficult for plans to terminate HMO contracts with providers that demand relatively high payment rates. Plans must get permission from DMHC to drop a hospital from a network, a time-consuming and uncertain proposition. Also, plans are required to pay the hospital full charges while the agency reviews the adequacy of their HMO network.

Plan respondents said that permission to terminate is usually denied. Products regulated by the CDI, on the other hand, do not require similar approvals to make provider network changes. The same is true for self-insured plans. To the degree that DMHC regulation of HMO products increases costs, their cost advantage over PPOs diminishes; similarly, self-insured employers have less motivation to offer fully insured HMOs alongside self-insured PPOs.

HEALTH PLAN STRATEGIES GO NATIONAL

Health plan consolidation at the national level and the subsequent shift in management of some key California plans outside of the state have also contributed to erosion of the delegated model. National health plan strategies have emphasized PPOs over HMOs in general. And since the delegated model is not prevalent outside of California, national plans have little motivation to include this model in their national product. The shift to national plans that exclude the delegated model was perhaps most striking in United's 2005 acquisition of PacifiCare, which had pioneered the model.

Numerous respondents commented that management and strategy changes at United and WellPoint indicated that major decisions were made at the companies' headquarters in Minnesota and Indiana, respectively, with increasingly less consideration of the distinct features of the California market. As one medical group executive noted, "The mindset of the big national players is that delegated capitation doesn't work." Rising HMO costs relative to PPO costs in California also may further contribute to this trend. A medical group executive lamented that if "there isn't the difference in quality and cost in the two models, [why] pay capitation to groups?" Several respondents also pointed to United's limited experience in contracting with medical groups and IPAs in California before acquiring PacifiCare.

Other developments within the California insurance market also may have contributed to erosion in use of the delegated model. Respondents indicated that United had lost

“a lot of [PacifiCare’s] relationship equity as it centralized its decision-making outside the California market; it also suffered from many customer service problems during the acquisition of PacifiCare.” As a result, other health plans, most of which did not emphasize capitation as much as PacifiCare, were able to attract dissatisfied PacifiCare members. For example, Blue Shield reportedly increased its membership substantially, in part at PacifiCare’s expense.

PROVIDER SUPPORT FOR DELEGATION

In many medical groups, longstanding support for the delegated model continues, as do the reasons for that support. A respondent in Los Angeles said, “We still do [seek capitation] because we can manage it through utilization,” and a respondent in another community reported that “Capitation creates the right financial incentives and creates efficiency.” Some respondents suggested that the delegated model is becoming increasingly effective at increasing efficiency and quality, aided by electronic medical records that enable IPA physicians to practice in a more coordinated fashion. A medical director of a physician organization that includes both a medical group and an IPA predicted that, in time, the IPA physicians will have lower per capita costs than those in the medical group. This would be a reversal from the longstanding pattern of IPAs being unable to achieve per capita costs as low as those of capitated medical groups.

Some respondents see capitation simply as a way for physicians in an organized group to make more money. Others, however, view it as a path to higher quality care. A medical group respondent declared, “Even though financially it might be in our best interest to drop capitation, we believe the alignment for physician relationships helps drive the quality.” Another delegated-model enthusiast expressed disdain for the fee-for-service alternative, describing it as “doctors eat[ing] what they kill. The gimmick is to do more, because the more they do, the more they get paid.”

IPAs provide continuing strong support for the delegated model, at least in part because IPAs have less freedom than

medical groups to abandon the model. Federal antitrust law constrains IPAs from negotiating payment rates with health plans unless such negotiation is necessary for financial or clinical integration. The absence of joint financial risk makes it more difficult to conform to Federal Trade Commission and Department of Justice guidelines on joint negotiation of prices. Thus, when the payment structure is fee-for-service, individual medical practices often must negotiate separately with health plans—without the IPA’s clout and thus with diminished bargaining advantage.

Despite continued support for capitation among many physicians, enthusiasm for it is less widespread than in the past. Some believe that the shift in leverage from health plans to providers over time is the key factor behind this change. Plans had substantial leverage over hospitals and physicians in the early to mid 1990s because of both excess provider capacity and greater consumer acceptance of networks with less choice of provider. At the time, physicians saw capitation as an opportunity to avoid cuts in income from declining fees—under capitation, declining payment could be offset, at least in part, by reducing utilization.

Today, the leverage situation is reversed. Provider capacity is tight and consumers have less tolerance for narrow provider networks. While small physician practices in California tend to receive relatively lower payment rates from commercial insurers than from Medicare, larger and more specialized practices are often able to negotiate considerably higher rates. In addition, physicians aligned with hospitals that have contracting leverage gain higher rates to the extent that hospitals negotiate rates for them.⁴ Physicians in practices with negotiating leverage are thus less likely to continue taking on the challenges of the delegated model.

Avoiding stringent utilization management by health plans was another motivating factor behind physicians’ preference for the delegated model in the 1990s. But, in response to the managed care backlash, utilization management by plans is less restrictive now, so there is less

utilization-related motivation for physicians to choose the delegated model.

As previously discussed, the dwindling share of HMO enrollment in the non-Kaiser segment of the commercial insurance market is another factor impacting the delegated model. As the percentage of patients covered under the delegated model diminishes, it becomes less compelling for a practice to invest the resources needed to manage under this model. Some respondents also suggested that the declining HMO market share is exacerbating adverse selection, with those in poorer health remaining in HMOs because of lower

patient cost-sharing while comparatively healthier individuals choose lower-cost PPOs, thus making it more difficult for physicians to succeed financially with the delegated model.

Conclusion

The delegated model of managed care has been seen by many as particularly effective—engaging physicians to take responsibility for such activities as managing utilization, instead of leaving it to insurers to do through authorizations and claims review. The model also engages physicians in managing the care of patients with chronic conditions, which often involves promoting effective preventive activities and coordinating care. The delegated model may have played an important role in California’s success, relative to other states, in containing costs over a long period of time.

To the extent that use of the delegated model in California is declining, however, the continuing effect of these accomplishments is threatened. Indeed, should the decline in HMO enrollment and the delegated model continue, California could experience higher spending trends than the rest of the nation. Given the current stress on the state’s economy, higher spending trends would be particularly burdensome to both employers and consumers.

Some of the factors behind the erosion of the delegated model, such as diminished interest in the model by national insurers, cannot be addressed by state policymakers. But state officials might examine whether HMO regulation, meant to protect consumers, has in fact made the HMO product less attractive to some consumers by increasing its costs. Such regulation may leave fewer consumers with access to the benefits of the delegated model for two reasons: first, by reducing the number of people covered by commercial insurance products that incorporate the delegated model; and second, in the longer term, by diminishing health plans’ and providers’ interest in supporting the model as it accounts for a decreasing share of their business.

Leaving the Delegated Model:

The Scripps Health Example

The 2006 shift by Scripps Health from capitation to fee-for-service payment for commercial HMO patients was a significant event in the San Diego market. The other major integrated delivery system in the market, Sharp HealthCare, has continued to use the delegated model. As a highly-regarded delivery system, Scripps has the leverage to negotiate attractive fee-for-service rates for its medical groups. Problems with adverse selection were pointed to as a factor in the decision by Scripps to move away from the delegated model. Scripps believed that a significant number of HMO enrollees who had designated a primary care physician outside of Scripps were transferring to a Scripps physician when afflicted by serious disease, such as cancer, because of the system’s reputation for outstanding specialty care. This meant that Scripps did not have capitation payments from those enrollees’ healthy years to balance the high spending that resulted from treating the serious disease.

Employers believe that the shift by Scripps to a fee-for-service system has substantially increased their insurance premiums. In response, some health plans have developed narrow-network HMO products that exclude Scripps Health. Respondents indicated that these products have been successful in some segments of the San Diego market, although the long-term impact of these narrow-network products remains to be seen. The magnitude of the shift to narrow-network products will likely determine the degree to which abandoning the delegated model is an effective strategy for integrated delivery systems.

Capitation and Medicare: Accountable Care Organizations

Federal policymakers are currently exploring how to bring elements of capitation into the traditional Medicare program through Accountable Care Organizations (ACOs), in which providers would take some responsibility for the amount of spending per beneficiary and for quality of care. ACOs would use a shared-savings model that incorporates capitated incentives by continuing to pay providers on a fee-for-service basis but that also includes bonuses for improved efficiency (measured on a per-enrollee basis) and quality.⁵ Federal policy discussions have emphasized the negatives of fee-for-service payment, such as its built-in incentives to generate increased volume and its lack of incentives to coordinate patient care.

California's experience with the delegated model provides an interesting context for Medicare ACO proposals. California medical groups and IPAs with highly developed infrastructures and extensive experience managing care through the delegated model are well positioned to succeed as ACOs, should they choose to. As one respondent put it, "the proliferation of local experiments [with the delegated model] has given us a strong foundation to guide the country." But the erosion of the delegated model in California can also be seen as a caution to such a federal initiative, both in California and nationally. Just as increasing provider leverage and a diminishing share of patients affected by capitation have undermined the delegated model in California, the relatively modest scope of proposed ACO payment arrangements (which involve limited financial incentives and initially would apply only to patients in traditional Medicare) may limit their ability to reshape the delivery of care.

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California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to www.chcf.org/topics/almanac.

ENDNOTES

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- 5 See California HealthCare Foundation. *Reforming Physician Payments: Lessons from California*, September 2009.