

Issue Brief

Findings from HSC



WALL STREET COMES TO WASHINGTON:

Market Watchers Evaluate the Health Care System

Purchasers are tolerating double-digit premium increases for health plans and agreeing to employee demands for open-access products and wide choice of doctors largely because of the robust economy and tight labor markets, according to a panel of analysts at the fifth annual Wall Street roundtable convened by the Center for Studying Health System Change (HSC). The analysts, who specialize in health care companies, also discussed the challenges facing managed care and how health plans are evolving. This Issue Brief reports on these and other trends, including employers considering defined contribution approaches, techniques to control pharmaceutical spending and the impact of the Internet on the health care system.

Double-Digit Premiums Expected

This year's surge in health insurance premiums, according to a panel of Wall Street analysts, will continue for the next several years. The analysts predict premium increases of 10 percent or more in 2001 and 2002. According to Norman M. Fidel, senior vice president of Alliance Capital Management, commercial premiums went up between 7 and 7.5 percent in 1999 and will rise around 9 percent in 2000.

Currently, premium increases are exceeding underlying cost increases, signaling change in the underwriting cycle. This cycle begins when cost increases are higher or lower than expected, leading to insurer profitability diverging from the norm. Thus, when cost increases unexpectedly declined during the first half of the 1990s, the high profitability of the industry attracted a great deal of

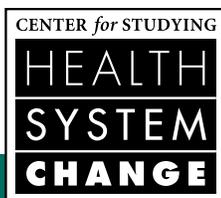
capital. As insurers sought to expand market share through low premium quotes, premium increases were lower than cost increases, and profits declined. With insurers ultimately willing to sacrifice market share to restore profitability, the industry entered the current phase of the cycle in which premium increases exceed cost increases.

Purchasers' ability to negotiate lower premiums has also been constrained by their need to offer good health plans with broad choice to attract and retain scarce employees. "Right now," said Fidel, "people want more freedom, and corporations are willing to go along with that because there has been an unusual period of prosperity." The panelists also observed that the passage of patient protection laws in almost every state has added appreciably to the recent rise in health

plan premiums, estimated by Merrill Lynch managing director Roberta Goodman as a contribution of 1 to 2 percentage points.

Goodman suggested that large premium increases will only be acceptable for so long. Many employers are facing their first premium spike since they rushed to jump from expensive indemnity insurance to managed care in the early 1990s, she noted. She raised the question of whether employers will continue to have confidence in managed care. "What they are facing now is what they saw a decade ago from the indemnity sector. Plan sponsors are looking at an industry that is not solving the cost problems that it was set up to address in the first place."

As tight labor markets loosen, employers will seek options for dealing with rising premiums while





This Issue Brief is based on a roundtable sponsored by HSC on June 21, 2000, in Washington, D.C.

PANELISTS

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Alliance Capital Management

Roberta Walter Goodman

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broadening plan choice, the analysts concurred. More employers may implement fixed-contribution arrangements, broadening product offerings but contributing the same amount of money no matter what plan their employee selects. The contribution would be pegged to the lowest-cost plan offering.

In addition to fixed contribution, the analysts discussed other ideas employers are considering that fall under a broad term called "defined contribution." None of these innovations has been implemented, but they do address employers' desire to shoulder less of the premium burden and be less accountable for how health plans they offer are managed. The defined contribution idea includes arrangements where employees essentially get a voucher for a set amount for health coverage, and then select a plan on the open market, bearing the cost for more expensive coverage. Another approach removes the plan from the equation, allowing consumers to choose whatever providers they would like and to pay for their care from a medical spending account.

Samuel W. Murphy III, vice president and senior equity analyst at American Express Financial Advisors, saw "a huge drive" behind defined contribution. "At the end of the day, it may be the one thing that allows health care spending to come under control: having consumers be responsible for their own spending and see the effects of how they spend their dollars," he said.

There are large obstacles to implementing these concepts, the analysts said, from tax deductibility questions to the opposition of labor unions, but the potential for a more predictable budget for health benefits and perhaps decreased liability from being taken out of the medical management loop will make defined contribution more attractive, particularly if right-to-sue legislation becomes a reality.

Modest Improvements for Providers

Only a portion of premium increases is being passed along to providers, and what is passed along varies considerably across markets and type of provider, the analysts

said. Dennis Farrell, managing director of public finance for Moody's Investors Service, noted that hospital systems in large markets have secured rate increases of from 4 to 5 percent up to 10 percent from their managed care partners, while many smaller, stand-alone institutions have not seen their rates budge in recent years.

For-profit hospitals have been especially strong players of late, said Murphy. "They—like their nonprofit counterparts—have come through a period of pain," he said. "Five years ago they really did not know what managed care organizations were and how to react to them."

In general, hospitals have been financially strained after going through a period of robust profitability. The pressures they face stem from unfavorable contracts they struck with managed care organizations, rising pharmaceutical costs, reductions in Medicare funding stemming from the Balanced Budget Act of 1997 and labor shortages, panelists said.

One widespread response by hospitals has been divestiture of costly physician practices and renewed focus on core inpatient and outpatient care. "Hospitals are actually going back and calling themselves hospitals," Farrell said. "They are also recouping or addressing the impact of some very bad contracting decisions they made in the mid-1990s," added Goodman.

The analysts said that despite the way providers might feel, insurers recognize when providers are cutting too close to the bone. In some places, insurers have intervened to keep providers from going under. HSC associate director Joy M. Grossman said, "During our site visits we heard that plans are concerned about the financial viability of providers." Insurers know that as they do better, "they need to pass on some of those revenues. The question is how much and when," she said.

Doctors are in an even tougher spot than hospitals, according to Fidel. "A well-entrenched hospital system in a specific region has very good bargaining power against managed care, but not too many physicians do, because where physicians are organized in large groups, managed care organizations also are very large, so the bargaining power is equaled out."

How Is Managed Care Changing?

Although it was heralded as signaling a new path for managed care when it was announced, most of the panelists noted a recent policy shift by United Healthcare brought about only modest change across the industry. United replaced its traditional utilization management programs with less intrusive physician profiling in hopes of demonstrating that the latter “can have a positive impact without being in the face of the provider,” Goodman said.

The analysts noted that United was already a relatively open plan, without a gatekeeper requirement. Geoffrey E. Harris, global head of corporate finance in the health care division of UBS Warburg, said that United had begun by shifting the focus of its utilization management efforts to the chronically ill and big-ticket items, while trying to reduce obstacles to providing most routine care. The company found that it could influence physician behavior and save money. Harris added that United hoped to reduce its \$100 million annual budget for utilization management by implementing its new policy.

Farrell said that despite United’s claim that it had saved money, it is virtually impossible to measure whether such approaches will be more efficient and, at the end of the day, will mollify doctors. Harris said that other plans will try and move in that same direction, but it will be slow going. Goodman agreed, noting that “some plans think that if the economic conditions change, they can go back to doing things the way they always have. I don’t think there has been a philosophical adjustment for a lot of them.”

Meanwhile, capitation, a system many hoped would restore provider profits and autonomy, is on the decline. Panelists characterized capitation as inconsistent with the point-of-service, open-access insurance plans consumers are demanding. It also has not offered plans the predictability of costs they were looking for or providers the profits they had hoped for, said Goodman.

Another reason why providers may be resisting aggressive moves toward

capitation is the increasingly litigious environment they find themselves in, fearing perhaps they might wind up facing liability for medical restraint in an environment where they are at risk, Harris said. Murphy went so far as to call capitation “another failed experiment in American health care.”

Managed Care Challenges

There has been an outbreak of class action suits recently accusing health plans of a wide variety of wrongs, from malpractice to racketeering. “The strategy of the plaintiffs’ bar is to throw everything they can up against the wall and see if anything sticks,” Fidel said. The analysts saw little chance of the suits having an impact. Plans may be paying more attention to disclosing their policies and practices as a result of the suits, but they are not changing how they manage care, Fidel added.

Although the analysts were quick to say that they didn’t think it feasible, they noted that if physicians were successful in gaining collective bargaining rights, it

could represent a real shift in the balance of power between plans and providers and also could eliminate managed care techniques doctors find onerous.

Physicians are backing a bill in Congress proposed by Rep. Tom Campbell (R-Calif.) that would allow collective bargaining by independent physicians, attempting to gain through political means what they are having difficulty achieving in the market. Given the broad array of opponents—including the Clinton administration, pro-market Republicans and consumer groups—the analysts predicted that it was very unlikely the Campbell bill would become law.

Another issue that some plans have been dealing with is the failure or poor performance of newly acquired plans. While myriad factors affect whether these merged organizations and new arrangements are successful, the analysts agreed that paramount among them is when the deal was implemented relative to the underwriting cycle.

When you are in a healthy underwriting environment, said Harris, it is not apparent which newly merged

INTERNET LETDOWN

In spite of enormous amounts of money flowing into the information technology sector in recent years, and high hopes that the Internet will carve billions of dollars of administrative costs out of the health care system, the analysts uniformly saw the web as an evolutionary, not a revolutionary, technology. “I don’t think the Internet is a big enough change to get over intrinsic hurdles in the industry,” said Murphy. Health care is “massively fragmented” and “extremely complicated,” he noted. It is also difficult to get physicians and other caregivers to adopt and reliably use computer-based tools.

Murphy said that the persistent lack of standardization in health information systems raises questions about the veracity of estimates that a sixth of the U.S. health care budget could be saved by eliminating unnecessary paperwork. “If it was \$200 billion, the industry would have figured out how to pare down the paperwork by now,” he noted.

Health plans rather than the new e-companies are likely to chart the course for how information systems are deployed and used, and the next 12 months will reveal a great deal about how successful they will be, the analysts said. Through consortia, plans may finally overcome the most severe hurdle to building information networks: the fear doctors have of being required to have separate systems for each of the many plans they bill. The Internet’s most profound impact probably falls on insurance brokers, because the web is especially effective at finding best prices and carving out middlemen.

According to the Analysts

“Everybody is getting out of capitation. The reality is, it’s virtually impossible to control physicians and consumers,” said Farrell.

“The threat of price controls for drugs is a chiller. If it became a greater probability, it would be very negative for pharmaceutical R & D spending,” commented Fidel.

“It will be difficult to move back to very restrictive health plan models because the mood of the public toward such models has been extremely negative and will remain so,” asserted Goodman.

“Health plans beware: Employers will become much tougher when the economy weakens significantly, when there are layoffs or the labor markets loosen and when corporate profits are under pressure,” noted Harris.

“The only way that any information technology can have an impact on care is if you get broad acceptance at the physician level—at the point of patient care,” said Murphy.

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organizations will be success stories in the longer run. In such an environment you can buy some time to fix problems. “But if you are skating on thin ice to begin with, and you lose track of your cost trends, you get clobbered,” he said. “That happened to numerous plans over the last several years.”

The analysts were also skeptical about mergers across discrete markets, noting that because local market share is key, mergers among plans that have overlapping markets have a far better track record. “Buying another plan in a different location makes you bigger, but in practical terms, it’s much more beneficial to have mass in a market because it increases your bargaining power,” Fidel said.

Goodman added that plans that execute out-of-area deals frequently underestimate the importance of local market factors. “Health care is very much a local market business. Local markets differ in terms of the organization of the delivery system, the economy, the employer base and basic consumer preferences.” Some plans didn’t understand what they would need to contend with in the new markets they moved into, she added.

Pharmaceutical Spending

Drugs are becoming an ever-larger share of national health spending, and total spending on pharmaceuticals has grown dramatically in recent years. That will not change, but the rate of growth is likely to ease in the next few years, according to Fidel, because patents of some key drugs are about to expire, and the flow of blockbuster drugs coming on the market is slowing down. Fidel also pointed out that in other countries, pharmaceutical spending represents 15 to 25 percent of the total health care economy, but in the United States it is only 8 percent.

Fidel said that the growth in the amount health plans spend on pharmaceuticals, which has risen about 15 percent in each recent year, is likely to level off and perhaps decline in the next few years, as so-called three-tiered copayments proliferate. These are systems in which enrollees pay increasing amounts out-of-pocket for a broader selec-

tion of drugs to choose from. According to several panelists, consumers favor this system over closed formularies because they can get access to desired drugs if they are willing to pay the additional cost.

The wild card in pharmaceutical spending over the longer term is whether Congress will add a drug benefit to Medicare, something Fidel saw as quite probable. “Assuming that something does pass Congress, there’s going to be a tremendous increase in demand for drugs,” he said. “Only a third of people in the United States over age 65 have good drug coverage now.”

Much of the impact of a Medicare drug benefit on the industry would be determined by how the government pays for pharmaceuticals, and how it regulates the growth of that spending over the long term. Fidel said Medicare could use pharmacy benefit managers (PBMs) to negotiate prices for drugs, just as the private sector has done. But Goodman observed that PBMs have worked in the private sector because they limit options within certain categories of drugs, something Medicare would find difficult politically. It would probably take more stringent measures than PBMs to keep the program from getting out of control, Farrell commented, but he did not favor price controls either. Limiting spending under such a large new entitlement would be “very, very difficult,” he said. ●

Log on to www.hschange.org for a full transcript of this meeting or for a copy of last year’s roundtable discussion, “Wall Street Comes to Washington: Analysts’ Perspectives on the Changing Health Care System,” Issue Brief No. 21, September 1999.

For a richer discussion of defined contributions, see Issue Brief No. 32, to be released in October.