CHAPTER TEN

THE LIMITS OF PREPAID GROUP PRACTICE

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Rarely in health policy has so much been expected by so many from so few. Prepaid group practice (PGP) has been conceptualized by its sponsors as combining the organizational locus for physician collegiality with the economic incentives for practice efficiency and the marketplace context for informed, price-sensitive consumer choice.[1] Through various methods in various markets, prepaid group practice has achieved these goals, exerting a dramatic effect on the structure and performance of the health care system. It has moderated cost inflation, enhanced coverage for preventive services, focused attention on chronic disease management, and more generally, demonstrated that America can do better than a fragmented system of independent practitioners, piece-rate payment, and uninformed, cost-unconscious consumer choice.[2] Yet without doubt, the penetration and performance of prepaid group practice have fallen short of the anticipations of its advocates and even of the more cautious predictions of purchasers and policymakers.

After rising for two decades, the tide of consumer enrollment, entrepreneurial energy, and political interest has ebbed to the point where textbook PGPs are difficult to locate. Kaiser Permanente maintains a strong position on the West Coast, and hybrid entities that embody some, but not all, of the elements of prepaid group practice are to be found in many metropolitan areas. But the trend in the health care marketplace is toward broad network insurance products divorced from provider systems, retrospective rather that prospective payment, a purchasing

framework that emphasizes copayments at the time of service rather than cost-conscious choice at the time of insurance enrollment, and an institutional framework hostile to the principles and practices of managed competition.[3]

Four Core Elements

This chapter will provide a framework for understanding the limits of prepaid group practice by analyzing each of its critical components: multispecialty physician organization, capitation payment, exclusive organizational linkages between health care delivery and insurance, and a market framework that features multiple choice, defined contributions, and open enrollment. Not all four components need be present simultaneously. Group practice can thrive on fee-for-service payment, capitation can be applied to individual physicians outside the group context, medical groups can contract on a nonexclusive basis with multiple insurers, and sponsors can enforce purchasing discipline even when contracting with a single health plan.

In principle, a system of prepaid group practice that combines all four elements will outperform one that embodies only a few. But in practice, the four core elements seem to be separating from one another as employers reduce the number of health plan choices for their employees, health maintenance organizations (HMOs) shutter their staff-model products, provider systems divest their insurance entities, large medical groups fragment into single-specialty practices, and prepayment is applied narrowly to particular episodes of care rather than broadly to the full spectrum of services. To capture the legacy of prepaid group practice and better anticipate the future of American health care, it is important to consider the four components individually as well as in combination. To conceptually peel the onion of prepaid group practice, it is most useful to begin at the outermost layer, with the market framework of managed competition, and then move inward through vertical integration and capitation to arrive ultimately at the core, multispecialty group practice.

The Market Framework of Managed Competition

The market framework of managed competition has been conceptualized by its proponents as the mix of tax, regulatory, and health insurance purchasing policies that would foster growth among the most efficient forms of health care delivery, which were presumed to be vertically integrated prepaid group practices. In this perspective, the public and private sponsors of health insurance coverage were to move from their exclusive contract with a single indemnity insurer to nonexclusive

contracts with multiple plans, ensuring that all plans were open to all beneficiaries and that none practiced explicit or covert underwriting to avoid the sickest individuals. Health plans would be permitted to establish their own premiums, but sponsors would contribute a fixed amount that did not exceed the premium charged by the low-cost plan, requiring enrollees to pay the difference. Cost-conscious consumer choice of health plan would be strengthened by capping the tax exclusion of health insurance payment, which otherwise would subsidize with tax dollars consumers selecting high-cost health plans. Sponsors would risk-adjust their premium contributions, paying more for sicker beneficiaries than for their healthier counterparts, thereby ensuring that the contributions made by enrollees varied according to the health plan chosen and not according to the health status of the one choosing. In collaboration with researchers and health care providers, sponsors would develop methods for measuring the quality of care available in different settings, thereby fostering the patient's ability to make informed trade-offs between price and quality. Sponsors would specify a standard benefit package to facilitate apples-to-apples comparisons of health plans and to increase the price sensitivity of demand. Most generally, public and private sponsors would serve as sophisticated purchasers rather than as passive payers, providing the institutional support for the individual who seeks the best value for his or her health care dollar.

Barriers to the Model. Some elements of the managed competition framework were adopted by the various regulators and purchasers of health insurance. But the framework was never adopted in whole in any sector, and even the partial adoption has encountered serious obstacles and appears now to be in retreat. Sophisticated purchasing requires large scale, which in turn requires that individual sponsors coordinate their efforts and amalgamate their purchasing dollars. But the organizational obstacles to the formation of purchasing alliances proved powerful, and the entrepreneurial rewards for their creation proved weak. Only a very small portion of the trillion dollars that annually flows through the public and private health insurance systems ever has been coordinated by alliances.

Corporate paternalism and the vested interests of brokers and consultants kept private purchasers fragmented and inefficient, while bureaucratic lethargy and the vested interests of insurers and providers impeded the ability of public programs to defend their budgets with any but the bluntest of weapons. Medicare has not, as yet, been able to develop a successful purchasing strategy, underpaying health plans in some regions while overpaying them in others. Many state Medicaid programs indulged in a shortsighted strategy of bait and switch, offering generous payment rates to attract health plans and then cutting the rates until the plans dropped out. Administrative costs and adverse selection undermined the

willingness of private employers to contract with multiple insurers, and recent years have witnessed the reduction of contractual partnerships even by public employee programs that once trumpeted broad consumer choice.[4] The popular aversion to taxes and enthusiasm for tax loopholes prevented the capping of the open-ended tax exclusion for health insurance. Many consumers proved unwilling to accept the two-step choice process underlying managed competition, according to which they were to choose a multispecialty physician organization at the time of annual insurance enrollment, when they were healthy, and then stay within that system later, when they got sick.

Current Trends. The institutional framework of the U.S. health care system is currently in turbulence and flux, with no obvious direction. Loud calls for renewed regulation mix with equally emphatic announcements of the dawn of a consumer era free of governmental constraints. Depending on the moment, the nation's health care system seems to be moving toward either nonmanaged competition or managed noncompetition but in any event away from managed competition. Private purchasers are abandoning multiple choice and pursuing single-plan contracting strategies and flirting with mechanisms to extricate themselves from the thankless task of monitoring and motivating the health insurance system. Medicare is retrenching to its core as an indemnity insurer with monopsony pricing power (although Republicans in Congress are attempting to reverse this trend), while Medicaid programs in many states are abandoning the effort to mainstream their beneficiaries in favor of a renewed reliance on safety net providers. Public regulation and private litigation impose ever greater burdens on any entity that promotes provider integration or capitation payment. There are huge short-term political benefits to bashing managed care, even if the long-term alternative is a mix of higher taxes, higher premiums, higher deductibles, and higher rates of uninsured citizens. It now is hard to remember that the institutional framework of managed competition once was promoted by policy analysts and American presidents from Richard Nixon to Bill Clinton.

Vertical Integration Between Providers and Insurers

Organizational exclusivity between an insurer and a provider of health care services, as in the pure PGP model, is analogous to the vertical integration between a manufacturer and an upstream supplier or downstream distributor elsewhere in the economy. Vertical integration contrasts with other forms of organizational affiliation, including horizontal integration (merger of two firms offering the same product in the same market), product diversification (one firm offering multiple complementary products), market diversification (one firm offering the same

product in distinct markets), and conglomerate diversification (one firm offering multiple unrelated products).

The broader economic literature is highly skeptical concerning the efficiency and viability of vertical integration, except in special circumstances. Whereas the coordination of supply, production, and distribution is important for efficiency and quality, nonexclusive contractual mechanisms typically outperform unified ownership, as the latter sacrifice the benefits of scale, scope, and managerial attention that can accrue when each firm focuses on one product or service while purchasing complementary components from independent entities.[5] A manufacturer that produces its own inputs, for example, typically cannot achieve the same results in the production of each component as can be achieved by independent suppliers. Independent suppliers can achieve economies of scale by producing for multiple manufacturers, can benefit from volume-related learning curves to improve quality and sustain innovation, and can avoid the managerial distractions that inevitably attend participation in multiple markets with distinct technologies, regulatory environments, and consumer purchasing characteristics. Vertical integration also forces the firm to participate in sectors where the optimal scale and scope of production are quite different. The market for health insurance, for example, is regional or national, whereas the market for health care services is localized to the community or even the neighborhood. At the most basic level, unified ownership of the various stages of supply, production, and distribution increases the overall size of the firm and can bring bureaucratic politics and an attenuation of effort and entrepreneurship.[6]

Successful vertical integration is to be found at particular periods within the evolution of every industry and at all periods for industries with particular technologies. Life cycle theories of vertical integration note the necessity of unified ownership in emerging or declining industries where there is insufficient consumer demand to support independent suppliers and distributors because the technologies are too new or because they are too old and consumer demand is shifting elsewhere.[7]

The early prominence and subsequent erosion of vertical integration in health care is best understood in terms of the life cycle of the PGP "industry" and the emergence of multiple contractual partners for both medical groups and insurers as managed care moved from the margins to the mainstream of American health care. Until the 1980s, it was difficult for a provider organization interested in prepayment to find a willing and able insurance partner, and many group practices and hospital systems were forced to create their own. Investor-owned insurers such as Humana, Maxicare, and FHP, clinic-sponsored health plans such as Ochsner, Marshfield, and Mayo, and innumerable hospital-sponsored HMOs were launched in this manner.

Conversely, insurers that wanted to offer staff-model HMO products often were forced to hire individual physicians and create new medical groups that subsequently could be paid on a capitation basis, as no independent medical groups were available. The staff-model experiments of Prudential, Aetna, CIGNA, and several Blue Cross Blue Shield plans were created for this reason. As the prepaid group practice sector matured, the potential for nonexclusive contractual relationships emerged between insurers and providers. Where sufficient group practices were available, insurers could contract on a capitated basis with multiple medical groups, while the medical groups could contract with multiple insurers.[8] These nonexclusive network structures, such as those pioneered by Pacificare and HealthNet, permitted insurers to offer broad choice and benefit from the scale and learning curve economies achieved by the medical groups. Most of their vertically integrated competitors were restricted to narrow networks of small medical groups, as they had insufficient consumer enrollment for more, and were driven from the market.

Vertical integration survived only where the staff and group-model HMOs constituted a large portion of the local market and hence offered sufficient physician choice and enjoyed economies of scale comparable to those of nonintegrated competitors. Kaiser Permanente's successes in California and Oregon and its failures in Dallas, Raleigh-Durham, and Kansas City were due in part to the large scale it was able to achieve in the former markets but not in the latter ones. It was able to build scale on the West Coast from the 1950s through the 1970s, when the industry was young and independent medical groups were scarce, which allowed it to achieve a network scale and scope no one could achieve today, when the industry is mature and competitors abound. When Kaiser Permanente expanded outside its core markets in the 1980s, the industry was maturing, competitors were everywhere, and replication of the vertically integrated model in new geographical markets was difficult. Large scale is a necessary but never a sufficient condition for industry success, however, as evidenced by the high failure rate among vertically integrated health plans that gained first-mover advantages during the 1970s and 1980s but were not able to parlay them into sustainable advantages in the 1990s.

Some health plans sought to combine the virtues of organizational integration with the attractions of contractual promiscuity by wrapping a network of independent physicians around a core of an integrated group practice. In many cases, these "mixed model" hybrids, such as Harvard-Pilgrim and FHP, proved to be nothing more than resting points on the road to vertical disintegration and full independence between the insurance and delivery components. In Washington, however, Group Health Cooperative has combined a core prepaid group practice with a contracted network of solo and small group practices and thereby has

defended its market share. However, it has not been able to leverage the distinct virtues of integrated efficiency and broad choice into a comparative advantage, and it remains a niche player in a market increasingly dominated by broad-network insurance products and fee-for-service payment.

Capitation Payment

Prospective payment on a per-member-per-month basis creates economic incentives for group practices that contrast dramatically with the incentives generated by retrospective, fee-for-service reimbursement for each provider, procedure, and product. Capitation payment rewards efficiency in all its forms, allowing the medical group to retain the savings thereby engendered, whereas fee-for-service often cuts medical group revenues dollar for dollar in response to reductions in expenses. In principle, capitation spurs physician organizations to adopt the most efficient scale and scope for their enterprise; the appropriate mix of primary care physicians, specialists, and nonphysician caregivers; and most important, the clinical processes that minimize long-term costs, including appropriate technology, evidence-based guidelines, and disease prevention.[9]

The full social benefits of capitation are to be obtained only if patients have good information on access and quality and can vote with their feet for the best settings, though the importance of quality data and consumer choice extends to all payment mechanisms, including fee-for-service. Despite its theoretical advantages, however, capitation payment suffers under a sullied reputation and is in retreat from many parts of the health care system. Several decades of experience have brought to the fore the vices as well as the virtues of prospective payment. Today, the American health care system exhibits a variety of different payment mechanisms, many of which embody elements of both capitation and fee-for-service. The vicissitudes in payment methods have meaningful implications for the scope and significance of prepaid group practice.

Limitations of Capitation. The choice between capitation and fee-for-service payment in medicine is analogous to the choice between prospective and retrospective payment mechanisms elsewhere in the economy, such as between fixed bids and time-and-materials payment in construction and between monthly salary and piece rates in retail sales or harvest labor. There exists an extensive economic literature on the theoretical incentives created by various payment methods and on the actual experiences obtained using those methods in different industries, occupations, and institutional settings.[10]

While prospective payment offers attractive incentive features, it also suffers from characteristic limitations. Most obviously, fixed payment contracts, capitation,

and other prospective payment methods reward recipients for reducing costs by inappropriate as well as by appropriate methods, thereby potentially reducing quality in ways that may not be easily perceived by consumers and payers. Prospective payment also rewards health care providers who obtain a mix of patients that is healthier than average, as payments can never be fully adjusted for risk and disease severity. In contrast, fee-for-service rewards with higher payments those physicians who treat sicker patients in need of intensive intervention.[11] To the extent that capitation payment covers services beyond those directly provided by the group practice, it converts the capitated entity into a fiscal intermediary that must contract with outside providers and assume responsibility for adjudicating and paying their claims. Some successful medical groups, such as HealthCare Partners in Los Angeles, are capitated for a wide range of outside services, while others, such as the Permanente Medical Groups in nine states and the District of Columbia, are capitated for professional services only.

Blended Payment Methods. Even when restricted to clinical services provided directly by the prepaid group practice, capitation imposes on physicians not only the financial responsibility for efficient delivery of care, which is appropriate, but also for the underlying incidence of disease, over which the physicians exert only limited influence.[12] In principle, pure insurance risk should be spread widely over an insured population and not concentrated on relatively small physician organizations. The economic literature argues that mechanisms blending elements of prospective and retrospective payment offer a better mix of incentives than purely prospective and retrospective methods do and finds that most real-world payment mechanisms embody elements of both.[13]

When considering payment methods for physicians and physician organizations, two dimensions of blending present themselves. First, the payment method used for the physician group can differ from the method used for the individual physician (for example, capitation for the former, salary or fee-for-service for the latter).[14] Second, prospective payment can be used for some services (such as physician office visits and routine procedures) while retrospective payment is used for others (such as rare procedures and hospital admissions).[15]

Retrenchment. Inadequate attention to the liabilities of capitation and to the opportunity to supplant pure capitation with blended payment methods has doomed numerous prepaid group practices and nongroup capitated entities such as independent practice associations (IPAs) and hospital-centered integrated delivery systems. The successful group practices today appear to maintain some elements of prepayment for the group while paying the individual physician on a salaried basis, with the salary being linked to various measures of productivity and

hence embodying some of the incentives of fee-for-service. Outside the group context, health plans and physician-owned IPAs appear to be shifting toward fee-for-service and away from capitation for individual physicians, retaining elements of prospective payment through bonus payments linked to achievement of specified goals in efficiency and quality. The scope of capitation at the group level is shrinking as medical groups realize they cannot manage the patterns of utilization and the financial risks associated with hospital and pharmaceutical services.[16] Global capitation for all clinical services is being replaced by professional services capitation that covers only primary and specialty physician services, with varying degrees of risk sharing for ancillary services.[17] The retrenchment of capitation from global to professional services implies that prepaid group practice, by itself, will be financially responsible only for a shrinking minority of total medical costs, because hospital and pharmaceutical services together constitute not only the largest but also the fastest-growing component of health care expenditures in the United States.[18]

Multispecialty Group Practice

The core of prepaid group practice, in terms of its economic and clinical effects on the health care system, is neither its organizational relationship with insurance entities nor the scope of its financial responsibilities but rather its structure as a multispecialty physician organization. Capitation, vertical integration, and the institutional framework of managed competition encourage the growth of multispecialty group practices by allowing them to earn a financial reward for their efficiency and to compete on a level playing field with smaller physician practices for consumer and patient loyalty. Pioneered by the Mayo Clinic and propagated by generations of enthusiasts and entrepreneurs, group practice offers the potential for higher quality and lower cost than the cottage industry of solo and single-specialty providers through economies of scale, clinical coordination, and a physician culture of peer review and responsibility.

The best group practices achieve economies of scale through volume purchasing of supplies and equipment, state-of-the-art computer information systems, the spreading of the insurance risk that accompanies capitation payment, access to financial capital at lower interest rates, a prominent brand name in the community, and the ability to attract experienced administrative and physician leaders. They achieve economies of scope in the coordination of clinical care by combining the services of primary care physicians, specialists, and nonphysician providers (see Chapter Seven); by avoiding undercapacity in primary care practitioners and overcapacity in specialists; and by retaining clinical responsibility for their patients from the home through outpatient, inpatient, and long-term care

settings. Multispecialty group practices can forge a culture of physician cooperation and team medicine through internal payment and promotion policies that foster a concern for the entire enterprise rather than for one specialty or service (see Chapter Nine).

External and Internal Barriers to Replication. Impressed by the theoretical advantages of group over solo practice, generations of physician reformers have ascribed the merely modest role played by medical groups in the American health care system to external obstacles created intentionally by the medical establishment (which remains fundamentally based in solo and small group practice) and unintentionally by public policy. It goes without saying that anticompetitive boycotts, tax disincentives, misguided purchasing strategies, and regulatory restrictions have slowed the growth of group practice. The partial alleviation of these disabilities over the past two decades has spurred the creation of many new medical groups and the expansion of others. Nevertheless, it is imperative to recognize that the merely incremental growth of group practice, whether prepaid or not, is due in part to the limitations inherent in large physician organizations and, conversely, to the continued vitality of solo and single-specialty practices in some settings and for some purposes. Despite their many virtues, multispecialty group practices often suffer from the vices of excessive scale, excessive scope, and the special problems that afflict employee-owned firms.

As they grow, all economic organizations are beset by bureaucratic lethargy, internal factionalism, a widening chasm between individual initiative and group performance, incentives for each participant to ride on the coattails of others, and, more generally, by ever-growing difficulty in maintaining the coordination and cooperation essential for any enterprise. The liability of size is compounded when large scale is achieved through broad scope, the combination of diverse participants to provide diverse services. Diseconomies of scope derive from a loss of managerial focus, the necessity of competing in multiple markets with different technologies and consumers, the difficulty in assigning rights and responsibilities, the increasing politicization of internal "transfer" pricing compared to external market pricing, and more generally, the tower of Babel that emerges when too many activities seek to be coordinated through direct control within a single organization rather than by indirect control across a market setting.[19]

Employee-owned medical groups are plagued by a reluctance to invest any budgetary surplus in capital equipment or financial reserves, as opposed to distribution to employee shareholders. More important, the diversity of contributions and preferences within the ownership ranks impedes the unity of purpose and vision that is essential for long-term success.[20] Employee-owned firms in the modern economy are found almost exclusively in occupations where the workforce is relatively homogeneous (albeit often quite skilled), as in the legal and

medical professions, or where mutual monitoring is easy and the allocation of rights and responsibilities is uncomplicated. As they grow and diversify into multiple specialties, medical groups risk losing the homogeneity and transparency that fostered collegiality and facilitated decision making.

Future Role. After two decades of expansion, medical groups are retrenching geographically and refocusing on a more restricted set of occupations and activities. The ill-fated attempts by physician practice management companies to create regional and national physician organizations are now but a fading memory. Many hospital systems have divested the medical groups they once built in hopes of achieving the economic and clinical benefits of prepaid group practice. Many independent medical groups are divesting outlying sites that were designed to feed patients into the core, relying on external referrals over internal employment to obtain services from specialists and subspecialists, spinning off affiliated entities such as wraparound IPAs, and in several prominent instances, breaking apart altogether as the member physicians decide they would prefer to practice in traditional solo and small group settings.

Kaiser Permanente has retreated from several money-losing and ego-bruising expansions, and in no instance has a medical group once part of the Kaiser Permanente system survived after the financial subsidies from the insurer were terminated. Many medical groups retain dominant positions in their local communities, however, and several regions, such as the Pacific Coast and the upper Midwest, continue to be characterized by group rather than individual physician practice. Multispecialty group practice preceded capitation and vertical integration and will retain a prominent place in the clinical landscape even if they disappear. Without doubt, however, prepayment and close linkages with insurance entities helped medical groups counterbalance the bureaucratic and incentive liabilities that attend large scale, diverse scope, and employee ownership. The safest prediction is that the multispecialty medical group will retain a minority rather than majority presence in the health care system and will remain dependent on local physician culture rather than on any organizational blueprint that can be replicated in new geographical settings.

Domino Theories of Prepaid Group Practice

Group practice in the United States traces its heritage to the founding of the Mayo Clinic more than a century ago; prepaid group practice to the consumer cooperatives and industrial medicine programs of the 1930s (see Appendix); vertical integration to the offering of prepaid medical services on an insured basis after World War II; and the institutional framework of managed competition to the

efforts twenty-five years ago to find some middle ground in health policy between laissez-faire competition and bureaucratic regulation. In the theory of how and why prepaid group practice would come to dominate the health care delivery system, each of the four elements served as a domino that, when pushed by the one behind it, would push on the one in front. The managed competition institutional framework would favor vertically integrated health plans; vertical integration would push insurers to shift from retrospective piece-rate to prospective capitation mechanisms for health care providers; prepayment would reward economical patterns of care and hence favor group over solo physician practice; and group practice would lay the organizational groundwork for continuous innovations in health care quality and efficiency.

Currently, we are witnessing a domino process of change, but one that is proceeding in the direction opposite that predicted by the advocates of prepaid group practice. Managed competition never materialized fully in either the public or the private purchasing context; the absence of a supportive institutional framework favored the growth of broad-network insurers that abjure exclusive linkages with providers; the retreat from vertical integration undermined capitation and substituted for cooperation the contemporary war of all against all; the narrowing of prepayment led to a narrowing of the range of specialties and services brought together within physician organizations. It is no longer difficult to envision a scenario in which the structure of physician practice in 2020 will approximate that of the profession a century earlier.

Conclusion

All organizational and institutional systems must be judged relative to realistic alternatives. Passive third-party payment, broad network insurance products, fee-for-service payment, and single-specialty physician practice—elements of the brave new medical world toward which we seem to be headed—contributed in no small degree to the health care hyperinflation of the 1970s and 1980s. And despite wishful thinking among their proponents, this paradigm may not be the final resting point for the health care system. The contemporary flirtation with constraint-free choice, cost-plus reimbursement, and single-specialty physician practice is a prolongation of the economic intoxication of the 1990s, one that is creating a hangover of escalating premiums, aggressive deductibles, shrinking insurance enrollment, and ubiquitous demands that some entity be crucified for the nation's health care sins. Nevertheless, it is important to acknowledge that the original domino theory of managed competition, vertical integration, prepayment, and group practice has failed the test of the political and economic marketplace. Politicians manifest no desire to develop a supportive tax and regulatory framework;

purchasers show no enthusiasm to offer multiple choices and fixed dollar payments; health plans exhibit no eagerness to build or buy delivery systems; medical groups evidence no zeal to assume more financial responsibility; and physicians have little inclination to create new physician organizations. The safest prediction is for the continuation of today's mixed system, with some providers and patients embracing prepaid group practice, others favoring fee-for-service and solo practice, and the majority lingering in a purgatory of organizational and financial hybrids.

The economic and organizational heterogeneity of health care in the United States imposes costs that would not be borne by a homogeneous system with a single form of physician practice, payment, and oversight. It offers, however, valuable opportunities for experimentation, comparison, and mutual learning that would be lacking in an organizational ecology without diversity. The enduring virtues of broad networks, fee-for-service payment, and small organizational units put a brake on any tendency within vertically integrated, capitated group practices to slide toward monopoly power and conglomerate hypertrophy. On the other hand, the enduring virtues of prepaid group practice set a limit to the clinical fragmentation and variation that plague traditional forms of health care. Over time, the most efficient and effective systems are those most open to competition and innovation, not those that uniformly adopt the best economic and organizational structures available at some particular point in time. Prepaid group practice challenged and fundamentally changed the medical mainstream and in its turn has been challenged and changed. Its enduring contribution to American health care is not to have moved it from one organizational and financial equilibrium to another but rather to have restored dynamism and creativity to a system at risk of self-satisfaction and stasis.

Notes

1. A. C. Enthoven, *Health Plan: The Practical Solution to the Soaring Cost of Medical Care* (Washington, D.C.: Beard Books, 2002; originally published 1980); P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); W. A. Zelman, "The Rationale Behind the Clinton Plan," *Health Affairs,* 1994, *13*(1), 9–29.
2. H. S. Luft, "Health Maintenance Organizations: Dimensions of Performance," in M. L. Millenson, ed., *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (Chicago: University of Chicago Press, 1997); R. H. Miller and H. S. Luft, "Does Managed Care Lead to Better or Worse Quality of Care?" *Health Affairs,* 1997, *16*(5), 7–25; R. H. Miller and H. S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997–2001," *Health Affairs,* 2002, *21*(4), 63–86.
3. J. C. Robinson, "The End of Managed Care," *Journal of the American Medical Association,* 2001, *285,* 2622–2628; D. A. Draper, R. E. Hurley, C. S. Lesser, and B. C. Strunk, "The Changing Face of Managed Care," *Health Affairs,* 2002, *21*(1), 11–23; M. A. Peterson, "The Managed Care Backlash: Politics, Misperception, or Apropos?" *Journal of Health Politics, Policy, and Law,*

1999, *24,* 873–876; J. K. Iglehart, "Changing Health Insurance Trends," *New England Journal of Medicine,* 2002, *347,* 956–962.
4. J. Maxwell and P. Temin, "Managed Competition Versus Industrial Purchasing of Health Care Among the Fortune 500," *Journal of Health Politics, Policy, and Law,* 2002, *27,* 5–30.
5. M. K. Perry, "Vertical Integration: Determinants and Effects," in R. Schmalensee and R. D. Willig, eds., *Handbook of Industrial Organization,* vol. 1 (Amsterdam: North-Holland, 1989).
6. P. Milgrom and J. Roberts, "An Economic Approach to Influence Costs in Organizations," *American Journal of Sociology,* 1988, *93*(Suppl.), S154–S179; D. S. Scharfstein and J. C. Stein, "The Dark Side of Internal Capital Markets: Divisional Rent-Seeking and Inefficient Investment," *Journal of Finance,* 2000, *55,* 2537–2564.
7. G. J. Stigler, "The Division of Labor Is Limited by the Extent of the Market," *Journal of Political Economy,* 1951, *59,* 185–193.
8. J. C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Berkeley: University of California Press, 1999).
9. L. P. Casalino and others, "External Incentives, Information Technology, and Organized Processes of Care to Improve Health Care Quality for Patients with Chronic Diseases," *Journal of the American Medical Association,* 2003, *289,* 434–441.
10. C. Prendergast, "The Provision of Incentives in Firms," *Journal of Economic Literature,* 1999, *37,* 7–63; G. P. Baker, M. C. Jensen, and K. J. Murphy, "Compensation and Incentives: Practice vs. Theory," *Journal of Finance,* 1988, *43,* 593–616; E. P. Lazear, "Pay Equality and Industrial Politics," *Journal of Political Economy,* 1989, *97,* 561–580; D.E.M. Sappington, "Incentives in Principal-Agent Relationships," *Journal of Economic Perspectives,* 1991, *5*(2), 45–66.
11. J. P. Newhouse, "Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection," *Journal of Economic Literature,* 1996, *34,* 1236–1263.
12. D. Emery, *Global Fees for Episodes of Care* (New York: McGraw-Hill, 1999).
13. R. P. Ellis and T. G. McGuire, "Supply-Side and Demand-Side Cost Sharing in Health Care," *Journal of Economic Perspectives,* 1983, *7,* 135–151; M. McClellan, "Hospital Reimbursement Incentives: An Empirical Analysis," *Journal of Economics and Management Strategy,* 1997, *6,* 91–128.
14. M. B. Rosenthal, R. G. Frank, J. L. Buchanan, and A. M. Epstein, "Transmission of Financial Incentives to Physicians by Intermediary Organizations in California," *Health Affairs,* 2002, *21,* 197–205.
15. J. C. Robinson, "Theory and Practice in the Design of Physician Payment Incentives," *Milbank Quarterly,* 2001, *79,* 81–96; J. C. Robinson, "Blended Payment Incentives in Physician Organizations Under Managed Care," *Journal of the American Medical Association,* 1999, *282,* 1258–1263.
16. J. C. Robinson and L. P. Casalino, "Reevaluation of Capitation Contracting in New York and California," *Health Affairs* (Web exclusive), 2001, W11–W19; J. C. Robinson, "Physician Organization in California: Crisis and Opportunity," *Health Affairs,* 2001, *20*(4), 81–96.
17. M. R. Gold and others, "Provider Organizations at Risk: A Profile of Major Risk-Bearing Intermediaries," *Health Affairs,* 2001, *20,* 175–185.
18. B. C. Strunk, P. B. Ginsburg, and J. R. Gabel, "Tracking Health Care Costs," *Health Affairs* (Web exclusive), 2001, W39–W50.
19. B. Holmstrom and J. Tirole, "Transfer Pricing and Organizational Form," *Journal of Law, Economics, and Organization,* 1991, *7,* 201–228.
20. H. Hansmann, *The Ownership of Enterprise* (Cambridge, Mass.: Harvard University Press, 1996).