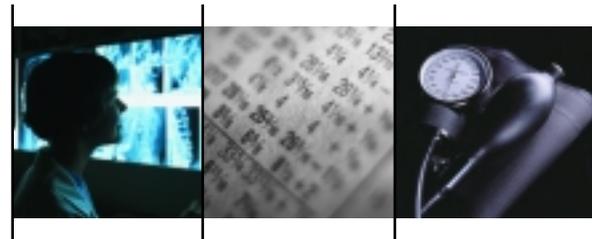


Issue Brief

Findings from HSC



WALL STREET COMES TO WASHINGTON: ANALYSTS' PERSPECTIVES ON THE CHANGING HEALTH CARE SYSTEM

Market forces and recent policy changes are rocking the health care system, according to a panel of Wall Street analysts who track health care companies. In the fourth annual Wall Street roundtable convened by the Center for Studying Health System Change (HSC), analysts discussed the reasons behind improved health plan profitability, providers' struggles to maintain—let alone increase—market power, trends in consolidation and the dramatic impact of federal legislation on all sectors of the industry. This Issue Brief reports on how the analysts see these and other forces playing out in the future.

Larger Premium Increases

After several years of low premium increases and declining profit margins that began to turn around in 1998, the managed care industry is rebounding. According to Wall Street analysts, health plan premiums increased by an average of 6 to 7 percent in 1999 and outpaced cost increases. This trend is likely to persist into 2001 or 2002, noted the analysts, as the industry continues to normalize its profitability following a period of artificially low pricing by plans to gain market share.

This is all part of the underwriting cycle in health insurance, which is key to understanding trends in health plan costs, pricing and profitability. (See the box on page 3 for more information on the underwriting cycle.) Recently, the analysts said, plans entered an upward phase in the insurance underwriting cycle.

"The whole cycle will repeat itself

in 2002," predicted Geoffrey E. Harris, global head of corporate finance for the health care division of Warburg Dillon & Read. "The industry will achieve substantial profitability, new entrants will come back into the market, premium pricing will get competitive again and then we'll have the downward phase again."

[However, HSC research conducted after the roundtable—to be published this fall—indicates that premium increases for 1999 are not yet large enough to exceed cost increases.]

For now, health plans are in a strong position with purchasers. The best example of plans' success in raising premiums is the California Public Employees Retirement System's (CalPERS's) agreement to average rate increases of 9.7 percent for year 2000, the biggest jump since the early 1990s. The analysts noted that smaller pur-

chasers with less clout than CalPERS may have to swallow even larger increases. CalPERS is the second-largest purchaser of health insurance in the country.

The nationwide labor shortage is another factor affecting purchasers. Many employers face intense competition for employees, so they are trying to maintain attractive benefit packages, observed Karen M. Boezi, venture partner with Coral Ventures. As a result, many are willing to accept higher premium increases without cutting back on benefits, she said.

At the same time, rising premiums may have an effect on product design. "We had a three-year period where premiums essentially didn't rise, the economy was strong and people were feeling flush, so they wanted more freedom," said Norman M. Fidel, senior vice president of Alliance Capital Management, LP.



This Issue Brief is based on a roundtable sponsored by HSC on June 9, 1999, in Washington, D.C.

Panelists

Karen M. Boezi
Coral Ventures

Norman M. Fidel
Alliance Capital Management, LP

Geoffrey E. Harris
Warburg Dillon & Read

Patricia F. Widner
Deerfield Management

Moderators

Paul B. Ginsburg
Joy M. Grossman
Health System Change

Log on to www.hschange.com for a copy of last year's roundtable discussion, Wall Street Comes to Washington: Analysts' Perspectives on Health System Change, Issue Brief No. 17, December 1998.

Purchasers, consumers and lawmakers have stepped up demands for more open access to health care services and fewer constraints on consumer choice. As a result, enrollment growth has shifted from classic health maintenance organization (HMO) products to more costly point-of-service (POS) and preferred provider organization (PPO) products.

With premiums on the upswing again, "The big question is: How does people's desire for freedom compare with their desire to keep costs down?" Fidel added. Harris predicted that by 2001 or 2002, there will be a resurgence of closed-panel products in response to escalating premiums.

Harris also predicted a major change in how purchasers design their benefit packages. Traditionally, he explained, purchasers have thought in terms of a defined benefit: They adjusted their premium contributions to pay for a predetermined benefit package. Now, he said, they are starting to think more in terms of a defined contribution—a set amount for premiums each month. If premiums increase beyond that amount, the difference is borne by the employee. Not only are employers headed in that direction, so is Medicare managed care, Harris believes.

Cost Trends Increase, Led by Pharmaceutical Spending

Meanwhile, underlying medical cost trends are increasing by about 5 to 7 percent a year—about 1 to 1.5 percentage points higher than 18 months ago, according to Fidel—but lag behind premium increases, so profitability is rising. He attributed some of that higher rate of increase to the consumer choice movement and the growth of open-panel products. Long-standing trends in technology and aging drive an annual cost increase of 4 percent, independent of other factors, said Harris.

Fidel noted, however, that the single largest driver of cost increases now, accounting for nearly half of the trend factor in medical costs, is pharmaceutical costs. Typically, pharmaceuticals account for 12 to 15 percent of a health plan's overall costs; that proportion has risen to 15 to 20 percent on average. He predicted continued double-digit increases

in drug costs for the foreseeable future. In a way, he added, the managed care industry has brought these increases on itself by expanding coverage for prescription drugs without implementing strong management controls.

Other medical cost components are under better control. Hospital costs, which typically represent about 25 percent of a plan's costs, are increasing 0 to 3 percent a year, Fidel said. Physician costs, which account for 30 to 35 percent of a typical plan's costs, are increasing 2 to 3 percent. For hospitals and physicians, these increases are mainly on the price rather than the utilization side. Plans have more difficulty managing hospital outpatient costs than inpatient costs, Fidel said. Outpatient costs account for the remaining 30 to 35 percent of health plan costs and are increasing at a rate of 5 to 6 percent.

Health Plans Maintain Upper Hand with Providers

Although health plans are doing better now, providers are not sharing equally in plans' rate increases. On average, plans' payment rates to providers are rising only 2 percent, in contrast to commercial premium increases of 7 percent, according to Fidel. Despite media accounts of some hospitals and physician organizations "getting tough" with plans on payment rates, those cases are few and far between, the analysts agreed.

Patricia F. Widner, managing partner of Deerfield Management, observed that providers, particularly physician organizations, still have a lot to learn about organizing and operating as businesses. She predicted that as providers become more experienced in this arena, they will fare better in their negotiations with plans.

Physician organizations, which in some markets were actively seeking risk-based contracts, are now moving away from capitation arrangements, particularly global capitation that covers the full range of physician and hospital services. Efforts by large physician practice management companies (PPMCs) to launch full-scale capitation on a national basis were "a big failure," Harris observed. Boezi described the response to this failure as

“decapitation.” The analysts agreed that most physician practices have neither the infrastructure needed to manage risk nor the large numbers of patients needed to spread risk adequately.

They also noted that many physician entities entering the risk market during the mid-1990s did so at a bad time, during a downswing in the underwriting cycle. While many health plans had enough capital to pull through, many provider-sponsored plans did not, according to the analysts. When increases in Medicare risk payments fell significantly under the Balanced Budget Amendment of 1997 (BBA), many physician organizations that had been attracted to the Medicare market took a double whammy, particularly in California. The long and short of it, said Harris, is that there is “no future” or, at best, a “substantially diminished” future for global capitation in the physician sector.

Consolidation and Vertical Integration Strategies

The analysts expressed mixed views about the drive toward consolidation in the health care industry during the past few years. Generally, they believed that mergers within local or regional markets were more advantageous than national or cross-market mergers. Within markets, plans and hospitals can increase their leverage by consolidating, but that benefit does not necessarily carry across markets.

In the health plan sector, these mergers are still shaking out, said Fidel. In addition, he noted, many of these consolidations occurred during a downturn in the industry. Overall, though, many health plan mergers look better than they did initially in terms of achieving economies of scale and improving market leverage, he observed.

The analysts were somewhat more skeptical of the benefits of hospital mergers. Although consolidations within a tight geographic area can be advantageous because of economies of scale, consolidations of entities in different markets offer

fewer opportunities for scale economies and do not increase leverage with health plans, Harris said. He cited the example of Humana holding Columbia/HCA “hostage” in negotiations in one market as it sought to leverage the upper hand it held vis-à-vis Columbia in another market.

Meanwhile, vertical integration strategies pursued for the last few years by managed care companies and providers alike have foundered, the analysts said. The view from Wall Street, according to Harris, is that “any time you hear ‘vertical integration,’ get out.” Paul B. Ginsburg, president of HSC, noted that in many of the communities that HSC is studying, vertical integration initiatives are unraveling. He added that the shift to broad choice of providers has undermined the basis for much vertical integration.

The health care industry is also suffering from a significant slowing of capital flow, the analysts said. According to Boezi, capital flow to publicly traded health service companies and venture capital for privately held companies are down.

Opportunities for Care Management

As risk is shifted back from providers to health plans, the analysts said that plans may be in a stronger position to play a more active role in care management.

Whether they will remains to be seen. For now, Wall Street is less interested in what plans are doing to manage care than in what they are doing to cover the basics, such as claims processing, pricing, estimating reserves and structuring benefits, said Harris. That is in sharp contrast to 1990-1994, when investors were interested in issues like quality improvement, he said. As plans’ margins improve again, Harris noted, attention may shift back to “more forward-looking ideas on how to better manage care.”

As things stand, most case management is still done at the individual patient level, through, for example, case rate risk management, in which plans pay physicians on a per-case basis for individual patients rather than on a population basis, Boezi noted. However, Widner said, many health plans have developed disease management programs that focus on very expensive or difficult conditions, such as asthma and diabetes, and have been successful in reducing hospital and emergency room admissions.

BBA Hits Industry Harder than Expected

The BBA is having a much more dramatic impact on the health care industry than anticipated. The old system of Medicare payment tended to reward inefficiencies

The Insurance Underwriting Cycle

Trends in health insurance premiums and the costs underlying them are the same over long periods of time. Over shorter periods, the differences in trends can be substantial, following a cyclical pattern. With premiums set up to 18 months in advance of the services the plans will pay for, the underwriting cycle begins when costs behave differently from predicted by the actuaries who help set those premiums.

A pronounced cycle began in the early 1990s, when cost trends declined sharply. The resulting substantial profitability among health insurers attracted additional capital to the industry. Insurers competing more vigorously for new business depressed premium increases below the trend of underlying costs. As profitability declined, capital began to exit the industry, leading to withdrawals of plans from market segments over the last few years. Some analysts are now predicting significantly higher premium increases, compared with cost increases, for 1999 and the immediate future.

According to the Analysts

Capital flow to publicly traded health service companies and venture capital for privately held companies are down, Boezi noted.

“If the question is: What impact has the BBA had on Medicare risk contracting, I think it is a deal buster in the longer term,” commented Fidel.

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and overutilization, and, from a policy perspective, some changes were needed. But the analysts said that cuts under the BBA may have gone too far, and, as a result, many organizations are facing either bankruptcy or substantial reductions in their services.

On the provider side, analysts said that many hospitals have shut down their skilled nursing units and gotten out of the home health business. They also predicted bankruptcies among post-acute care providers, including home health agencies. In addition, many health plans that participate in Medicare+Choice, Medicare’s managed care program, are pulling up stakes, raising premiums or reducing their benefits.

For hospitals, the BBA froze Medicare payment rates for 1998, then substantially slowed subsequent payment updates. It also spelled out a new policy that significantly reduces reimbursement to hospitals that transfer certain patients to step-down units or skilled nursing facilities. This will hit hardest those hospitals that have achieved large reductions in length of stay by shifting services to outpatient settings. Fidel noted, however, that the effects of the new outpatient prospective system are uncertain and will depend largely on regulations drawn up by the Health Care Financing Administration (HCFA).

Many post-acute care providers are being affected not only by a new, more constrained payment system under the BBA, but also by their own initiatives during the boom times to build up their businesses. They built up huge cost structures and overleveraged themselves, said Fidel, so that “when Medicare reimbursement got squeezed, it was curtains for those companies.”

The situation is affecting patient care, the analysts said. In the home care industry, for example, some 2,500 agencies have shut down during the past 18 months, and nursing homes are cutting back on their services. Utilization of rehabilitation therapy in nursing homes is dropping by more than 50 percent year to year, and limits on other services are being imposed. “Patients are definitely facing different levels of care from what they were before,” Fidel noted.

For Medicare+Choice, limits on annual premium increases of 2 percent for health plans in certain communities are having a negative effect, said Boezi. “We have seen benefit decreases and plan withdrawals,” she said. About 100 HMOs either scaled back or ended their participation in Medicare+Choice, according to Boezi, affecting about 450,000 beneficiaries. Nevertheless, the program did experience a net growth in 1998. Since the roundtable, 41 plans have exited Medicare+Choice, which is significantly fewer than left last year, and 58 plans have reduced their service area.

The worst is yet to come, and new risk adjusters will have an even bigger impact on payments to some plans, Fidel believes. “If the question is: What impact has the BBA had on Medicare risk contracting, I think it is a deal buster in the longer term. It will destroy the program, unless changes are made,” he said. If recent news reports of a proposal to create a generous prescription drug benefit under Medicare come to pass, the analysts agreed that the prospects for Medicare+Choice look even grimmer.

Gauging the Future

As premiums continue to increase in accordance with the underwriting cycle, cost will re-emerge as the dominant issue facing the health care industry, the analysts predicted.

“We are finding out that costs have not gone away,” said Harris. Given consumers’ demands for easier access to the providers of their choice, as well as for high-technology services, premiums will increase by 10 percent a year, he said. “We are going right back to where we started in terms of the cost-benefit debate and how to allocate health care.”

Renewed attention to costs, according to Boezi, ultimately will produce a tiered health care system with a minimum defined benefit set. In the future, those who can afford it will have the option of buying up. Risk will be shifted back to consumers, she added, as will the cost of better care. ●