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Physician Responses to the Marketplace: Group Practices and Hospital Alliances

Editor's Note: Congress is now debating legislation that would give independent physicians the right to bargain collectively with managed care organizations. Proponents argue that this legislation is needed to counterbalance the market power of managed care organizations; opponents argue that physicians can already gain leverage and negotiating strength by forming group practices or through joint ventures with hospitals. This debate has brought attention to the competitive nature of the health care marketplace, and physician responses to managed care. This Issue Brief examines how physicians are reorganizing their practices to meet the demands of the competitive marketplace.

Medical practice is being integrated into larger organizational forms

Over the past ten years, two prominent trends have swept the health care industry: managed care and the reorganization of physician practices. Both trends have emerged in response to pressures to control spending and provide accountable health care, and are viewed as private sector solutions to cost containment. Medical practice has changed in the following ways:

- Group practices are largely replacing solo practitioners. Between 1965 and 1991, the number of physician groups nearly quadrupled from 4,289 to 16,576. Since 1991, the rate of group formation accelerated, reaching 19,787 groups in 1995. In contrast, the proportion of physicians in solo practice fell from 40% in 1983 to about 30% in 1994.
- Advantages of group practice include sharing fixed costs and pooled revenues, internalizing patient referrals and cross-coverage arrangements, and building local market power.
- Medical practices are being integrated into larger organizations. This includes outright purchase of practices by hospitals, universities, staff-model HMOs, and (most commonly) other physicians. It also includes virtual integration through strategic alliances between a hospital and its medical staff.
- Compared with solo and small group practices, larger practice organizations offer physicians higher managed care contracting leverage and greater ability to bear capitation risk. Alliances serve as vehicles for hospital-physician

collaboration, joint contracting with managed care organizations, and in some cases, provide physicians with managerial expertise and capital in developing their practices.

- Integration of health care can be achieved in two ways: horizontal integration, which consolidates similar entities within one sector (such as merging hospitals), and vertical integration, which merges different interdependent sectors (such as hospitals and primary care practices). The following studies examine different methods of vertical integration.

Questions remain about the relationship between market forces and the emergence of new physician organizations and alliances

Researchers and industry analysts commonly assume that increasing levels of managed care in a market drive the formation of physician groups and hospital alliances. Physician-hospital integration is often mentioned as a provider response to increasing cost-containment pressures from managed care organizations. However, the drivers and direction of change in local markets is not clear, and many questions remain. For example:

- Does managed care penetration (the percentage of people insured by managed care in a market) really drive providers to integrate? Does managed care exert a threshold effect so that, at some critical number or penetration level of HMOs, we observe substantial alliance formation?
- Are alliances really provider mechanisms to reduce cost and improve quality, or are they merely a countervailing force to bargain with consolidated managed care organizations?
- How do market structure and competition affect alliance formation? Does the level of competition among managed care organizations or among hospitals influence the formation of integrated relationships with physicians?
- Do health care market conditions influence physician groups to sell their practices to larger organizations? If so, are these organizations more likely to be for-profit or not-for-profit?

Study assesses impact of managed care on the formation of physician-hospital alliances

Burns and colleagues assessed the relationship between managed care and hospital-sponsored alliances with physicians from 1993 through 1995 using national data from all urban markets. The alliances include independent practitioner associations (IPAs), physician-hospital organizations (PHOs), management services organizations (MSOs), and medical foundation models.

- Contrary to conventional wisdom, alliances are influenced by the number of HMOs in a market rather than by HMO penetration. This result confirms a growing perception that such alliances are contracting vehicles for managed care: the greater the number of HMOs to contract with, the greater the development of alliances.
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- When a small number of HMOs have deeply penetrated the market, few physician-hospital alliances form. In these highly concentrated HMO markets, alliance formation may be discouraged—or may be perceived as too late to provide an effective countervailing force.
 - However, alliance formation is linked to HMO consolidation (mergers and acquisitions that reduce the number of HMOs in a market). This result suggests that providers interpret HMO consolidation as increasing market power on the part of payers, which elicits a similar response from physicians and hospitals.
 - There appears to be a threshold effect of managed care, where alliances are most likely to appear in markets with at least four HMOs.
 - The formation of physician-hospital alliances is associated with hospital downsizing. This result suggests that hospitals may pursue an integration strategy in conjunction with other large-scale organizational changes.

HMO market competition is linked to the sale of physician groups to not-for-profit firms

Between 1991 and 1995, the number of physician groups owned by for-profit corporations nearly tripled from 126 to 341. As of 1995, 684 groups were owned by not-for-profit firms. In another study, Burns and colleagues examined the market characteristics that influenced the sale or formation of physician group practices in metropolitan areas from 1991-1995.

- For-profit acquisition of group practices is not driven by local market conditions, but rather by the buyer's assessment of the group's assets. Multispecialty groups were more than twice as likely as single specialty groups to be purchased by a for-profit corporation.
 - In contrast, not-for-profit acquisition of group practices appears to be driven by local competitive market conditions. These acquisitions were positively associated with the extent of local HMO competition (as measured by the number of HMOs in the market area), greater per capita physician supply, and the extent of horizontal integration by hospitals (as measured by membership in hospital systems).
 - Not-for-profit firms are significantly more likely than for-profit firms to purchase groups or form new groups that serve high proportions of Medicaid patients. It is possible that physician groups are acquired or formed by not-for-profit firms as part of their strategy to seek Medicaid risk contracts and manage utilization.
 - While for-profit firms typically acquire and centrally manage group practices across distant geographic markets, not-for-profit acquisitions are more localized. These results suggest that as competitive pressures in the local market intensify and self-governing physicians resolve to sell their practices, groups become integrated into other health care organizations already operating in the area.
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POLICY IMPLICATIONS

These studies add to a growing understanding of the relationship between managed care and the organization of medical practice. This relationship is complex, evolving, and not always intuitive.

- These results challenge the notion that managed care has a direct causal effect on vertical integration of health care. One possibility is that the causal relationship is reversed. Alliances may develop in anticipation that managed care is coming to a market, rather than in response.
- It may be that integrated health care is really a provider-initiated effort to achieve the same power as consolidated health plans at the bargaining table. Provider consolidation thus serves to blunt the downward force on hospital and physician prices dictated by large, powerful health plans, rather than to reduce costs or improve quality of care.
- Policymakers should consider these findings as they weigh the extent to which local market forces can influence cost and quality outcomes.

This Issue Brief is based on the following articles: L.R. Burns, G.J. Bazzoli, L. Dynan, D.R. Wholey. Impact of HMO Market Structure on Physician-Hospital Strategic Alliances. Health Services Research, April 2000, Part I, vol. 35, pp.101-132; L.R. Burns, R.A. DeGraaff, H. Singh. Acquisition Of Physician Group Practices by For-Profit and Not-For-Profit Organizations. The Quarterly Review of Economics and Finance, 1999, vol. 39, pp. 465-490.

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