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While greater numbers of Americans receive their medical care from managed care organizations, managed care’s track record for restraining costs has not been impressive. Premiums for conventional coverage and managed care programs recently have increased in double-digit ranges, exceeding 20 percent over 1989–1990.1 Perhaps more troubling is the fact that the different managed care products are rising at comparable rates, even though they use apparently different approaches to restraining costs. Even Wall Street is becoming less bullish on managed care. A recent Barron’s cover story on the managed care industry noted that health maintenance organization (HMO) profitability appears tied more to higher premiums than to holding down costs or increasing enrollments.2

The “managed competition” model of health system reform posits that the demands of a regulated market would produce greater flexibility, innovation, and responsiveness to consumer interests than would an alternative, regulatory control approach to restraining health care costs. Advocates of managed competition envision the development of mutually beneficial relationships between payers and providers, where providers reap the benefit of improving the quality of their practice.3 Unfortunately, managed care has not lived up to this promise. Instead, we have witnessed the development of marginally effective, follow-the-leader, regulatory interventions that are concerned more with restricting benefits and hassling providers than with developing cost-effective programs.

Why Managed Care Has Not Controlled Costs

Alain Enthoven and Richard Kronick, the main architects of the managed competition model, maintain that their version of managed competition has never been properly tested, and therefore the less-than-
impressive record of managed care organizations to control premium increases should be discounted. They plausibly argue that the more efficient managed care alternatives have no incentive to hold down their premiums because most employers do not pay a fixed amount on behalf of their employees, effectively subsidizing the more expensive options. Many believe that some managed care organizations engage in shadow pricing, content to limit enrollment increases, while profiting by not passing savings back to the purchasers of their product. Financially successful managed care organizations need be only slightly more efficient than the competition to increase their market share. While corporate purchasers of managed care products are not happy with double-digit premium increases, they have nowhere else to turn.

There are other reasons for the lack of cost-containing innovation in managed care organizations. Their administrators, often grounded in the private health insurance culture, spend more time and effort on the purchaser side of the product and less on the delivery side. At times, this tilt in emphasis results in managed care policies that respond to immediate expectations of purchasers and may conflict with alternative policies to improve the long-term efficiency of the delivery system.

Another major factor is that providers, particularly physicians, have not wanted to play. Many physicians still are protected by their ability to shift costs onto essentially unmanaged private payers. Virtually all physicians have considered managed care contracting an obstacle to clinical and financial autonomy. With rare exceptions, providers have not believed that managed care organizations, in fact, might permit them to practice higher-quality medicine, do as well financially, or experience more satisfying practices than is possible in the prevailing, disorganized system. While the theory of managed competition envisions successful managed care “marriages of convenience” between payers and providers, physicians have responded with “a plague on both your houses” to both public and private cost-containing activities.

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<th>Physicians’ Skepticism Toward Market Competition</th>
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<td>Many physicians are not philosophically sympathetic with the principles of marketplace competition, at least when it comes to their own professional activities. Witness organized medicine’s attitudes toward Medicare’s resource-based relative value scale (RBRVS), as developed by Harvard’s William Hsiao and colleagues. Physician leaders and participants in Harvard consensus panels generally proved willing to accept the premise that there are, in fact, “correct” relationships among services, based on objective notions of time and effort. Even specialties that would</td>
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lose the most under the reordered relative value scales supported the concept of resource use as a proper basis for setting fees. They disagreed mostly on details of calculation. One principle of market competition, however, contrasts with the medical profession’s views of fees. A market approach holds that there are no correct prices for physician services, but rather, negotiable prices that derive from supply and demand factors.

An example of the ideological differences between the market approach and the professional attitude toward health care is the issue of selective physician contracting. Many medical societies have proved sympathetic to physicians’ complaints of exclusion from managed care plans and have supported legislation that would severely restrict the ability of certain managed care organizations, particularly preferred provider organizations (PPOs), to contract with preferred subsets of the medical community or use gatekeeper programs. A recent Health Insurance Association of America (HIAA) report identified nearly 200 pieces of such legislation introduced, and a handful passed, in the first half of 1991 alone. Organized medicine invokes the need to protect patients’ freedom of choice as the basis for their protective proposals.

A cynical interpretation of medicine’s actions would be that of an economic cartel attempting to maintain control of the market. A more charitable view is that most physicians, trained to be collegial and share a professional bond, believe that those meeting acceptable standards of care should be entitled to practice unencumbered by market considerations. Many physicians hold more absolutist views of medical practice than markets permit, such as the following: physicians provide acceptable care or not; there is a correct price for a service; all physicians in good standing deserve the opportunity to unrestricted practice; and cost containment should focus on objective practice guidelines applicable to all, not on managerial policies that apply uniquely to some.

Another factor contributing to the general physician skepticism of managed care is that physicians understandably object to certain policies and practices of the insurance industry and, therefore, are suspicious of virtually any market-driven business decision. Similarly, risk-averse physicians are wary of being “taken” in their managed care contracting. They have little experience with contract law or with the arcane details of compensation systems, such as capitation with risk pools. Physicians naturally turn to advisers who value standardization and predictability more than innovation and flexibility. Because many physicians have had painful experiences with managed care organizations that have taken liberties with their obligations under provider contracts, they have become even less disposed to permitting variation in contract language and plan design. To exert more negotiating clout, some physicians have
successfully banded together, restricting the flexibility of managed care organizations to treat members of a panel of physicians differently.

Thus, while many physicians today feel pressured to participate with managed care organizations out of economic necessity, relatively few are philosophically supportive of the underlying premises of a competitive market or prepared to take avoidable risks. Because the health insurance market permits healthy profits as rewards for only marginal efficiencies and because physicians are reluctant participants, it is not surprising that managed care organizations have not developed more innovative approaches to delivering health care.

Regulatory View Of Managed Care

Managed care organizations have approached providers with roughly the same cost containment program as governments have. Thus, it is not surprising that physicians, experiencing the loss of control and autonomy in many aspects of their professional lives, do not distinguish managed care efforts from those of the federal government, as economic theorists think they should. Indeed, in the United States, managed care organizations currently perform regulatory functions that governments do elsewhere and that Medicare does here on behalf of its beneficiaries. Fee schedules, an improvement over the usual/customary/reasonable (UCR) method of fee-for-service reimbursement, are used in virtually all government-regulated health systems. Capitation, used by many individual practice association (IPA) HMOs, was borrowed from the British National Health Service. Mandatory triaging of care by primary care gatekeepers is standard operating practice in Great Britain and Sweden and in the heavily regulated private provider systems of the Netherlands and Germany. The detailed, case-by-case review of medical necessity that is the heart of most nonstaff- and group-model HMO managed care programs is an American invention but is performed similarly in the private and public sectors. Where government does not perform the activities directly, it may contract out the activity to the same organizations performing them in the private sector.

From a public policy viewpoint, it would be hard to justify restricting patients’ freedom of choice and imposing the administratively complex managed competition model on the American public if managed care organizations continue simply to function as governments can do, only with less market clout. Public payers, particularly Medicare, have used their market clout to achieve cost savings, while preserving broad physician participation, that managed care programs can only dream about. To justify their existence to corporations and others who foot the esca-
lating health care bill, managed care organizations must complement basic regulatory controls with market-based management techniques in ways that government is legally or politically precluded from applying.

For purposes of this discussion, I contrast “regulatory control” and “managed care” in a specific way. Regulatory control activities involve applying external rules consistently, uniformly, and mechanistically to participants in a program—in this case, patients and providers. Strictly enforcing a defined benefit package and paying physicians according to a fixed fee schedule are regulatory tools. Managed care involves discretionary and unique decisions on how to influence care through an interactive process with program participants. While rules provide a framework for managerial action, managed care takes advantage of opportunities for individualizing decision making, with regard to both patient and provider. Catastrophic case management, which involves approving and coordinating services not covered by the defined benefit package for individual patients, and paying different levels of fees based on evaluation of physicians’ utilization patterns and quality-of-care assessments are examples of true managed care.

From a national perspective, a system using regulatory controls attempts to limit the excesses inherent in the prevailing freedom-of-choice, fee-for-service style of care. On the other hand, a system based on managed care attempts to fundamentally alter the way medicine is actually practiced.

Prepaid group practice has demonstrated relative success in restraining costs. These HMOs rely much less on rules to govern physician behavior than on informal management systems that involve staff physicians integrally in development and operation. However, the capacity of prepaid groups to handle more patients seems limited. In addition, it appears that most Americans still prefer to choose their own physician, at least for special situations. Thus, managed care networks will have to involve many private physicians for further expansion of managed care. The goal for managed care organizations contracting with private physicians is to achieve a group practice without walls, preserving the decentralized access and responsiveness of community-based practices with the organizational efficiencies and support systems of large group practices.

Some managed care organizations, particularly relatively small HMOs, have tentatively moved in the direction of true managed care, in particular by identifying and working with a core group of physicians in a collaborative manner. However, for various reasons, most managed care organizations typically have contracted with too many physicians to permit anything other than a distant regulatory interaction. Correspondingly, physicians, particularly specialists, typically contract with most, if
not all, available managed care organizations; they feel no loyalty to any particular organization and expect common policies, procedures, and payment rates. By reviewing some of the currently used cost-containing techniques in managed care and contrasting these with rarely applied alternatives, I hope to demonstrate the fundamental difference in approach between regulating benefits and providers and managing care.\textsuperscript{13}

| Provider Contracting And Credentialing |

All HMOs and PPOs contract with a subset of the medical community in any service area. In exchange for the promise of increased numbers of patients, contracting providers agree to accept reduced reimbursement levels, to follow the utilization review requirements, and so forth. Despite widespread use of advertising that promotes their doctors as the “best,” managed care organizations’ bases for offering contracts to private physicians, in fact, have had little to do with quality, caring, or cost-effectiveness. Some have contracted with virtually any physician willing to accept discounted payments in exchange for the possibility of additional patients. Others have targeted the entire medical staff of contracted hospitals or have signed up entire IPAs whose membership is not selective.

In recent years, some managed care organizations have added credentialing policies to distinguish among eligible physicians (for example, contracts will be offered only to board-certified physicians).\textsuperscript{14} What has generally been missing is the willingness and ability to maintain contracts with physicians on the basis of explicit consideration of performance. Most managed care organizations already possess basic data that permit performance judgments of gross level of quality, patient satisfaction, and costliness. Perhaps available databases cannot easily distinguish between levels of acceptable performance, but they certainly permit identification of unacceptable provider performance. Yet, few managed care organizations aggressively use claims data and simple quality assessments to end physician contracts.

Managed care organizations do not need scientifically valid outcomes studies to proceed with much more selective contracting than they do now. Undoubtedly, many fear that selective contracting would generate a backlash from excluded physicians and their patients and possible legal and legislative challenges. However, managed care organizations that tread too softly in this area relinquish a fundamental advantage of the managed care model. Managed care organizations are positioned to channel much larger segments of services to specified providers within their networks, that is, to use cost-effectiveness assessments to selectively credential providers for specific services, consistent with the countervail-
ing needs to protect continuity of patient care and preserve relations with the providers. Different organizations should come to different credentialing decisions. Excluded physicians would complain, but their legal recourse would seem much less than if a public or dominant private payer attempted to limit their scope of practice.

The hope is that independent actions by competing managed care organizations would, in effect, provide the country a health professions policy that it lacks. Neither the medical profession nor the government has had the will to limit the production or direct the distribution of licensed physicians, at a great cost to society.\(^\text{15}\) Nor have the states and the medical profession had the commitment and courage to limit the autonomy of incompetent physicians. State licensing boards are underfinanced and ineffective and, in some cases, highly politicized.\(^\text{16}\) Most medical specialty societies are only now developing recertification programs. With a few exceptions, the design of these programs offers little hope of assuring the ongoing competence of physicians to perform diverse clinical activities.\(^\text{17}\) It is hard to imagine a single payer with the legal authority or political clout to exclude physicians from full participation except in the most egregious cases of fraud or incompetence. Thus, by default, managed care organizations could become society’s mechanism for sorting out the quality and efficiency of physician services.

### Physician Payment

Whereas staff- and group-model HMOs compensate their physicians by salary, the PPO/IPA models use either a form of fee for service or capitation. Primary care capitation with bonuses or forfeitures based on the financial performance of risk pools appears at first glance to be an innovative method for shifting physician incentives and sharing risk with physicians. Indeed, some of the IPA-model HMOs that rely on capitation seem to be among the more successful in the marketplace. There is no question that capitation corrects the wildly inflationary incentives of unreformed fee-for-service payment systems. Also, primary care capitation with gatekeeper requirements arguably discourages participation by less healthy patients, thereby promoting favorable selection.

However, some believe primary care capitation presents conflict of interest for the capitated physicians.\(^\text{18}\) In essence, an HMO takes the same physicians who it thinks abuse fee-for-service incentives and trusts them not to underserve their capitated patients while giving them direct incentives to do just that. The actuarial problems with capitation relate mostly to adverse selection. A doctor’s financial performance under most operating capitation schemes has far more to do with the selection draw
for the pool than with cost-effective care.\textsuperscript{19}

Even if the adverse selection problem were solved, consider the implications of using a capitation system that, by design, must be based on random assignment of enrollees. Under standard primary care capitation schemes, gatekeeper physicians receive a prepaid monthly amount, adjusted only for patients’ age and sex. To be actuarially fair, allocation of patients should be totally random. Thus, under a properly functioning capitation program, patients with specific medical problems cannot be matched with physicians best able to care for them. Endocrinologists cannot care for diabetics. Specialists in treating human immunodeficiency virus (HIV) disease cannot care for HIV-positive patients. Physicians who can skillfully manage patients with multiple, interacting chronic illnesses cannot be assigned as the capitated gatekeepers for these patients, even though the costs associated with chronic illness make up a huge share of expenditures in all health care systems. The implicit premise underlying HMOs’ use of capitation is that a mechanistic incentive payment system is more effective at reducing costs than is one that involves truly managing a delivery system by identifying and using the strengths of the providers in the network.

The alternative to capitation in HMOs has been fee for service, with or without limited physician risk. Fee for service remains the method for paying most specialists, even in IPA HMO programs that use capitation to compensate the primary care gatekeepers. Additionally, fee for service is more compatible than capitation with point-of-service patient option plans. In short, fee-for-service payment is not disappearing. Yet, many fee-for-service payment systems in managed care organizations still pay discounted charges or use fee schedules based on area charges.

The new Medicare RBRVS fee schedule is an advance over these methods, in that it introduces a defined basis other than charges for setting fees. Some managed care organizations recently have started using fee schedules that also correct some of the distorted fee relationships that derive from charge-based data. Many are sure to adopt the relative values of the Medicare RVS, while paying much more than Medicare will. However, as emphasized by Clark Havighurst, a relative value scale also serves the medical profession’s purpose of keeping insurers from becoming active purchasers of medical services. As long as the profession can agree to credible payment tools, payers would not be tempted or forced to invent new ones independently.\textsuperscript{20}

In fact, there are bases for setting fees that are potentially more creative than the RBRVS. For example, Mark Pauly has promoted the concept of an incentive-neutral fee system, in which physicians are financially indifferent in deciding among alternative treatments and therefore can
act as “perfect agents” of the patient regarding choice of services. While similar to an RBRVS, an incentive-neutral fee schedule would go further to eliminate services physicians view as “winners” and “losers.”

An incentive-based fee schedule would intentionally tilt the fees developed from the RBRVS to achieve specific policy goals. Such a schedule might pay extra for underprovided services, such as home visits and certain preventive services, and pay less for overprovided services, such as electrocardiograms. Another fee-for-service payment innovation would involve systematic rebundling of the more than 7,000 Current Procedure Terminology (CPT-4) codes to promote more efficient use of ancillary services and protect against the “creative” billing in which increasing numbers of medical practices engage.

A resource-based relative value scale is probably the only concept that the federal government could adopt for Medicare payment and still keep the entire medical profession in the fold. As demonstrated by organized medicine’s vigorous opposition to the 1990 Omnibus Budget Reconciliation Act (OBRA) legislation that limits separate billing for electrocardiograms, Medicare will have a difficult time paying physicians in any manner other than the strict dictates of an RBRVS-based fee schedule. Unfortunately, to date, relatively few managed care organizations have attempted to work with their physicians to develop compensation systems that provide better signals to physicians about desired practice or more appropriately reward deserving physicians.

The ability to distinguish among physicians to reward deserving physicians is a major advantage, still unrealized, that managed care organizations have over a public payer. Payers’ efforts to protect the integrity of the claims-paying process is just beginning and has had only a marginal impact thus far. Physicians, with their “we’re all in this together” attitude toward third-party payers, tolerate windfall payments to physicians who creatively bill and who perform unnecessary but harmless services. These unjustifiable payments drive up premiums and limit the ability of the managed care organization to offer fee schedule increases to all physicians. Yet, few managed care organizations have policies that formally link tight claims adjudication and claims review findings with the generosity of fee schedule increases or have set explicit expenditure targets that place physicians at collective risk, giving physicians a stake in the effectiveness of claims monitoring activities.

**Gatekeepers**

While little hard data exist to support the cost-containing role of gatekeeper triage, many managed care advocates consider gatekeeper
requirements, regardless of the accompanying payment method, to be a major source of managed care efficiencies. The major problem is patients’ acceptance of gatekeepers. Most managed care organizations apply gatekeeper programs mechanistically, taking little responsibility for assuring the qualifications of the selected gatekeepers. Thus, gatekeeper systems often serve a rationing function and may lead to an adversarial doctor/patient relationship. Also, patients who want or need direct access to specialized care are less likely to tolerate the regulatory hassles of gatekeeper referrals; this could lead to favorable selection. Sometimes the gatekeeper physicians themselves, especially if at financial risk, steer these relatively costly patients away from gatekeeper programs that frustrate patients’ access to specialized care.  

A different form of gatekeeper program would be one in which the managed care organization assumed responsibility for the competence of gatekeepers to act as providers of primary care and coordinators of specialized care. For example, most practicing internists have learned what they know about primary care dermatology, orthopedics, gynecology, addictive disorders, and even preventive medicine on the job, with varying degrees of success. As a rule, managed care organizations that use formal gatekeeper systems attempt neither to credential physicians based on their demonstrated primary care skills nor to provide remedial educational opportunities. Indeed, most managed care organizations will pay year after year for avoidable specialty referrals instead of developing a mutually beneficial educational program, at lower cost, for physicians to develop the competence to avoid referral in the first place.

Beyond the clinical aspects of gatekeeping, most medical practices also are not able to carry out the case management role envisioned for gatekeepers. Information management systems using computer technology have not developed widely in the prevailing nonmanaged care delivery system, partly because providers have no incentive to eliminate redundant care. Medical practices, other than large multispecialty practices and clinics, have neither the financial wherewithal, the economies of scale, nor the inherent interest in investing in information systems that would facilitate gatekeeper operations. Managed care organizations, on the other hand, have the capital, the scale, and the interest in promoting information management. They could administratively support gatekeepers’ managerial responsibilities. Up to now, they have not.

**Utilization Review**

It is understandable that indemnity insurance companies, third-party administrators, and public payers with no contractual arrangements with
providers rely on case-by-case review of medical care. Such reviews include preprocedure and prehospitalization authorization, continued stay review, second surgical opinion, and so on. Whether the occasional instances of ill-advised procedure averted and marginal hospital day saved justify the costly, demeaning intrusion into clinical practice is debatable. Case-by-case review is equivalent to having the Internal Revenue Service audit every tax return. American taxpayers would not tolerate that approach, and it is little wonder that American physicians object.

Managed care organizations have the ability to audit more efficiently. Working with a relatively small number of physicians with a significant volume of patients, they can profile their providers to identify outlier performance and then concentrate oversight activities on specific diagnoses and problematic providers. It seems, however, that the case-by-case model has taken on a life of its own and is performed by many managed care organizations, often on contract to private utilization review companies. Again, with this reliance on directly regulating physician behavior, managed care organizations are missing an opportunity to work cooperatively and creatively with physicians.

In general, purely educational attempts to change physicians’ cost-generating behavior have met with mixed success. However, these attempts have not been performed in the context of mutually beneficial managerial interventions using incentives and only targeted regulation. As an illustration, consider the escalating costs of pharmaceuticals. With the third party picking up the tab, physicians and patients naturally are predisposed to use more expensive drugs if they perceive even a slight benefit.

One approach managed care organizations use to this moral hazard problem is through incentives—placing the physician at financial risk for the part of the costs of expensive prescribing patterns. While theoretically appealing, the approach is limited by the actuarial and selection problems associated with risk pools discussed earlier. Other approaches include drug utilization review programs and regulating prescribing choices to some extent, for example, by requiring generic substitution and/or the use of closed formularies. However, overall, the ability of managed care organizations to control drug costs has not been impressive.

The potential benefit of educating physicians about drug costs and efficacy is real but rarely tried. Jerry Avom crafted a creative approach to educating physicians about drug selection by recognizing that a large part of physicians’ information about drugs comes from pharmaceutical company sales representatives, the so-called detailers. Avom sent out his own academic detailers to meet with busy physicians to offer objective information about relevant drugs. In a controlled study, Avom and Stephen Soumerai demonstrated improved drug therapy decisions by
physicians. Apparently, only one managed care organization, Kaiser Permanente, has put this kind of program into operation. It reports substantial success in reducing drug costs without interfering with physicians’ prescribing autonomy. Blue Cross and Blue Shield of Massachusetts is now starting the counterdetailing program with selected doctors.

Managed care organizations would appear to be the only institutions in the health system with the inherent interest, the scale, the managerial competence, and the political will to carry out large-scale applications of this type of creative educational intervention. While public payers, such as Medicaid agencies, regulate drug costs with formularies, it is hard to imagine that a public payer would either have the political ability to withstand drug companies’ opposition to public funding of such a large-scale program, or be able to pay the large front-end costs necessary to compete with the direct physician marketing efforts of drug companies.

**Conclusion**

Why have managed care organizations been so slow to manage care? To a very real extent, financial success in managed care has been too easy and has not required reforming the way health care is actually delivered. If it is possible to beat the traditional insurance competition through provider discounts and boilerplate utilization review, why borrow trouble by managing the care of physicians who did not want to be involved in the first place? In the face of spiraling premium increases, employers now appear more willing to accept more decisive actions on the part of their managed care organizations. Unfortunately, under increased cost containment pressure, managed care organizations often simply tighten their regulatory controls—increase patient cost sharing, make tougher benefit eligibility decisions, deny more patient hospital days, limit fee schedule increases, or impose increased withholding on payments to physicians.

In short, as the marketplace demands more cost savings from managed care, many managed care organizations’ reflexive actions have been to proceed with the kind of regulatory controls that government should be able to administer more efficiently. In this environment, managed care will lose its potential to reform how health care is provided in a decentralized market. Paradoxically, the best hope for reformed managed care might, in fact, be a national health program incorporating the Pepper Commission’s “play or pay” concept. To keep private business in the face of a public payer with monopsony power, managed care organizations other than prepaid groups will have to fundamentally change the way they do business. Instead of offering purchasers pale imitations of government regulatory controls, to compete effectively managed care organiza-
tions would have to offer alternative approaches that are more appealing to patients and some physicians. Similarly, when faced with the specter of an all-payer or single-payer government program, some physicians, at least, might look more kindly on managed care as an alternative strategy for health system reform. The kind of creative cooperation between managed care organizations and physicians necessary for the success of the managed competition model might then develop.

NOTES


4. Enthoven and Kronick, “Universal Health Insurance through Incentives Reform.”

5. A common example is the conflict between the marketability and the manageability of the provider network. The sales force of a managed care network typically wants to include more physicians in the network than the medical director can work with. The conflict becomes greater when the issue is whether to recruit specific physicians, requested by an employer, whose practice style presents a cost or quality problem.

6. Physicians do participate in entrepreneurial activities related to their own professional activities. However, these activities generally involve ventures promoting self-referral opportunities with very little financial risk. They succeed largely because the ventures are insulated from real market competition.


9. Some, including physicians, argue that quality is rewarded in a system where physicians are permitted to vary fees. Unfortunately, because of market failure, others, including myself, think relative charges bear little relation to quality of services rendered.


13. The Washington Business Group on Health has made a similar distinction between the first generation of managed care and what they call vertically integrated systems

14. While many managed care organizations have credentialing criteria, the criteria do not necessarily work well. For example, a commitment to include only board-certified specialists would exclude many excellent older physicians trained before board requirements, recent graduates not yet eligible to take the boards, and members of group practices in which the rest of the group is board certified. For understandable reasons, managed care organizations may make so many exceptions that criteria lose their utility.


22. Hadley and Berenson, “Seeking the Just Price.”

23. Ibid.

24. Berenson, “Capitation and Conflict of Interest.”

25. Physician financial risk payment systems can mitigate HMOs’ cost for avoidable referral to some extent. But on balance, even in aggressive capitation systems, the organization bears a greater cost of unnecessary referrals than do physicians. Also, a physician’s performance with a financial pool has more to do with whether the physician has a few high-cost patients than with the efficient management of routine problems.


