ASSEMBLY COMMITTEE ON HEALTH

INFORMATIONAL HEARING
Thursday, February 15, 2001
1:30 p.m., Room 4202

Medical Group/IPA Bankruptcy and Insolvency. What happens to patients when a medical group or IPA closes?

Note: This hearing continues the Assembly Health Committee hearing that was begun January 17, 2001, but was stopped midway because members were asked to return to session due to the energy crisis. At the first hearing, the Committee heard testimony from the following individuals:

Chris Ohman, President/CEO
CapMetrics
Meredith Rosenthal, Ph.D
Assistant Professor of Health Economics and Policy
Department of Health Policy and Management
Harvard School of Public Health
Ron Bangasser, MD
Medical Director, Beaver Medical Group
Seth Jacobs, Senior Vice President, General Counsel and Corporate Secretary
Blue Shield of California

In the briefing material are copies of their PowerPoint presentation or the written testimony/ comments submitted by those individuals. Additionally, the written testimony/comments of the following individuals who did not get an opportunity to testify are attached: Shelley Rouillard (Health Rights Hotline), Joy Higa (Department of Managed Health Care) and Beth Capell, Marjorie Swartz and Earl Lui on behalf of Health Access California, Consumers Union and Western Center on Law and Poverty.

Introduction

The recent bankruptcies and closures of major physician organizations has elevated public concern about the financial solvency of medical groups that deliver care on behalf of HMOs.

Caught in the middle of a financial, legal, political and public relations struggle between health plans and medical groups are patients.

When a medical group experiences financial difficulty, patients may have longer waits to receive care and difficulty accessing specialty care. When a medical group closes its doors, patients may have to be transferred to new providers or medical groups with the capacity to accept new patients. Changing physician groups may also change the specialists, home health care and durable medical equipment providers available to a patient. Procedures and appointments have to be rescheduled, and lab results, diagnostic tests, and medical records have to be transferred to new providers. Patients undergoing a course of treatment may have their relationship with their physician disrupted, affecting the patient's continuity of care.

The November 2000 closure of KPC Medical Management affected over 240,000 health plan enrollees with private commercial and Medicare coverage, as well as enrollees in the Healthy Families and Medi-Cal programs. The closure left patients without primary care physicians, health care and equipment providers with unpaid claims, and employees of KPC's network of clinics without jobs.

The members of the Assembly Health Committee will hear testimony from experts, stakeholders and regulators of the state's health care service plans on medical group financing, insolvency and its implications for policymakers and patients. In past legislative sessions, the financial battles between health plans, providers and medical groups have involved a number of legislative proposals that address various aspects of medical group financing and solvency. Legislation has been introduced over the last two sessions to require the Department of Managed Health Care (DMHC) to report regarding the need for legislation to expand the Department's existing jurisdiction over medical groups, independent practice associations, and other provider groups that bear significant financial risk, to require health plans to update the actuarial reports required at the time of licensure with an opinion by an actuary as to whether capitation payments are computed appropriately, to prohibit medical groups from accepting financial risk for prescription drugs, to allow health plans to enter into a direct full at-risk (physician and hospital) capitation contract with an integrated health services provider, and to increase the financial penalties imposed on health plans for late payment of provider claims. The Committee will hear testimony from many of the participants in this tug-of-war, who will provide their views on a variety of issues, including California's model of managed care, how patients are affected when medical groups and independent practice associations (IPAs) close, the solvency of medical groups, and the proposed draft regulations of the DMHC's Financial Solvency Standards Board.

The California Model of Managed Care

The growth of managed care has brought changes to the delivery and financing of health care. Physicians have shifted from practicing independently or in small groups to affiliating with organized provider groups (such as medical groups and IPAs). The method of paying health care providers has shifted from fee-for-service reimbursement to individual providers to capitation payments to an organized provider group in which the provider group is paid a fixed amount for

each person served for a period of time, regardless of the amount or type of services provided. Within the medical group or IPA are numerous methods of compensating individual health care providers.

According to "Health Care Trends and Indicators in California and the United States," in January 1999, 52% of California's population or 17 million people were enrolled in an HMO, compared to 30% nationally. Five HMOs in California accounted for 13.2 million or 77.7% of the state's total HMO enrollment (a figure which includes Kaiser's 5.8 million enrollees).

In California, health plans (primarily HMOs, which are "closed-panel" health plans) contract with groups of physicians such as integrated medical groups or IPAs to deliver health care to the health plan's enrollees. IPAs are groups of affiliated physicians working in their own private practices, and physicians may belong to more than one IPA. Physicians who belong to a medical group typically share offices, equipment, records, personnel and expenses. Because the health plan delegates clinical-decision making, utilization review and claims payment to the IPAs and medical groups, this model is often called the "delegated model."

The medical groups and IPAs receive a fixed capitation payment from the health plan for each person enrolled in the group. The capitation contract puts the medical group at direct financial risk for the delivery of care to the health plan's enrollees. If the cost of care for a group's enrollees is greater than the capitation payments for those enrollees, the medical group loses money. Capitation payments from health plans serve a number of purposes, including:

- Controlling health care costs;
- Providing a predictable payment 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.

When a medical group accepts capitation payments, they assume insurance risk. There is uncertainty about whether medical groups have the information systems, management expertise, financial stability and reserves necessary to successfully assume financial risk, and how this affects clinical practice and patient care. A capitated medical group with inadequate financial reserves runs the risk of becoming insolvent, which may disrupt patient care.

Why Are Some Physician Groups in Financial Trouble?

The answer to the above question depends upon whom one asks: providers and medical groups are likely to cite faults with the adequacy of payment and data they receive from health plans, and health plans are more likely to cite the management failures and lack of financial reserves of medical groups. Commonly cited reasons for the financial difficulties encountered by medical groups include the following:

- Inadequate, flat or reduced capitation payments from health plans;
- Reduced Medicare payments due to the federal Balanced Budget Act of 1997;
- Reduced revenues from hospital risk pools;
- Increased prescription drug costs;
- New drugs and medical technology;
- Inadequate data from health plans;
- Unfunded legislative mandates;
- Increased specialty care costs;
- Poor management;
- Inadequate cash reserves;
- Disproportionate health plan market leverage in California;
- Lack of information systems and actuarial experience;
- Insufficient size.

The Department of Managed Health Care (DMHC) and the Knox-Keene Act

The DMHC regulates and licenses health plans under the Knox-Keene Plan Act of 1975 but does not license or directly regulate medical groups. Portions of the Knox-Keene Act relevant to this hearing include the following, which:

1. Require each health care service plan to meet specific requirements, including requiring health plans:

   (a) to furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice;

(b) to make all services readily available at reasonable times to all enrollees, and to the extent feasible, the plan is required to make all services readily accessible to all enrollees;

(c) to have the organizational and administrative capacity to provide services to subscribers and enrollees. (Section 1367)

2. Require the health plan to have and demonstrate to the Director that it has a fiscally sound operation and adequate provision against the risk of insolvency (Section 1375.1), and establishes specific tangible net equity requirements for health plans through regulation. (Section 1300.76 of Title 10 of the California Code of Regulations)

3. Require health plans, at the request of an enrollee, to arrange for the continuation of covered services from a terminated provider to an enrollee who is undergoing a course of treatment from that terminated provider for an acute condition, serious chronic condition, or a high-risk or 2nd or 3rd trimester pregnancy at the time of contract termination, as specified. (Section 1373.96)

SB 260 and the Financial Solvency Standards Board

In 1999, the Legislature passed and Governor Davis signed into law SB 260 (Speier, Chapter 529, Statutes of 1999), which established the Financial Solvency Standards Board. Composed of seven members and the Director of DMHC, the board's purpose is to:

(1) Advise the Director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the Director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Monitor periodically and report on the implementation and results of financial solvency requirements and standards.

SB 260 also requires every contract between a health plan and a risk-bearing organization to include provisions concerning the risk-bearing organization's administrative and financial capacity. Risk-bearing organizations are required to furnish financial information to the health plan, and to meet any other financial requirements that assist the health care service plan in maintaining the financial viability of the plan's arrangements to provide health care services in a manner that does not adversely affect contract negotiations. Health plans are required to disclose information to the risk-bearing organization that enable the risk-bearing organization to be informed of the financial risk it assumes under the contract with the plan.

SB 260 also requires the Director of DMHC to adopt regulations on or before June 30, 2000, to provide for the following:

(a) A process for reviewing or grading risk-bearing organizations based on specified financial criteria.

(b) Audits to be conducted in accordance with generally accepted auditing standards of the risk-bearing organization.

(c) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles.

(d) A process for a mutually agreed upon corrective action plan where the review or grading indicates deficiencies that need correction, and contingency plans if the corrective action plan fails. The corrective action plan is required to be approved by the Director. If the health plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the Director is required to determine the corrective action plan.

(e) Disclosure by the health plan of enrollee information, risk arrangements and information on incentive payments and income and expenses assigned to the risk-bearing organization to enable the risk-bearing organization to be informed regarding the risk assumed under the plan contract.

A copy of the latest draft regulations promulgated by the Financial Solvency Standards Board is attached.

Discussion Questions:

- When a medical group fails, how is patient care impacted?
- Are health plans meeting their obligations under the Knox-Keene Act to provide continuity of care and geographic accessibility to care when their contracting medical groups close?
- Do existing laws and regulations adequately protect the public when medical groups are encountering financial difficulties or become insolvent?
- If implemented, how will the Financial Solvency Standards Board's draft regulations affect the financial viability of medical groups and IPAs?
- Should medical groups and IPAs that accept financial risk have to meet specific financial solvency standards?
- Why do some medical groups and IPAs succeed when others fail?
- Should state law restrict what services can be included in a capitation payment from a health plan to a medical group?
- Should provider organizations be able to accept full risk or global capitation in which the medical group assumes the financial risk for professional (primary and specialty care) and institutional (hospital) care?
- What is the basis for the claim that capitation payments to providers are inadequate?

Sources:

(The following were provided to members in the first hearing. Additional copies are available from the Health Committee.)

Brewster, Linda R., Leslie Jackson, Cara S. Lesser. "Insolvency and Challenges of Regulating Providers that Bear Risk." *Issue Brief Findings from Center for Studying Health System Change*. February 2000, Number 26.

Bodenheimer, Thomas. "California's Beleaguered Physician Groups -- Will They Survive?" *New England Journal of Medicine*. (2000) April 6, 2000 -- Vol. 342, No. 14.

Casalino, Lawrence, James C. Robinson. "The Evolution of Medical Groups and Capitation in California." *Kaiser Family Foundation*. September, 1997.

Figueroa, Richard. State Senator Jackie Speier, Chair, Senate Insurance Committee, Senate Insurance Committee Oversight Hearing on Risk-Bearing Entities: Limited License Plans, Medical Groups, and Independent Practice Associations. March 10, 1999.

Fountain, Douglas L., Joy M. Grossman, Roger S. Taylor, Effie Gournis, Claudia Williams. "Market in Turmoil As Physician Organizations Stumble" Community Report, Center for Studying Health System Change. Spring 1999.

Schauffler, Helen. "A Risky Proposition? Risk-Bearing and Solvency in California's Medical Groups" California Health Policy Roundtable Policy Brief. February 2000.

Schauffler, Helen, Sara McMenamin, Hal Zawacki, Larry Levitt, Janet Lundy. "Health Care Trends and Indicators in California and the United States - A Chartbook from the Kaiser Family Foundation." Kaiser Family Foundation. June 2000.