CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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Wall Street Comes to Washington: Analysts' Perspectives on Health System Change

Security analysts took a hard look at the latest trends in the health care industry at the third annual Health System Change Wall Street roundtable held earlier this year. The roundtable focused on costs and premiums, evolving financial relationships among industry leaders, industry consolidation and pharmaceutical and technology development. The analysts' conclusions: some market strategies—including vertical integration, provider risk-sharing and equity arrangements and the use of formularies to rein in drug costs—haven't worked out as expected. Health plans and provider organizations have yet to find a magic bullet for controlling costs while responding to purchasers' and consumers' demands for broader choice. This Issue Brief reports on the trends discussed at the roundtable.

COSTS AND PREMIUMS

Nationally, medical costs are increasing about 3 to 5 percent a year—a rate slightly higher than it was a few years ago, but still much lower than during the early 1990s. So why are health plans struggling with tight profit margins? The real culprit, four Wall Street analysts agreed, is undisciplined pricing.

"In the early '90s, the cost trend was in the high single digits, and profit margins were rising because prices were going up more than costs," explained Norman M. Fidel, senior vice president at Alliance Capital Management, L.P. "The industry was increasing prices at a rate of 7 to 10 percent."

Fat profit margins during 1993-94, combined with the national debate on health care reform, brought renewed pricing pressures on health plans, which lowered their premium increases to 0 to 2 percent for three years between 1995 and 1997. But costs were rising faster than prices. The result: a severe loss of profitability for health plans. In 1996, only 35 percent of publicly traded HMOs were profitable.

Now premiums are on the rise again. Premiums for employment-based health insurance increased 3.3 percent this year, compared with a 2.1 percent increase in 1997. Still, this growth is far slower than the predictions of 5 to 7 percent that several industry experts reported in the news media.

Geoffrey E. Harris, managing director for Salomon Smith Barney, noted the effect of competition on premium pricing. "The swings in the premiums are principally capacity-driven," he observed. "The number of HMOs actually declined from 1989 through 1993, largely because of the tremendous losses incurred just before that period. So in the early 1990s, we had a declining number of competing plans and rising enrollment, and that led to a reasonably favorable pricing environment and profitability.

"As the industry peaked, everybody jumped into the business," Harris continued. As a result, he added, the number of HMOs competing in local markets has grown since 1993 from about 550 to more than 800 today.

Profitability then declined with the entry of new plans. "In view of current losses, we are going to see the number of plans start to diminish again as struggling companies like Oxford Health Plans and Foundation Health begin to pull out of markets," Harris maintained. "That is what is going to drive the premium trend back up and the corresponding increase in profitability."

During the early 1990s, plans tried to take advantage of what turned out to be aberrant cost trends to grow their markets and their

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Panelists

Karen M. Boezi
Coral Ventures

Norman M. Fidel
Alliance Capital Management, L.P.

Geoffrey E. Harris
Salomon Smith Barney

Roberta L. Walter
Merrill Lynch

Moderators

Paul B. Ginsburg
Joy Grossman
Health System Change

product lines, commented Roberta L. Walter, managing director of Merrill Lynch. "That led to a lot of very foolish behavior by the plans—not only on pricing, but in expanding into new geographic markets and products with which companies had relatively low levels of expertise," Walter said. She agreed with Harris that many plans are now pulling back and rethinking their business, especially with Medicare, Medicaid and point-of-service products.

Consumers want choice, and employers are loathe to force consumers into plans that restrict that choice.

THE RISING COSTS OF PHARMACEUTICALS

Although overall health care costs have not risen significantly, pharmaceutical spending has accelerated dramatically since 1995. According to Harris, drug costs as a proportion of total costs for managed care plans have risen to about 15 percent; in 1997 alone, they jumped by as much as 20 percent. Within 20 years, pharmaceutical spending may account for 30 percent of all health care costs, Karen M. Boezi, venture partner at Coral Ventures, predicted.

Fundamentally, Fidel noted, drug benefits under most managed care plans are more generous and easier to access than they were under traditional fee-for-service plans. In addition, many Medicare risk plans are providing drug benefits for which beneficiaries under fee-for-service have to purchase supplemental insurance. As a result, consumers have come to appreciate—and expect—richer drug benefits under managed care. As the over-65 population continues to grow, pharmaceutical use will escalate even more dramatically, Boezi pointed out. Direct-to-consumer advertising is also helping drive demand. The pharmaceutical industry will spend about $1.5 billion on direct-to-consumer advertising this year, versus $500 million just two years ago, Boezi noted.

On the supply side, production is booming. The U.S. drug industry is expanding by about 15 percent this year; as much as 90 percent of that growth is in units, not price, according to Fidel. He attributes that expansion to "newer and better drugs." For example, the Food and Drug Administration (FDA) approved 42 new drugs in 1997 and 54 in 1996. "Previously, we were getting 20 to 25 new drugs approved," he said. At the same time that the FDA has streamlined and accelerated its approval process, drug companies have been making major technological advances in developing very expensive treatments, like Viagra, that improve quality of life, as well as drugs for diseases, like cancer and AIDS that extend life. (See *The Impact of New Drugs and Other Technologies* on page 3.)

Attempts by managed care plans to temper pharmaceutical costs with formularies have not been successful. Only 5 to 10 percent of Americans are in plans that have restricted formularies, according to Fidel. "The capability of the plans to control drug spending is just not as great as we perceive it to be," he said. The reason: consumers want choice, and employers are loathe to force consumers into plans that restrict that choice.

A critical and yet unanswered question is what effect pharmaceutical use has had on overall health care costs. Although pharmaceutical costs have increased substantially, other costs, including hospital and physician costs, have generally fallen. However, Harris noted, health plans to date have not identified the extent to which these trends are related. Instead, they examine each area of expenditure separately. As a result, the magnitude of the offset, in reduced hospital days and other costs resulting from increased pharmaceutical use, is unclear.

SECOND THOUGHTS ABOUT FINANCIAL ARRANGEMENTS

The analysts agreed that industry leaders are having second thoughts about capitation and risk-sharing as business strategies, in light of many providers' difficulties with managing capitation. Harris

pointed out that some payers have had to bail out financially troubled providers or restructure their financial arrangements and take back risk. At the same time, industry data show that although some managed care plans are increasing their use of capitation, consumers are opting to enroll in point-of-service, preferred provider and other types of plans that tend to use little or no capitation. "The actual percentage of managed care patients in capitated arrangements has gone down," Walter noted. "The structure has spread, but the volume has actually shrunk."

In some markets, managed care companies have experimented with capitating specialists as an alternative to capitating primary care physicians. The objective is to promote better utilization and cost management, but progress on this front has been limited by lack of information. "HMOs really do not have a handle on their costs for individual diseases, so to do single-specialty capitation has been very difficult because they don't have the numbers to negotiate the rates," said Boezi.

Capitation at any level may not be a feasible approach for managing utilization and costs among the fast-growing open-access and point-of-service plans, Walter noted. For specialty care, consumers are less likely to stay within a plan's network—especially when that care involves serious, expensive diseases like cancer. "Companies are going to have to look beyond capitation as a tool for medical management," she said.

Managed care companies are increasing their use of capitation in government-sponsored plans, especially in Medicaid, where rates are very unpredictable, said Fidel. Medicaid capitation has proved to be a very risky strategy for providers, Walter observed, although on the Medicare side, providers have fared better. However, Fidel pointed out that in the face of smaller rate increases, some of the bigger plans are looking to capitation to help them offload risk onto providers. It is uncertain whether providers will do any better than plans under these circumstances.

Industry leaders are having second thoughts about capitation and risk-sharing as business strategies.

NETWORK DESIGN UNRESOLVED

Network design continues to pose murky questions for plans. Analysts noted that some plans are struggling with achieving the proper balance of provider access, breadth and cost control. From a cost management standpoint, it may be easier to control utilization in narrow provider networks. But because consumers place high value on provider choice—and often have been willing to pay extra for that choice—those designs have not always succeeded.

Provider access is key to making more open network designs succeed, said Walter. Plans with adequate provider networks and access to those providers will experience less out-of-network use, she said. Otherwise, expensive out-of-network utilization can become a problem. "This is a very complex product to manage," Walter observed.

The analysts said that broad networks do not necessarily mean higher costs for plans. "We have seen some plans that have open access and very broad networks, where the cost trends seem to be as low as those in other plans," Fidel said. "It's a question of how good the information systems are and how well all the managed care techniques are practiced within a plan." A lot depends on a plan's approach to managed care, Harris observed. "If you think managed care means concentrating your purchasing power so that you have greater price leverage over your providers, then broadening networks and opening access could reduce your control over costs," he said. But if managed care is viewed as "an information-intensive exercise on how to better treat people and provide preventive care," network size and open access have less relevance for costs.

The Impact of New Drugs and Other Technologies

Advances in pharmaceutical and other technologies are significantly prolonging and improving the quality of life. They are also having an impact on costs. Geoffrey E. Harris of Salomon Smith Barney predicted that breakthroughs in health technology will fuel overall annual cost increases of 4 to 5 percent, regardless of what else is done to manage care.

Consumers are eager for the benefits that these new technologies offer, thus health care will continue to consume a larger share of the gross national product, Harris said. But that is only reasonable. "It is unfair to hold health plans accountable for keeping cost trends at or below the rate of inflation if at the same time we are imposing on them the responsibility of providing the latest in technology and pharmaceuticals," he said. For example, a new treatment for hepatitis C can get results that are five to 10 times better than traditional therapy. But a course of this new therapy will cost thousands of dollars, which could increase national health care spending by $500 million a year.

These new treatments are light years ahead of the drugs that drove cost increases during the 1980s. Karen M. Boezi of Coral Ventures predicted that soon they will be better targeted as well, because of breakthroughs in genetic profiling.

Sound Bites: What the Analysts Said

The swings in premiums are principally capacity-driven.

—Geoffrey E. Harris, Salomon Smith Barney

The capability of the plans to control drug spending is just not as great as we perceive it to be.

—Norman M. Fidel, Alliance Capital Management, L.P.

Companies are going to have to look beyond capitation as a tool for medical management.

—Roberta L. Walter, Merrill Lynch

Plans have done a poor job in getting the information they need to capitate specialty care adequately.

—Karen M. Boezi, Coral Ventures

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CONSOLIDATION AND OTHER STRATEGIES

The analysts predicted that the industry-wide trend toward consolidation will continue, although different sectors may move forward at varying paces. In addition, local market forces will have a significant impact on how merger and acquisition activities play out.

In local markets, competition usually boils down to a handful of competing plans, analysts noted. Smaller, more marginal plans cannot achieve the market-level economies of scale that are so important to keeping costs down. As a result, many local markets are becoming what Walter calls "natural oligopolies," with three to five plans claiming the lion's share of the market.

Despite the dominance of large plans, Harris said he still sees plenty of room for further consolidation in most local markets. "If you look at the percentage of the largest players as a percentage of the entire insured population in these markets, it is still relatively small, so I think we are going to see a lot more merger and acquisition activity and consolidation."

Consolidation among hospitals is also proceeding, although Fidel remarked that the pace of not-for-profit conversions has slowed markedly in the aftermath of hospital giant Columbia/HCA's legal and organizational woes. Columbia's difficulties have created new opportunities for its for-profit competitors, even in the not-for-profit sector, Harris observed. "The overall trend toward consolidation continues, and Columbia, notwithstanding its problems, set a lot of that in motion," he said.

Vertical integration has definitely slowed, analysts noted, especially with respect to the purchase of home health agencies and physician practices. It makes very little financial sense for hospitals to buy physician practices, Fidel noted. In addition, publicity over Columbia's business practices and relationships with physicians has cast a pall over those deals. "Now we are seeing many hospitals divest themselves of those physician groups," Fidel said. "This is just another example of how vertical integration doesn't work."

The analysts said they expect physician consolidation to pick up dramatically. Currently, 41 percent of physicians are still in one- and two-physician practices, according to HSC data. Boezi cited three factors fueling physician consolidation: the spread of managed care, the transfer of risk and the need for expensive information systems to implement managed care contracts and capitation. As a result, physician practices need both contracting expertise and access to capital.

Early models that were designed to meet these needs—such as physician practice management companies (PPMCs) and independent practice associations (IPAs) served by management service organizations (MSOs)—have largely failed. These provider organizations have not proved any better than plans at managing care and containing costs. But new models that don't involve the sell-off of assets by physicians are under experimentation. Boezi expressed optimism that these new models might achieve better results.

Harris noted that physicians in some markets may feel burned by the failure of some of these earlier ventures. The PPMCs have not delivered to physicians in terms of the services they promised—information systems, practice integration, marketing—or income.

MIXED FEELINGS ABOUT THE FUTURE

The four Wall Street analysts expressed mixed feelings about what the future holds for the health care industry. Despite experimentation with various methods to manage care and control costs, no magic bullet has emerged. The road ahead is a tough one, especially in view of purchasers' and consumers' continuing demands for greater choice.

For plans, this means investing in information systems that will support managed care, and taking a more disciplined approach to pricing and structuring their products. Meanwhile, providers have had no more success than health plans at managing care, as illustrated by the failure of provider-sponsored plans in many local markets and the slow down in vertical integration. How these trends play out will almost certainly vary according to local market conditions. ■