CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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WALL STREET COMES TO WASHINGTON

While health care cost trends likely will continue slowing through the end of 2004, the longer-term outlook for a sustained slowdown in underlying costs and private health insurance premiums largely depends on the strength of the economy, according to market and health policy experts at the Center for Studying Health System Change's (HSC) ninth annual Wall Street roundtable. Even as cost growth slows, insurers are practicing pricing discipline to keep premium trends ahead of cost trends to maintain profitability. Employers will continue to shift costs to workers through higher deductibles, copayments and coinsurance, but an improving economy could temper this trend as labor markets tighten. Employers remain skeptical of new health insurance products, including tiered-provider networks and consumer-driven health plans. Although growth in hospital use has slowed, the industry remains in the throes of a building boom. Increased payments to managed care plans could reinvigorate private plan participation in Medicare, but concerns about the federal budget deficit could prompt Congress to roll back rate increases.

Health Care Cost and Insurance Premium Trends

Although HSC research shows annual health care cost growth per privately insured American slowed significantly for the first time in nearly a decade in 2003 to 7.4 percent, down from 9.5 percent in 2002, Wall Street and health policy analysts agreed that all bets are off on whether costs will continue to moderate in the coming years.

Gary Taylor, principal of equity research at Banc of America Securities, predicted that cost trends would continue to slow through 2004 but could rebound in 2005 and 2006.

"What happens on the employment side is very important, and the question is, when employment picks up, do the employers still push the consumer-driven button—do they still push on the utilization side?" Taylor said.

Robert Reischauer, president of The Urban Institute, agreed, saying, "We are going into a period where labor markets are going to be tighter, inflation is going to be a bit higher and interest rates are going up. The question is how these will feed into the health marketplace—in general, health seems to have been insulated from the overall impact of the economy for the last few years, but that won't hold necessarily over the long term."

Research shows that general economic performance is a predictor of health care cost trends, but with a lag of three or four years, said HSC President Paul B. Ginsburg, who moderated the roundtable.

"Some of the basis for slower cost trends now is the weaker economy a few years ago, and to the extent the economy picks up this year and continues, that certainly has implications for higher cost trends a couple of years out," Ginsburg said.

Health Plan Mantra: Pricing Discipline

In recent years, health insurance premiums have increased at a faster rate—by several percentage points—than underlying health care cost trends. As cost trends for inpatient and outpatient hospital care, physician services and prescription drugs have slowed, average private insurance premium trends continued to accelerate but peaked in 2003 at 15 percent, dropping to 12 percent in 2004. A key question going forward, according to Ginsburg, is whether the spread between premium and cost trends is going to shrink, grow or remain about the same.

Norman Fidel, senior vice president, Alliance Capital Management, said that traditionally when premiums increased less than medical cost trends, insurers didn't

"There will be more cost shifting to patients, but I think the pace will lessen somewhat because of a reduced cost trend in general and a better economy."

—Norman Fidel, Alliance Capital Management

"*I remember the forecasts around 2001 about how rapidly hospital use was going to go up—aging baby boomers, new technology and the like—but now we see a flat trend in hospital use."*

—Paul Ginsburg, HSC

"Payers still have much more of an information technology advantage over providers in general, and there are signs that may change, but it hasn't happened yet."

—Gary Taylor, Banc of America Securities

anticipate the acceleration of medical costs and were caught "flat-footed" because they price their products at least a year in advance and can't correct pricing until the following year. For the time being, most publicly traded insurers are pricing ahead of cost trends and maintaining a positive spread between cost and premium trends to maintain profitability.

"However, if costs were to reaccelerate, that positive spread could certainly disappear and go negative," he said.

Robert Laszewski, president of Health Policy and Strategy Associates, predicted that premium trends would slow but not drop below cost trends because insurers are committed to maintaining profitability.

"I've never seen discipline in the industry from a pricing standpoint like I've seen now," he said, adding, that the tremendous consolidation among insurers has produced bigger, more sophisticated players. "So, to paraphrase Bill Clinton, the rates are going to stay high because they can."

The price wars and insurer financial meltdowns in the mid- and late-1990s are still fresh in many corporate treasurers' minds, and many of the surviving companies have invested in information technology to keep better tabs on claims trends, said Frank Sustersic, senior portfolio manager and equity analyst with Turner Investments.

"The major consolidators have strong IT systems that have quicker response and can know the trends more quickly than in the past. So the big surprises and wide cycles are likely not to occur in the future," he said.

Fidel noted that the last time there was significant price competition among insurers in the mid-1990s, there were "literally hundreds of plans" created by providers to try to keep control of patients during the managed care boom.

"Virtually all of those provider-based plans have been washed out and have disappeared, and the number of health plans today is lower by half what it was eight years ago," he said.

For-profit plans now represent about 45 percent of all health plan members compared with 25 percent in the late 1990s, Fidel said, adding, "There's more concentration in fewer hands, and those fewer hands are more focused on the bottom line than was the case eight years ago by the industry in general."

Employers Missing in Action

So far, most employers have not pushed back at providers and insurers to lower cost and premium trends, relying instead on shifting costs to workers through higher patient cost sharing—higher deductibles and coinsurance, for example. The panelists agreed that in the near term employers will continue to shift costs to workers but that cost sharing as a long-term cost-containment strategy won't work.

"We haven't seen the employers kick in because their first line of defense has been cost shifting, which has been an effective strategy in the short run, but you can only raise the deductible to $1,000 one time. So there's a cliff here that we're coming to," Laszewski said.

One exception to the lack of purchaser pushback against higher cost and premium trends is the California Public Employees Retirement System, or CalPERS, analysts agreed, but they were skeptical that CalPERS' decision to exclude several dozen hospitals from its health maintenance organization (HMO) networks would prompt other purchasers to take a harder line. Taylor characterized CalPERS' move as a "shot across the bow at the most egregious providers."

Both Ginsburg and Taylor were surprised that there hasn't been more demand for a return to restricted provider networks.

"If consumers were willing to go back into HMOs, and the insurance company was negotiating with three hospitals out of 10 in the market, hospital prices would be a heck of a lot lower than they are today… but there's been no mandate whatsoever to save costs by giving up choice," Taylor said.

Insurers and employers are skittish about restricting provider choice because

Medicare Advantage Bonanza

While members of Congress are hoping for robust competition among Medicare preferred provider organizations (PPOs) in a couple of years, they may not want to hold their breath, according to Wall Street analysts. The real action in the renamed Medicare Advantage program is likely to be the expansion of existing HMOs that can use the generous payment rate increases to craft attractive drug benefits to draw Medicare beneficiaries into private plans.

"The profit opportunity in Medicare Advantage [HMOs] is extraordinary…The Medicare regional PPO in '06, no one's interested in that. Why would you be interested in the Medicare PPO with all the limitations, the regional issues, all of the complexities, when you can make a pile of money in Medicare Advantage choosing a county at a time?" Laszewski said.

Fidel agreed, saying that health plans operating Medicare Advantage HMOs believe they can offer drug coverage comparable to what people receive in the commercial market, while Medicare beneficiaries opting for the new stand-alone drug coverage will face big coverage gaps.

Contrary to Congress' intentions, insurers are likely to look at Medicare Advantage markets very selectively, Laszewski said, and operate where they can clearly make a profit, while bypassing unprofitable markets.

While health plans are gearing up to go after new Medicare business, they are likely to keep in mind the recent history of boom and bust in Medicare managed care payment rates, Goodman said. Pointing to the large federal budget deficit, Reischauer agreed, saying, "The generous payments to Medicare Advantage plans have a life expectancy of an ice cube on a Jamaican beach."

memories of the managed care backlash are still fresh in their minds, Laszewski said.

"When you talk to people who run health plans, they say, 'I remember the patients' rights rebellion, and I'm not going through that again,'" he said.

New Products Meet Skepticism

Employers also are skeptical of new health insurance products, including tiered-provider networks and consumer-driven health plans, the analysts agreed. Tax-favored health savings accounts (HSAs) tied to high-deductible coverage are likely to be attractive to people who buy nongroup coverage and small employers who are already moving toward high-deductible policies. But HSAs won't save costs or transform health care as their advocates tout.

"If you're going to move to that $1,000 deductible anyway, it's a no brainer to take advantage of the HSA," Laszewski said, adding, "I do not believe HSAs are going to transform the market or save money, but they are restructuring the way benefits are marketed."

Reischauer questioned whether HSAs would gain traction, pointing out that the "vast bulk of Americans are nowhere near to taking full advantage of existing retirement tax preferences. So they aren't up at the margin saying, 'Give me a new break.' It's a tiny, tiny fraction of the population, most of whom are in this room."

Part of the motivation behind consumer-driven plans, including HSAs, is to get consumers more directly involved in their care, Sustersic said, but right now there isn't adequate price and quality data available to guide consumer decision making.

Roberta Goodman, principal of Health Care Analytics, said employers remember past panaceas that never panned out.

"Employers want to wait and see what the evidence is over a longer period of time…It's easier to watch somebody else take the plunge and see how it works out than be the guy diving off the board," she said. Goodman also noted that advances

"There will be focus on hospital pricing practices because it's good headlines—it makes it look like you're doing something, but it's not really asking taxpayers to give up anything or to accept trade-offs in terms of access and perceptions of quality."

—Roberta Goodman, Health Care Analytics

"You can't get Republicans to vote for cost controls in Medicare, but you can get them to vote to use the price controls of Luxembourg through drug reimportation."

—Robert Laszewski, Health Policy and Strategy Associates

"*Insurers should be nervous no matter what the outcome of the election, simply because we have a serious deficit problem…and it will come down to what part of Medicare gives.*"

—Robert Reischauer, The Urban Institute

This Issue Brief is based on HSC's ninth annual Wall Street Comes to Washington conference held June 24, 2004, in Washington, D.C. A full transcript of the conference is available at www.hschange.org.

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in medical technology can cut both ways, sometimes lowering costs but probably more often contributing to higher spending. Ultimately, more overt choices will have to be made about what care is provided, she said, adding "We have to look at what it is we are spending—what kind of trade-offs we're expecting from different parts of the system."

Hospitals Under Fire...

Hospitals increasingly are under fire on a number of fronts, including questions about their charges and collection practices for uninsured patients and their tax-exempt status in the case of nonprofit hospitals. A spate of suits has been filed against hospitals alleging they have charged uninsured patients more than insured patients, and several congressional committees are reviewing hospital billing practices.

"Managed care isn't the principal villain any more in health care," Fidel said. "Now it's drug companies and hospitals, and in five years, it will probably be somebody else."

Taylor said the real issue isn't what hospitals charge the uninsured but rather hospital collection practices.

"We've seen some providers go over the line and repossess people's mobile homes, and I would argue that's where the public policy attention should be focused…but the whole thought that hospitals aren't generating the tax benefit that they get when they're losing billions of dollars on this payer class is way off in the wrong direction," he said.

...As the Building Boom Continues

While hospital utilization trends have slowed, hospitals continue to add capacity, raising questions about whether they will end up overbuilding.

"What's the potential that hospitals could find themselves with underused facilities and in a weaker bargaining position with insurers?" Ginsburg asked.

Taylor responded that the industry does run the risk of overbuilding but that external factors such as likely Medicare payment cuts should temper the building boom.

Goodman cautioned that if hospitals do overbuild, it will add unneeded costs to the system.

"The problem with the hospital industry is if you build it, they will come… capacity drives demand, so the availability of the facility will create the utilization for that facility to some degree," she said.

Fidel pointed out that a great deal of recent hospital capacity expansion has been concentrated in areas where demand has grown rapidly—orthopedics, cardiology and expensive diagnostic equipment.

"If demand continues in those areas, it won't be as much excess capacity as it appears at first glance," he said.

Ginsburg questioned whether the explosion in orthopedics and cardiology was demand driven or reimbursement driven because those services are the most profitable, and Fidel responded, "It's both—you don't do it exclusively for one. You can't do it because reimbursement is good if there is not demand, so I think it's a combination of both."

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