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Physician Response to Selective Contracting in California

by Lucy Johns and Michael W. Jones

Prologue: After Congress gave states, through authority granted in the Omnibus Budget Reconciliation Act of 1981, far greater latitude to design innovations for their Medicaid programs, California imposed the concept of selective contracting on hospitals and physicians that participated in its Medicaid (MediCal), program. A similar initiative also enabled private third-party payers to contract with providers selectively. Under the concept, MediCal and private third parties were given the discretion to violate a policy long cherished by organized medicine and the hospital industry: a requirement that payers finance the care of eligible beneficiaries without stipulating who would render the care. Now, five years later, Lucy Johns and Michael Jones report on the status of this experiment, as perceived by California’s private physicians Johns, who holds a master of public health degree from the University of California, Berkeley, has been an independent and well-respected health care consultant for more than a decade. She codirected the most comprehensive privately funded (The John A. Hartford Foundation) evaluation of California’s experiment with selective contracting and has continued to follow the program’s progress closely. Johns currently is assessing the future role of the faculty at a private medical school long associated with care of the poor as the school acquires new private practice facilities on its campus. She also is involved in helping a self-insured employer to establish a California-wide preferred hospital network. Michael W. Jones, who holds a master of business administration degree, was until recently director of the California Medical Association’s Division of Research and Socioeconomics. In September he joined the California Workers’ Compensation Institute in a similar capacity.
A California physician remarked in 1984, “It is clear that . . . while we (the profession) have been avoiding a headlong collision with socialism, we have been blind-sided by capitalism.” California physicians, virtually immune from the cost-containment pressures exerted by third-party payers on hospitals throughout the 1970s, reeled when selective contracting legislation was passed by the state in 1982. The statutes enabled both the Medicaid program (Medi-Cal in California) and various private third-party payers (Blue Cross, insurers) to contract, as of July 1983, with only those physicians agreeing to “alternative rates,” that is, fees stipulated by the payer in the contract.¹ Such contracts would form the basis for preferred provider organizations (PPOs), virtually unknown in the state up to that time.

The potential of selective contracting to alter referral patterns and other traditional prerogatives, as well as to reduce physician income, induced anxiety in the profession and attempts, in early 1983, to amend the laws. The effort failed; proponents of contracting deemed the policy to be simultaneously a concession to fee-for-service medicine and a necessary dose of “market discipline” in an era of intolerable health care cost inflation. Selective contracting thus has become an unavoidable factor in the practice of medicine for tens of thousands of physicians.

Two studies, one completed in 1984 by the National Governors’ Association (NGA) and the other in 1986 by the California Medical Association (CMA), document the response of California physicians to selective contracting and its early effect on their practices and attitudes. This article presents selected findings and discusses their policy implications.

### Two Physician Surveys

Data concerning selective contracting with physicians are not routinely reported to any state agency. Statistics concerning number of physicians offered and under contracts, nature of payment, effects on decision making, services, and so on, must be collected privately from either physicians, PPOs, or both.

The CMA mailed a questionnaire to a random sample of 1,600 members in late 1985 and early 1986. Responses were received from 713 physicians (45 percent), 675 of whom billed on a fee-for-service basis and thus might be affected by selective contracting. This group of 675 physicians, generally uniform across age, specialty, and geographic groups, was then partitioned to isolate responding physicians who had signed only PPO contracts and no health maintenance organization (HMO) contracts. The responses of this subset of 180 physicians (27 percent of all fee-for-service respondents) registers directly the effects of the 1982 selective contracting legislation. Although physicians themselves may tend to lump HMO and PPO contracts together, this article
focuses solely on the effects engendered by PPO contracting.

Physician data from the earlier NGA study were collected through two-hour interviews, guided by a standard protocol, with twenty-seven physicians in the summer and fall of 1984. Although neither large nor random, the sample represented a cross-section of physicians legally subject to selective contracting and probably concerned about its effects. Of the group, 85 percent were in solo or single-specialty group practice, two-thirds were located in urban areas, 55 percent were in primary care specialties, and two-thirds were active in organized medicine. Interviewers were experienced health care consultants under contract to NGA.

**Findings.** Data from both studies suggest that physicians are being more selective about the contracts they sign than are PPOs about the physicians they select. The proportions of both study samples of physicians offered at least one PPO contract were over 90 percent, despite the difference in size and timing of the surveys. In the CMA study, 97 percent of 675 respondents had received at least one PPO contract, over half had received more than five, and more than a quarter (28 percent) reported having received more than ten contracts. The proportions of both samples actually signing at least one PPO contract are smaller but still high: 66 percent in the early study, up to 76 percent later. Thus, as late as 1986, about one-quarter of physicians remained sufficiently secure and/or apprehensive enough about contracting not to sign any PPO contracts that might be offered.

The substantial proportion of physicians signing PPO contracts contrasts with the vehement philosophical opposition to the new state policy expressed by virtually all of those interviewed in 1984. Sentiments such as the following were voiced by signers and nonsigners alike:

> “Contracting is an insult to independence,” an “infringement on free enterprise,” an “emascula-
> tion,” and “a shackle around my neck.”

> “The government is singling out doctors; it doesn’t tell anyone else what to charge. We have less freedom now than the grocer down the block.”

Even then, however, pragmatic considerations took precedence for a majority of physicians offered contracts, an early pattern substantiated and strengthened by the 1986 data. In the words of some of the signers:

> PPOs are “a straight business proposition,” an inevitable response of payers to UCR (usual, customary, and reasonable rates), which physicians “are guilty” of having strongly defended.

> Patients have no loyalty; they will go with their pocketbooks: “If they are to come to/stay with me, I’d better be on those lists.”

Philosophy notwithstanding, the potential for losing patients, an intended consequence of the competition to be engendered by selective
contracting, clearly is affecting physician behavior.

Physician characteristics. Comparison of some characteristics of physicians signing and not signing PPO contracts suggests that the two groups differ noticeably only by specialty (Exhibit 1). Age, location, and form of practice yield only very slight tendencies for older, solo, and rural practitioners to refrain from signing. By specialty, however, the proportions of referral physicians, both medical and surgical, are notably higher among the signers.

Looking more closely by specialty, there is some tendency for the primary care physician to resist PPO contracts. The proportion of nonsigners within each specialty exceeds 5 percent only among general and family practitioners, internists, obstetrician/gynecologists, and anesthesiologists. The primary care physicians appear to be banking on patient loyalty, other sources of income, or imminent retirement, while the anesthesiologists have more control over their flow of patients than do other physicians.

PPO contract characteristics. Blue Cross’ Prudent Buyer Plan and Blue Shield’s Preferred Plan are the dominant contractors, while pro-

<table>
<thead>
<tr>
<th>Exhibit 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison Of California Physicians Signing And Not Signing PPO Contracts, By Selected Characteristics, 1986</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondent characteristics</th>
<th>All respondents</th>
<th>Respondents signing</th>
<th>Respondents not signing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percenta</td>
<td>Number</td>
</tr>
<tr>
<td>All respondents</td>
<td>675 b</td>
<td>513</td>
<td>76.0%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 40</td>
<td>96</td>
<td>82</td>
<td>85.4%</td>
</tr>
<tr>
<td>40–59</td>
<td>410</td>
<td>314</td>
<td>76.6%</td>
</tr>
<tr>
<td>Over 60</td>
<td>168</td>
<td>116</td>
<td>69.0%</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General/family practice</td>
<td>114</td>
<td>75</td>
<td>65.8%</td>
</tr>
<tr>
<td>Medicine</td>
<td>182</td>
<td>146</td>
<td>80.2%</td>
</tr>
<tr>
<td>Surgery</td>
<td>246</td>
<td>197</td>
<td>80.1%</td>
</tr>
<tr>
<td>All other</td>
<td>129</td>
<td>93</td>
<td>72.1%</td>
</tr>
<tr>
<td>Type of fee-for-service practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo</td>
<td>420</td>
<td>309</td>
<td>73.6%</td>
</tr>
<tr>
<td>Other c</td>
<td>250</td>
<td>201</td>
<td>80.4%</td>
</tr>
<tr>
<td>Practice location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major metropolitan</td>
<td>496</td>
<td>386</td>
<td>77.8%</td>
</tr>
<tr>
<td>Other metropolitan</td>
<td>133</td>
<td>97</td>
<td>72.9%</td>
</tr>
<tr>
<td>Semi-urban/rural</td>
<td>46</td>
<td>30</td>
<td>65.2%</td>
</tr>
</tbody>
</table>


aPercentages based on number of all respondents.
bIncludes those not offered any (n=23) contracts and those not answering the question (n=7).
cIncludes single and multispecialty groups, partnerships, and other “nongroup arrangements.”
Provider-sponsored PPOs currently are only a minor factor in the markets place (Exhibit 2). Just over half of all physicians now under PPO contract are associated with at least one of the Blue Cross/Blue Shield PPOs. Two out of five respondents have contracted with PPOs sponsored by insurance companies. The relatively small number of signers of provider-sponsored PPOs is unexpected in view of the large number of such entities. A widespread provider reaction to selective contracting was the formation of their own PPOs. In 1985, two-thirds (131) of all PPOs in California were provider sponsored.  

Exhibit 2 also shows that payers are serious about setting alternative rates. The “fixed fee/schedule of maximum allowance” pattern of payment is highly prevalent. Percentage-of-fee methods, in which the payer is at risk for fee increases, appear in about 25 percent of contracts signed,

### Exhibit 2

**Selected Characteristics Of PPO Contracts By Percentage Of California Physicians Signing Only PPO Contracts, By Grouped Medical Specialty, 1986**

<table>
<thead>
<tr>
<th>Contract characteristics</th>
<th>All specialties (n=180)*</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=25)</td>
<td>(n=42)</td>
</tr>
<tr>
<td><strong>Sponsorship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Cross</td>
<td>56%</td>
<td>76%</td>
</tr>
<tr>
<td>Blue Shield</td>
<td>55</td>
<td>40</td>
</tr>
<tr>
<td>Foundation for medical care</td>
<td>41</td>
<td>48</td>
</tr>
<tr>
<td>Insurer</td>
<td>43</td>
<td>40</td>
</tr>
<tr>
<td>Hospital/physician joint venture</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Hospital only</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Physician only</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Employer</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Payment method</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed fee/schedule of maximum allowances</td>
<td>77</td>
<td>92</td>
</tr>
<tr>
<td>Percent of usual fee</td>
<td>28</td>
<td>20</td>
</tr>
<tr>
<td>Percent of community prevailing fee</td>
<td>23</td>
<td>12</td>
</tr>
<tr>
<td>Capitation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Risk pool</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

**Gatekeeper concept incorporated**

| Yes | 46 | 40 | 41 | 48 | 51 |
| NO  | 50 | 60 | 52 | 48 | 46 |
| No answer | 4 | -  | 7 | 4 | 3 |

**Source:** California Medical Association, “Physician Contracting Survey,” Winter 1986, Tables 7a, 8, 13.

*Of the 513 physicians from Exhibit 1 who signed PPO contracts, 180 (53 percent) also did not sign HMO contracts. Respondents signed at least one, but possibly more than one, PPO contract.
with a visibly higher proportion of “other” physicians reporting this contract characteristic. Although the sample number of “other” physicians is small, it is reasonable to infer that hospital-based specialists who dominate this category (anesthesiologists, radiologists, pathologists) have somewhat more bargaining power with payers than other physicians have. It has been observed that anesthesiologists have been especially resistant to PPO contracting. Capitation and the formation of risk pools, payment patterns largely associated with HMOs, are, predictably, almost nonexistent.

The final contract characteristic documented in Exhibit 2 is the widespread occurrence of the “gatekeeper” approach to specialist referrals. A feature of many HMOs, the gatekeeper mechanism is incorporated in contracts signed by nearly half the respondents who have signed only PPO contracts.

**Effects of selective contracting.** The early effects of selective contracting on patient load, gross revenue, and fees are shown in Exhibits 3, 4, and 5. A substantial number of respondents had yet to experience any measurable impact. In fact, 42 percent of those who had signed PPO contracts by early 1986 had yet to see any PPO patients at all. Although

---

**Exhibit 3**

Effects Of PPO Contracts On Patient Load By Specialty Of California Physician Signer, 1986

<table>
<thead>
<tr>
<th>Patient load factor</th>
<th>All specialties (n=180)</th>
<th>Specialty</th>
<th>GP/FP (n=25)</th>
<th>Medicine (n=42)</th>
<th>Surgery (n=75)</th>
<th>Other (n=37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have not yet seen any patients</td>
<td>42%</td>
<td>48%</td>
<td>41%</td>
<td>36%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Have seen patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients have increased</td>
<td>71%</td>
<td>77%</td>
<td>72%</td>
<td>70%</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Patients have not increased</td>
<td>29%</td>
<td>23%</td>
<td>28%</td>
<td>30%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patient load under contracting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 5 percent</td>
<td>53%</td>
<td>80%</td>
<td>59%</td>
<td>38%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>5–10 percent</td>
<td>22%</td>
<td>10%</td>
<td>29%</td>
<td>18%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>11–20 percent</td>
<td>19%</td>
<td></td>
<td>12%</td>
<td>35%</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Over 20 percent</td>
<td>6%</td>
<td>10%</td>
<td>–</td>
<td>9%</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Patients have requested physicians to enter contract</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42%</td>
<td>52%</td>
<td>48%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>58%</td>
<td>48%</td>
<td>52%</td>
<td>60%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>Patients lost because physician not participating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>68%</td>
<td>84%</td>
<td>74%</td>
<td>67%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>29%</td>
<td>16%</td>
<td>26%</td>
<td>29%</td>
<td>41%</td>
<td></td>
</tr>
</tbody>
</table>


*Includes “no answers” at 1.7 percent for all.

*As a percentage of those who have seen patients and excluding “no answers.”
this is a significant improvement from the 96 percent who had seen no patients in late 1984, it is still a substantial proportion. The lag is probably attributable to the long lead time that is required to establish and market a PPO, a fact that many overlooked in their anxious response to the new state policy, and to some respondents’ having entered into contracts in the recent past.

Nevertheless, the majority had seen PPO patients, and, of these, 71 percent reported experiencing some increase in patient load (Exhibit 3). This increased volume for PPO contract signers appears to validate the theory of competition underlying selective contracting: that contracting will increase volume in return for negotiated prices. The increases, however, appear slight thus far. The numbers reporting more than a 5 percent increase are very small compared to the total sample.

Whether or not patients have yet been seen, patient load will in many cases be affected to some degree by PPOs (Exhibit 3). Approximately half of the responding primary care physicians reported their patients had requested that they enter a PPO contract, and over three-fourths believe they have lost patients because of nonparticipation. Thus the competitive pressure exerted on physicians by selective contracting seems to be present and felt.

A final effect of great interest to policymakers as well as to physicians is the extent to which selective contracting lowers fees. More than four out of five respondents reported that contracted fees are at least 10 percent below their usual fees (Exhibit 4). Almost one-quarter state that fees received are 20 to 30 percent below their usual fee, while 15 percent indicated cuts of 30 percent or more. The fees of primary care physicians

---

**Exhibit 4**

Effect Of PPO Contracts On Usual Fee. Received, By Specialty And Practice Arrangement Of California Physician Signers, 1986

<table>
<thead>
<tr>
<th>Physician characteristics</th>
<th>Over 100 percent</th>
<th>91–100 percent</th>
<th>81–90 percent</th>
<th>71–80 percent</th>
<th>61–70 percent</th>
<th>60 percent or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>All respondents (n=180)</td>
<td>1%</td>
<td>16%</td>
<td>34%</td>
<td>24%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Grouped specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General/family practice (n=25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine (n=42)</td>
<td>2%</td>
<td>14%</td>
<td>31%</td>
<td>17%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Surgery (n=75)</td>
<td>1%</td>
<td>8%</td>
<td>40%</td>
<td>31%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Other (n=37)</td>
<td>27%</td>
<td>22%</td>
<td>22%</td>
<td>20%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Practice arrangement a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo (n=123)</td>
<td>1%</td>
<td>17%</td>
<td>30%</td>
<td>24%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Group (n=55)</td>
<td>15%</td>
<td>45%</td>
<td>24%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


a The California Medical Association study categories are the same as those used by the American Medical Association. “Group” includes partnerships, same specialty, and multispecialty groups.
are reported to be discounted less than those of surgeons and others. The data show a slight pattern of difference associated with practice arrangement; physicians in groups appear to do somewhat better than solo practitioners, with 60 percent of the former reporting fees at 81–100 percent of UCR, compared to only 47 percent of the latter.

Thus far, volume increases and/or lack of patients with PPO coverage have limited the effect of these price reductions on revenue (Exhibit 5). However, this cushioning effect is highly dependent on patient volume, in turn a function of PPO marketing, enrollment, and use patterns. Although prices have clearly been depressed, the ultimate financial effect on physicians of PPO contracting still is unknown.

The effects of contracting documented in Exhibits 3, 4, and 5 validate two of several early speculations on the impact of selective contracting by the physicians interviewed in 1984. Half of the group predicted that patient loads of physicians who contracted with PPOs indeed would increase and that physicians would accept lower fees to protect the flow of patients. Exhibits 3 and 4 corroborate these expectations.

A few other speculations, however, are worth reporting to compare with any future tests: physician/hospital relations will deteriorate; quality of care will decline; physicians will leave California and/or the field of medicine; interspecialty rivalry “in the gray areas of medical care” will increase; and contracting will disrupt teaching programs, since length-of-stay norms will prevent proper workups.

### Exhibit 5

**Effect Of PPO Contracts On Gross Revenue, By Specialty Of California Physician Signers, 1986**

<table>
<thead>
<tr>
<th>Effect on gross revenues</th>
<th>All specialties (n=180)</th>
<th>Specialty</th>
<th>Specialty</th>
<th>Specialty</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GP/FP (n=25)</td>
<td>Medicine (n=42)</td>
<td>Surgery (n=75)</td>
<td>Other (n=37)</td>
</tr>
<tr>
<td>Revenue up</td>
<td>3%</td>
<td></td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Revenue down</td>
<td>23</td>
<td>20%</td>
<td>48</td>
<td>55</td>
<td>49</td>
</tr>
<tr>
<td>No change</td>
<td>53</td>
<td>68</td>
<td>48</td>
<td>55</td>
<td>49</td>
</tr>
<tr>
<td>Do not know</td>
<td>17</td>
<td>8</td>
<td>14</td>
<td>16</td>
<td>24</td>
</tr>
</tbody>
</table>

**Source:** California Medical Association, “Physician Contracting Survey,” Winter 1986, Table 12.

**Satisfaction with contracts.** Although some intended effects of selective contracting are already evident, survey respondents tended to be cautious about expressing any overall impression about their contracts. Virtually half of the respondents (48 percent) cannot yet say whether they are satisfied or dissatisfied (Exhibit 6). This reticence holds across all specialty groups, practice arrangements, contract sponsorships, and even experience of seeing patients, where 40 percent of those who have seen PPO patients are still “unable to generalize” or think that it is “too
Exhibit 6
California Physician Satisfaction With PPO Contracts
By Experience With Patients And Impact On Revenue, 1986

<table>
<thead>
<tr>
<th>Selected variables</th>
<th>Degree of satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do not know yet</td>
</tr>
<tr>
<td>All respondents (n=180)</td>
<td>48%</td>
</tr>
<tr>
<td>Experience with PPO patients</td>
<td></td>
</tr>
<tr>
<td>Have seen increase (n=101)</td>
<td>40%</td>
</tr>
<tr>
<td>Have not seen an increase (n=76)</td>
<td>26%</td>
</tr>
<tr>
<td>Experience with gross revenue</td>
<td></td>
</tr>
<tr>
<td>Increased (n=5)</td>
<td>20%</td>
</tr>
<tr>
<td>Decreased (n=42)</td>
<td>23%</td>
</tr>
<tr>
<td>No change (n=96)</td>
<td>60%</td>
</tr>
<tr>
<td>Do not know (n=60)</td>
<td>60%</td>
</tr>
</tbody>
</table>

Source: California Medical Association, “Physician Contracting Survey,” Winter 1986, Tables 19f, 19g, 19h.

soon to judge.” Only when a respondent reports a decrease in gross revenue is there a clear signal of dissatisfaction. Yet even in this group, 23 percent still are reserving judgment, and 17 percent report themselves as “satisfied.”

The half of the sample ready to judge their contracts leaned somewhat toward dissatisfaction. Despite the predictable “revenue effect,” this position appears to have complex causes. Indeed; one respondent whose revenue had increased still is dissatisfied. Among PPO contractors who have seen patients, 31 percent nonetheless are dissatisfied to some degree, barely more than those who have not yet seen any. Of those whose patient census had increased, 24 percent are dissatisfied and 11 percent “very” dissatisfied. Even among the group of fifteen respondents whose patient loads had increased by 11 percent or more thanks to contracting, five (33 percent) profess to be dissatisfied, including one who is “very” dissatisfied.

Withdrawal from a contract is always an option when dissatisfaction exceeds any perceived benefit. Thus far there have been very few; only fifteen respondents had withdrawn from any PPO contract as of early 1986. Spread evenly among the specialty groups, the only unusual number of withdrawals was among dermatologists, of whom three out of ten who had signed PPO contracts also had opted out. By far the most prevalent reason for withdrawal among all the respondents was inadequate fees (cited by twelve), followed by “unacceptable utilization review,” “slow payments,” and “no patient increase.” The very small numbers here make generalizations about the prospect of future withdrawals or their causes quite risky.
Implications For Policymakers

First, physicians appear to be receiving and accepting contracts in adequate numbers to preserve access to care organized through initial PPO networks. The policy of selective contracting carries the risk that too few providers may be approached or persuaded to enter such arrangements, thereby diminishing access for consumers confined to (or propelled into) a restricted network. While there are no standards for judging sufficiency of physicians in a PPO, and virtually no data yet available on use of such physicians, it is reasonable to infer that an overall PPO contract acceptance rate of 76 percent should be adequate to assure access to medical services. The marketplace certainly deems the current PPO physicians lists acceptable; the state has at least sixty PPOs available to four million people. Our data suggest that these PPOs, on average, probably have adequate physician capacity.

Second, California physicians in private practice, like other working groups in the United States today, appear willing to tolerate reductions in the price of their labor, presumably in return for some protection of their ability to work. The policy of selective contracting was designed expressly to lower the prices that third-party payers would have to pay. Competition for contracts would be the mechanism. The evidence is strong that this has worked with regard to hospitals’ prices, and the responses here indicate the same is true for physicians’ prices. Whether the utilization review so prevalent in PPOs will counter a natural tendency for volume to rise (to preserve gross income) remains to be seen.

Third, California physicians, as a group numerous and generally considered politically potent, were unable to block development of a new payment mechanism that directly threatened their livelihoods. Disaffection from the policy of selective contracting is widespread, but so is disunity concerning problems of health care financing and appropriate societal intervention. Nor is it clear that any viable professional opposition can ultimately emerge. Competition for contracts may divide fellow specialists, separate specialties differentially affected by contract requirements, and split older physicians, many of whom are determined to resist change, from younger ones who are generally more inclined to acquiesce. If a state adopts selective contracting in defiance of opposition from organized medicine, physicians likely will fall into disarray, as personal practice philosophies and requirements supersede the laborious process of developing a collective response.

Early data thus indicate that selective contracting can accomplish its economic goals without jeopardizing access to physician services. There is a final implication of the policy, however, that may be of deeper significance in the long run. As selective contracting challenges physician independence, so it also undermines the position of medicine as the
“heroic exception,” the profession most resistent to the corporate form and ethos so pervasive in American life. The power that has sustained this status has been deplored by many. But the ethic of concern and selflessness that has justified it is important in the health care field and to American society as a whole. A surgeon interviewed in 1984 defended the medical ethic: “Medicine will survive because it’s real . . . . People love their doctors and doctors love medicine. We’d do it for nothing.” However, the strength of this ethic in relationships defined by commercial contracts is unknown.

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NOTES

1. Blue Shield, entirely separate from Blue Cross in California, is not covered by the legislation. It could have contracted selectively at any time, had it so chosen, and can do so now. Although it has set up a PPO involving selective contracting with hospitals, Blue Shield simply folded all of its physician members into the PPO as “preferred providers.”
3. Johns et al., selective Contracting for Health services in California, Table 7 (131 out of 208 entities).