Issue Brief
Findings from HSC

WALL STREET COMES TO WASHINGTON:

Market Watchers and Policy Analysts Evaluate the Health Care System

As health care costs surge again, most insured consumers are enjoying greater access to care, many health plans are prospering and employers are wringing their hands over how to pay for it all, according to market and health policy analysts at the Center for Studying Health System Change's (HSC) sixth annual Wall Street roundtable. Panelists discussed the outlook for managed care, including the Medicare+Choice program, hospitals and pharmaceutical costs; the untapped promise of evidence-based medicine to help control costs; and the growing animosity between health plans and providers.

Managed Care Backlash Unleashes Higher Costs

In the wake of a booming economy and a tight labor market, health care cost-control efforts have taken a back seat to consumer demand for more care and a broader choice of physicians and hospitals. Insurers have responded by offering plans with wide provider networks at a higher cost. And employers, so far, have taken few steps to shift costs to workers as employers face another round of double-digit premium increases in 2002.

"The backdrop right now is not toward cutting costs; it's toward providing more care," said Norman M. Fidel, a senior vice president at Alliance Capital Management. In fact, the big surprise so far in 2001 is that employers have done so little to shift costs to employees, he said.

But consumers shouldn't get too comfortable with the status quo, because declining corporate profits and increasing medical costs and insurance premiums will eventually force employers to shift more costs to workers, panelists agreed.

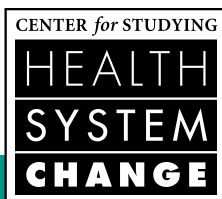
Robert Reischauer, Ph.D., president of The Urban Institute, believes three main factors will determine how quickly employers begin major cost shifts to employees. First, if the tight labor market significantly loosens, employers will no longer have to compete as aggressively to attract and retain workers. Second, if corporate profits continue to shrink, firms will have less leeway to absorb higher premiums. And finally, the magnitude and duration of underlying medical cost increases may push employers to increase cost sharing.

"Right now, the plans and the employers are sort of helpless, but I don't think that can continue very long in the face of underlying cost increases," Reischauer said. "I think more of this burden is going to be pushed off onto employees."

Currently, consumers' health care expectations are almost limitless, said Roberta Walter Goodman, a Merrill Lynch managing director. "If you look at what we expect out of our health care system, we think it should cover anything we need, anytime we want it, from whomever we want it with no delays…and we think that somebody else ought to be paying every last dime of the care, and that's our basic problem," she said.

Higher Medical Costs Fuel Premium Increases

While pharmaceutical costs continue to be a major driver of increasing medical costs, drug spending appears



This Issue Brief is based on a roundtable discussion, "HSC's Sixth Annual Wall Street Comes to Washington: Market Watchers and Policy Analysts Evaluate the Health Care System," held on July 12, 2001, in Washington, D.C.

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to be tapering off slightly because of drug patent expirations and increased consumer cost sharing, Fidel said. At the same time, inpatient hospital, physician and outpatient costs are increasing significantly.

"Now we have everything else accelerating—hospital costs are moving into the high-single digits from the low-single digits," Fidel said. "Physician costs, which used to be flat to down, are now in the mid-single digits, and outpatient care is now the largest single incremental cost trend facing health plans."

Employers will have to respond because they can't absorb double-digit premium increases every year and remain competitive in today's global marketplace, Fidel said, adding, "So, to me, the only solution is to put the costs on the consumer."

Based on information gathered during HSC's recently completed site visits to 12 nationally representative communities across the country, HSC Associate Director Joy M. Grossman, Ph.D., said health plans are exploring new types of products, but few actually have been launched.

For example, some plans are looking at creating multiple provider networks with different consumer cost-sharing requirements at the point of service. Other ideas include a cost-choice trade-off at the time of enrollment by allowing consumers to decide up front whether they want to pay a higher premium or face increased cost sharing down the road. Another option, usually geared at small employers, could be a return to narrow-network products where consumers give up broad provider choice in exchange for lower costs.

In recent years, consumers largely have been sheltered from rising health care costs, as the strong economy and tight labor market prompted employers to offer generous health benefits, Goodman said. "Consumers have wanted more, and the real out-of-pocket cost sharing has gone down very substantially."

Despite the slowing economy, large employers will move cautiously in redesigning health benefits because they must still attract and retain workers, Goodman said. If some major employers move toward restructuring benefits to prod workers to make more cost-conscious health care choices, she said, "I think you'll see others follow suit, but I think they have a very hard time going first."

The Promise of Evidence-Based Medicine

Goodman predicted more health plans will abandon restrictive care-management practices such as preauthorization for care and instead invest in information technology to analyze physician and hospital practice patterns to determine whether patients are receiving the best care based on current scientific evidence.

Research shows that there are "substantial gaps between what is done in the marketplace by practicing physicians and what we know from evidence-based medicine to be more appropriate. To the extent that managed care companies can identify and help close those gaps through quality incentives … that can have a very positive impact on costs over an extended period of time," she said.

Fidel agreed that identifying providers who are providing high-quality, evidence-based care—often at a lower cost—and focusing on disease-management techniques for high-cost illnesses are worthwhile goals but will require significant information technology investment. "Health plans are striving to do that, but it's a long and expensive process," he said. "But the whole idea of disease management, trying to treat the very expensive diseases—which represent so much of the cost—is a direction it's going."

However, Grossman said HSC site visits indicated investments in quality initiatives and information technology "are still pretty fledgling, and most of the people we spoke with didn't really have any sense of cost effectiveness."

Given the wide variation in how physicians treat the same medical conditions across the country, gaining physician buy-in for evidence-based medicine may prove challenging for health plans. Physician responses will vary, Goodman said, with some readily accepting a shift to evidence-based practice, while others will question plans' motives.

"The issue that some companies will face is that if they've had a fairly confrontational set of relationships with the physician community…there's going to be a level of distrust that whatever is being said is being said because of concern about cost and not because of concern about quality," she said.

Plans and Providers Play Hardball

Some providers, especially prominent hospital systems, have gained the bargaining clout needed to demand significantly higher payments from health plans, panelists agreed. As providers and plans square off over contracts, already tense relationships have grown more contentious.

"There's an extraordinarily adversarial relationship going on right now that is not necessarily healthy for the industry, let alone the participants....It's eat or be eaten," said Dennis M. Farrell, a managing director at Moody's Investor Service who follows not-for-profit hospitals.

Health plans and providers alike have changed strategies, shifting from tactics to gain market share to restoring profitability. "The distinguishing factor between five years ago and today is five years ago it was market share at all costs, and today it's fiscal discipline for survival," Farrell said, adding that the "self-induced pain" for plans and providers as they pursued market share was "phenomenal."

While the stars have aligned—in the form of increased Medicare and commercial plan payments—to put hospitals in a better overall position, hospitals that successfully consolidated and gained market share are prospering, while others are in "dire financial straits, and insurance companies want to prop them up" to ensure markets remain competitive, Farrell said. He added that he is "skeptical" that hospitals in general have really gained that much leverage over health plans.

HSC President Paul B. Ginsburg, Ph.D., who moderated the roundtable, noted that many examples of hospitals winning significant payment increases have involved "the very prestigious hospitals" that consumers want in their health plan networks.

There's a Reason They Call It Risk Contracting

Burned by significant financial losses, many providers are shying away from risk contracts with health plans, which pay a set monthly fee for each patient's care, a practice known as capitation.

"Capitation was a huge, huge fiscal problem for providers," Farrell said. "If an insurance company was giving you an opportunity so easily, you ought to look at it carefully. There's a reason why they're letting you take that risk on."

Goodman characterized capitation as a "flawed model" because physicians were unaccustomed "to managing patients on a population basis, they're used to managing them one-by-one as they come in the door." Initially, payments were large enough, but as health plans ratcheted down payments, concerns about care rationing generated tremendous ill will toward the managed care industry, she said.

Robert A. Berenson, M.D., a senior adviser at the Academy for Health Services Research and Health Policy, said capitation didn't work for many reasons, including the lack of risk adjustment to compensate providers for caring for extremely sick patients and providers taking on risk for services not directly under their control.

"That was a mistake. In many cases, the risk was unlimited," he said. "And I think the public lost faith because of the absence of disclosure about what this was all about."

Berenson warned that a return to the old fee-for-service system won't work either, but using physician profiling "to reward those who are doing the right thing" might hold some promise. "I find it unfortunate that capitation didn't work out, and I'm not convinced that it won't be coming back" in some form, he said. "I hope we learned some of the lessons of where it failed."

Pharmaceutical Costs

The one area where employers have moved swiftly to stem rising costs is the adoption of three-tier pharmacy benefits, where consumers, for example, pay $5 for a generic drug, $10 for a preferred brand-name drug and $25 for a non-preferred name-brand drug. Fidel estimated that 55 percent of health plans offer a three-tier pharmacy benefit structure. While a three-tier benefit saves employers some money

Medicare+Choice: Send in the Money

Originally envisioned as a way to save money and expand benefits, the Medicare risk-contracting care program, known as Medicare+Choice (M+C), has fallen on hard times in recent years. Health plans continue to exit the program, complaining that payments are too low. Asked what marketplace or policy changes would be needed to revitalize M+C, Wall Street analysts and policy experts agreed increased payments will be needed to entice health plans back into the fold.

Berenson suggested that policy makers must first decide what the program's main purpose is—either a vehicle to save money compared to traditional fee-for service Medicare or a way to offer beneficiaries more choices. "There's no agreement at this point on what we're doing with Medicare+Choice," he said.

Reischauer said the only thing that can save Medicare+Choice is "rapid and persistent increases in Medigap premiums" because M+C's main competition is traditional Medicare packaged with Medigap coverage. "To the extent that Medigap becomes much more expensive, Medicare+Choice plans should be able to market an attractive product," he said.

Because the government M+C payment is fixed, plans facing rising medical costs often have no alternative but to reduce optional benefits or charge beneficiaries a premium. "Reluctantly, many of the plans are coming off of zero premium, but their reluctance was largely because of adverse selection concerns—that those who would stay with them would be sicker," Berenson said. While Medicare+Choice looks like a better deal compared to traditional Medicare and Medigap, "the sale isn't happening once you move off of a zero premium," he said.

According to the Analysts

"Greater focus on best practices and weeding out the 30 percent of care that's inappropriate, ineffective or outright harmful is really what the managed care companies ought to be doing," Goodman said.

"I think one of the issues will be whether plans get the gumption to steer patients with different complexities to different settings, either through financial incentives or through other mechanisms," Reischauer said.

"Maybe we'll be talking about $70 copayments for a month's supply of drugs, possibly in a few years," Fidel said.

"There has been no reaction from employers, principally because of zero unemployment. This should change now that the bloom is falling off the rose," Farrell said.

"In the absence of risk adjustment, the government is actually losing a fair amount of money on the Medicare+Choice program," Berenson said.

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and may decrease utilization, it does little to lower the overall cost of pharmaceuticals "because you're off-loading higher copayments onto the individual," he said.

"And, in fact, with the good drug benefits that managed care offers, there's been a real acceleration in demand for drugs, and so managed care actually turned out to benefit the drug companies, and they've been in a real period of prosperity," he said.

Both physicians and patients are susceptible to pharmaceutical company pitches for expensive new drugs, several panelists agreed. "The American Medical Association had a resolution about reconsidering direct-to-consumer advertising, as if you could put the genie back in the bottle at this point," Berenson said. "In fact, I think one of the scandals, as documented recently by *The Wall Street Journal*, is the relationship between physicians and pharmaceutical company detail people. As one of the doctors said, he goes out to dinner every night on a different drug company."

In some areas, public health officials and health plans have launched "counter-detailing" approaches to educate physicians about proper and less expensive medication use, including generic drugs, and health plans might be well advised to work together on that kind of a project, Berenson said.

Consumers also must take more responsibility, Goodman said, adding, "You also need counter-detailing on the patients themselves because I think one of the things you hear from doctors is that patients come in convinced that they need whatever it might be, Lipitor or Claritin. If the doctors try to say, 'No, you really don't,' patients threaten to move to another physician, so they end up writing the prescription because it's the easiest thing to do and they don't want to alienate patients."

The Age-Old Trade-Off: Cost, Quality and Access

Asked by Ginsburg what it would take to "galvanize either employers or government" to take action to stem rising health care costs, the panelists agreed the flash point for change is still quite distant.

"I think if you have the economy really slow, have unemployment really rise, have people who are middle class or perceive themselves to be middle class facing catastrophically high expenses or the potential of losing their coverage, then the debate shifts and it's the old three-legged stool," Goodman said.

"You know, we fluctuate among being concerned about access, being concerned about quality and being concerned about costs, and I think right now we are very concerned about quality measured by, 'I have the ability to get whatever I want whenever I want it,' and access as in, 'I have that access,' not necessarily that the less privileged have that access," she said. "And the cost and broader access issues have really receded."

Public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) are facing the same cost pressures as private purchasers, and Ginsburg asked how states are likely to respond to rising costs.

After pushing to expand coverage to the uninsured, especially through SCHIP, Reischauer noted that many states are now facing budget shortfalls, driven in many cases by rising health care costs. "Some states are going to find that they've bitten off more than they can chew in this area over the next couple of years and are going to stop expanding coverage, if not retrench," he said. ●

Log on to *www.hschange.org* for a full transcript and audio webcast of the roundtable or a summary of last year's roundtable, *Wall Street Comes to Washington: Market Watchers Evaluate the Health Care System*, Issue Brief No. 31, September 2000.

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