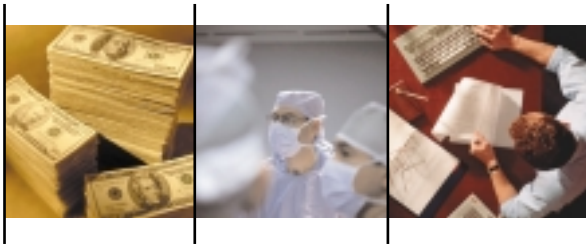
Issue Brief
Findings from HSC



WALL STREET COMES TO WASHINGTON:

Where Is Health Care Headed?

Although health care spending trends have slowed slightly, employers and consumers can expect another round of double-digit health insurance premium increases in 2004, according to a panel of market and health policy experts at the Center for Studying Health System Change's (HSC) eighth annual Wall Street roundtable. Firms will continue to shift costs to workers but are skeptical of new insurance products, including consumer-driven health plans and tiered provider networks. Most health plans are thriving as they continue to price products ahead of cost trends and gain administrative efficiencies. Many hospitals, facing revenue pressures from increasing competition from physician-owned specialty facilities, are continuing aggressive building campaigns, raising concerns about increased costs if they overshoot and add too much capacity. Efforts to revive the ailing Medicare managed care program face an uphill climb as Congress debates reforms as part of prescription drug legislation.

Health Care Cost Trends Moderate but Remain High

After surging in recent years, underlying health care spending trends have slowed but remain high, indicating that another year of double-digit health insurance premium increases is likely in 2004. "With the retreat from tightly managed care, there are really few viable tools for controlling health care costs," said Joy Grossman, HSC associate director. In a soft labor market, "employers have gotten much more aggressive about shifting" costs to workers, she added.

Underlying health care spending growth per privately insured American slowed for the first time in five years in 2002 to 9.6 percent—down slightly from 10 percent in 2001, according to HSC research. Premium trends continued to accelerate in 2003, increasing an average 15 percent, and they would have climbed 18 percent if employers had not shifted more costs to workers through higher deductibles, copayments and coinsurance.

The cost and premium outlook for the near term is mixed, Grossman said. Increasing cost sharing may slow spending a bit, but expanded capacity, especially for profitable cardiac, cancer and orthopedic care, could drive costs up. With no brake on costs, "premiums are likely to continue to rise rapidly, consumers are likely to become responsible for an even larger share of their medical expenses and more people are likely to lose coverage altogether," she said.

Wall Street analysts predicted cost and premium trends will continue to moderate, but Norman M. Fidel, senior vice president of Alliance Capital Management, said insurers are likely to keep pricing premiums ahead of cost trends because they fear getting caught flat-footed if costs accelerate again.

In recent years, there has been a significant enrollment shift from health maintenance organizations (HMOs) to more loosely structured preferred provider organizations (PPOs) because people wanted more choice and fewer restrictions on care. Many HMOs also have loosened unpopular restrictions on access to hospitals and specialists. Health plans "were tired of getting hammered daily in the press for being the bad guys. Essentially, they decided if this

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"We expect that consumers' financial burden is going to continue to rise and that we're likely to see an increase in the number of people who are uninsured."

–Joy Grossman, HSC

"Doctors are [no] different from everyone else. Money is an influence on their behavior."

–Norman Fidel, Alliance Capital Management

"Health plans are not going to be able to drive pricing that will match what the government does by fiat."

–Roberta Goodman, Merrill Lynch

"What's striking is the degree to which managed care plans have adopted aspects of the Medicare physician payment system."

–Paul Ginsburg, HSC

is what society wants, this is what we'll give them. But there's a cost to all of these things, and that has been a significant push behind the higher costs in recent years," he said.

HSC President Paul B. Ginsburg, who moderated the roundtable, pointed out that since the transition from "tight to loose managed care is pretty much over," that's another factor contributing to the lower cost trend.

Roberta Goodman, a first vice president of Merrill Lynch, said managed care companies need to anticipate cost trends better so "they can achieve stability and predictability in the costs they present to their customers, rather than underpricing one year and trying to catch up with dramatic cost increases in the following years."

To that end, many insurers have increased administrative efficiency by investing in information technology. "To the extent that you can process your claims faster and more accurately, you have a better sense of what your cost trends actually are doing and you can price accordingly, rather than get surprised six months into the fiscal year," she said.

Where's the Silver Bullet?

In the years ahead, the challenge of controlling health care spending is "very real," Goodman said, ticking off new technology, the aging population and Americans' seemingly insatiable desire for health care. "The societal attitudes we have toward health care are different and do promote higher usage, and there has also been a pervasive failure in this country to follow evidence-based medicine, which has tended to increase costs," she said.

Employers are continuing to tweak benefits rather then embrace big changes such as tiered provider networks and consumer-directed health plans, Goodman said. Some plans are experimenting with tiered networks to steer patients to less costly, higher-quality hospitals and physicians, but Goodman predicted the strategy would take hold only in larger markets, where there are significant pricing differences among providers.

Despite the buzz, employers are skeptical that consumer-directed health plans are the "silver bullet to address health care costs," she said. While engaging consumers and making them more aware of the true costs of care can help slow spending growth, there are two fundamental problems with consumer-directed plans.

"There is the concern that if you start segmenting the risk pool with structures that pull the 25-year-old single guys in, you're going to be left in the rest of the plans with 55-year-olds with diabetes and hypertension," she said, adding, "The notion that a consumer-directed health plan is going to address that small portion of the population that actually generates most of the costs is not realistic."

A better approach for these high-cost patients would be to identify them prospectively, improve coordination of their care and close treatment gaps, Goodman said. "At the end of the day, it doesn't matter what kind of plan you're in; it matters what data you have, what kind of clinical programs you have and whether or not the interactions with the consumers and providers are constructive and motivate changes in behavior on both sides."

Hospitals Gain Ground, Physicians Try to Catch Up

"The last few years in the hospital industry are probably the best we've seen in 20 years," said Gary Taylor, principal and senior research analyst at Banc of America Securities. Occupancy rates have rebounded, giving hospitals more leverage in health plan negotiations.

"This is a classic case of an industry that built itself to excess capacity. Then pricing came down, and pricing trends descended all through the '90s," Taylor said. "Only with the rebound of occupancy rates has commercial pricing power increased." A generation ago there were 5,000 acute care hospitals with 1 million beds; today there are 4,800 with 800,000 beds. Taylor said 2001 was the first year licensed bed capacity had increased since 1983, and total industry margins rose in 2002 for the first time since 1996. Hospitals, especially for-profit ones, have raised rates aggressively, and Taylor predicted that hospitals will remain "very aggressive" about raising prices.

Hospitals, especially large systems with "brand-name recognition in their local communities," have gained the upper hand

Specialty Hospitals on the Run

The number of hospitals specializing in cardiac care, orthopedics and other high-profit procedures is proliferating. Existing federal law limits physicians' ability to refer Medicare and Medicaid patients to health care facilities, such as clinical laboratories, in which the physicians have a financial interest, but the law exempts physician investment in whole hospitals.

But the Centers for Medicare and Medicaid Services (CMS) and some lawmakers now are concerned that the specialty hospital boom is being driven more by greed than by concern about patients. This spring, CMS announced it was considering changing the rules to bar specialty hospitals owned by physicians from claiming the whole hospital exception. However, CMS abandoned that tack after determining the agency lacked the legal authority to act on its own, CMS Administrator Tom Scully said, urging Congress to narrow the exception.

Banc of America's Taylor said there are now only 100 specialty hospitals, but the market is booming. Cardiovascular services are a $140 billion market and growing almost 10 percent a year, and orthopedics is almost $100 billion and growing about 7 percent annually. "These services have 20 to 30 percent operating margins, so if you are a private investor or private equity firm looking for a place to start a business, these look pretty attractive," Taylor said. Physician ownership "is absolutely critical to the growth of this industry," he added. If Congress removes the exemption, "this industry goes away overnight, or certainly the growth will."

Scully said he has nothing against specialty hospitals, but "I am very concerned about the perverse incentives created by the whole hospital exemption." He added, "I believe surgery hospitals will grow anyway, just because physicians are looking for better services and better places to go." But that growth should not "be artificially fueled by pouring gas on the fire" with the whole hospital exception, he said.

None of this affects ambulatory surgery centers, which are already 4,000 strong. Taylor said, "I still think you're going to see tremendous growth in the specialty business, especially in the surgery centers." That poses a risk to some hospitals, especially urban nonprofits, he said.

Other services also are migrating out of hospitals and into physicians' offices. "Hundreds of thousands of cataract procedures that . . . were done in hospitals now are being done in physicians' offices because it's more profitable for the doctor," said Fidel. "They're using $30 lenses instead of $300 lenses that they ordered when it was being done in the hospital. Gastroenterologists are doing most of their scoping in their offices now."

in contract negotiations with health plans, Grossman said, but in some contract showdowns it's "hard to tell exactly who's winning."

Health plans have gotten tougher in negotiations with hospitals, especially over stop-loss provisions for high-cost cases, Goodman said. For example, Blue Cross Blue Shield of Tennessee added 200,000 customers in Tennessee after refusing terms sought by HCA hospitals. Patients' loyalty is to their physicians, not their hospitals, she said.

Physicians have fared less well in winning higher payment rates, Fidel said, because they just don't have the clout of hospitals. But physicians are investing increasingly in specialty facilities, especially outpatient centers (see box). He added that physicians have been "at the low end of the totem pole as far as rate increases, and that's contributed to them taking a lot of procedures into settings where they can make more money in the process."

Hospital Building Boom

With interest rates at 45-year lows, hospital construction spending rose 20 percent last year and is up another 20 percent so far this year. Eighty-six percent of nonprofit hospitals surveyed by Banc of America planned to expand over the next two years, Taylor said, and the hottest markets are suburbs with affluent demographics and a mix of payers.

Not everything about hospitals' balance sheets is rosy. Bruce Gordon, senior vice president of the Public Finance Health Care Ratings Group of Moody's Investors Service, said only three times in the past 15 years

"When hospitals are full, they have a lot of negotiating leverage. When they're not full, they don't."

–Gary Taylor, Banc of America Securities

"If you're in a nice, growing, affluent suburban area, hospitals can almost do no wrong. If you're in the urban inner city . . . you're going to find yourself under a lot more fiscal pressure."

–Bruce Gordon, Moody's Investors Service

"When I ran a hospital association, I used to go up to the Hill and whine about not getting enough money, and then hop on a shuttle and go to New York and say to investors, 'Things are great. Buy our stocks and bonds.' I don't think people should get away with that now that I'm a regulator."

–Tom Scully, Centers for Medicare and Medicaid Services

This Issue Brief is based on HSC's eighth annual Wall Street Comes to Washington: Where Is Health Care Headed? conference held June 18, 2003, in Washington, D.C. A full transcript of the conference is available at www.hschange.org.

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have hospital bond rating upgrades outpaced downgrades. So far in 2003, there have been 3.5 times as many downgrades as upgrades. Ten percent of nonprofit hospitals are rated below investment grade, making it difficult to access public bond markets, Gordon said. Still, he added, Moody's believes that hospitals' credit quality will remain stable this year but "face strong pressure in 2004 and beyond."

Gordon said hospitals are doubling the size of their emergency departments and outpatient facilities. "Almost every ER we go through, patients are waiting in chairs to be seen because there are not enough bays," he said. He thinks these are a better use of hospital capital than the mergers or expensive acquisitions of physician practices of years past. Three-quarters of those moves "stumbled coming out of the blocks," Gordon said. "Hospitals have gotten back to the basics and focused on providing health care." Slowly they realized "that they could sit down and demand higher rates of reimbursement" from managed care companies. But the hospital business is extremely local, Gordon noted, and business is much better in affluent suburbs than in inner-city teaching hospitals with large indigent caseloads.

Noting completion of the transition to looser managed care and the new trend toward higher patient cost sharing, Ginsburg asked, "Do you think there's a chance that major errors are being made, in a sense an overshooting, on some of the hospital construction that's planned?"

Gordon disagreed that hospitals are overbuilding, but Taylor voiced concern that nonprofit hospitals "may overshoot the mark. …They've done that historically."

Medicare Advantage

Tom Scully, administrator of the Centers for Medicare and Medicaid Services, believes the Medicare reforms tied to prescription drug benefits for seniors, now moving through Congress, will make Medicare managed care—now known as Medicare+Choice but to be renamed Medicare Advantage—attractive again. Before the Balanced Budget Act of 1997, "Medicare HMOs were unbelievably popular, especially with poor people in inner cities," Scully said. "HMOs follow the money like everybody else. When there's not enough money in the pot, they bail out. When there's enough money in the pot, they'll get back in."

Wall Street analysts expressed reservations, however, about how the Medicare revamp will work out. "Right now, the street is in a sense of euphoria about the Medicare reform and drug benefit representing an opportunity for everybody throughout health care," Goodman said. "And I personally think that is unrealistic."

Drug manufacturers are under heavy political pressure to make drugs more affordable for the elderly, Fidel said. He believes a Medicare drug benefit will boost drug sales by 4 percent to 6 percent. "The big question will be how long do market forces control it?" Fidel said, adding that drug makers' "ultimate fear" is that the government will impose price controls if outlays accelerate.

Fidel doubted that any pharmacy benefit manager "would accept risk in a stand-alone drug benefit as part of a Medicare program," as the Senate bill proposes.

Goodman sounded a similar note, saying, "It could be a party. . .to which hardly anybody comes." ●