CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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THE CENTER, SUPPORTED BY THE ROBERT WOOD JOHNSON FOUNDATION AS PART OF ITS HEALTH TRACKING INITIATIVE, IS AFFILIATED WITH MATHEMATICA POLICY RESEARCH, INC.

Two years ago, the Center for Studying Health System Change brought together a group of highly respected Wall Street securities analysts who track health care companies. Their purpose: to discuss significant developments in the health care industry and possible future trends. The analysts met again this spring to discuss how the industry has changed since then. This Issue Brief reports on that roundtable discussion, during which the analysts addressed four major topics: managed care, health plans and providers, consolidation and public policy .

Patients, Profits and Health System Change:

A Wall Street Perspective

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THE TRAJECTORY OF MANAGED CARE

The large, established, for-profit, publicly held health maintenance organizations (HMOs) have experienced the strongest enrollment growth among health plans, according to Wall Street analysts. About a dozen such companies are averaging growth rates of 15 percent to 25 percent a year. These companies are grabbing market share from Blue Cross-Blue Shield plans, which have lost about 15 percent of their membership during the past 15 years, and other not-for-profit entities.

The exceptionally fast growth of these companies is being fueled by a number of factors, including:

- access to capital;
- good balance sheets with large amounts of cash;
- highly valued stock that they can use as cash to make acquisitions and grow;
- highly sophisticated marketing and operating abilities; and
- innovative product development that responds to consumer interests and demands while controlling costs.

Despite the impressive growth of this small cadre of companies, much of the industry is not profitable now. According to the analysts, 40 percent of the country's HMOs lost money in 1995. One analyst estimated that only 35 percent were profitable in 1996—down substantially from 90 percent in 1993 and 1994. This trend holds significant implications for health care premiums in 1997 and beyond.

Premium levels continue to drive health insurance markets, and many purchasers have proved willing to switch health plans for small differences in price. While health care service cost increases per enrollee have been in the 4 percent range, the last two to three years have seen premium increases of only 0 percent to 2 percent, the analysts said. "When an industry is losing money, it usually means that prices are going to go back up," one analyst noted. In fact, premium hikes of 4 percent to 5 percent are projected for 1997.

Purchasers will have little choice but to accept these across-the-board increases. In the past, plans responded to employers' demands for lower premiums because they wanted to secure or expand their market shares. But the significant decline in industry profitability is forcing plans to draw the line on premiums. The difference between 1997 and the previous two years, one analyst explained, is that now plans are prepared to walk away from business "rather than push for

This Issue Brief is based on a roundtable sponsored by the Center for Studying Health System Change, which took place in Washington, D.C., on March 21, 1997.

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market share at the expense of their margins."

It seems clear, however, that employers will continue to aggressively pursue a reduction in their outlays for health insurance in a number of ways, including:

- shifting employees into managed care plans;
- narrowing the number of health care companies with whom they do business to concentrate their purchasing power and maximize their leverage; and
- transferring an increasing share of health care costs to employees.

A negative public image of managed care, fueled in part by provider interest groups, has developed. With their emphasis on cost-cutting and efficiency, many people believe that managed care companies withhold necessary and appropriate care to save money, or that they enroll only the young and the healthy. The analysts said that these perceptions are unsubstantiated.

"Where the HMOs have faltered a bit is that in their drive to be visible and efficient and grow, they act to some degree like teenagers who are awkward and large but don't really know how to coordinate themselves yet, and along the way they sort of bruise people," commented one analyst. Yet overall retention levels for managed care, she added, are high: Once enrolled, people tend to stay put.

Consumer demands for broader service networks and greater and easier access to specialty care are shaping "the next battlefield" for market share. Customer service and concern for quality are on the cusp of becoming important competitive factors. In response to these consumer demands, cutting-edge companies are developing and successfully marketing innovative products that often are commanding a premium in the marketplace and enjoying large enrollment growth.

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HEALTH PLANS AND PROVIDERS: SHIFTING ROLES

Relationships between health plans and providers have been driven largely by the industry's focus on controlling costs. Health plans, in early attempts at cost control, used fairly crude measures, including leveraging aggregated purchasing power to negotiate price discounts with providers. They turned their attention next to the potential for shifting service delivery from inpatient to outpatient settings. Concurrently, they pursued strategies for reducing service demand.

"Now we're at the stage where cost savings ultimately will come from managing care better," one analyst contended. As managed care companies invest more heavily in sophisticated information systems and activities that can support disease management, outcomes studies and detailed cost-effectiveness analyses, improved resource allocation will be their goal. This new emphasis has important implications for risk acceptance by providers, care management and ownership and contractual arrangements between plans and providers.

Risk Acceptance by Providers. The willingness of different providers and health plans to enter risk-sharing arrangements varies by entity, product and market. Some providers are eager to accept risk because they believe they can profit from capitated arrangements with health plans. "Providers look to HMOs as the pot of gold at the end of the rainbow," asserted one analyst. They think they have the ability to control costs and are looking to be rewarded for it.

Some plans aggressively offload their risk to providers, while others prefer to maintain risk management responsibility—capturing profits from savings for themselves and controlling the cash flow. These plans also want to ensure that their own reason for being is not diminished. "HMOs are not just middlemen; they are not just brokers. They are insurance companies and

they do shoulder risk," one analyst pointed out.

A health plan that assumes that a capitated provider arrangement absolves it of managing costs may find that assumption coming back to haunt it if its providers do not manage the risk adequately, one analyst noted. There have been cases where plans have had to bail out capitated providers with additional payments. Plans have a codependent relationship with providers and have a vested interest in making sure providers maintain financial viability.

Care Management. To manage risk, providers must be able to manage care. Risk may be extended successfully to large, sophisticated provider groups that can perform managed care functions, but providers in most markets are not prepared to take on these functions.

Providers' success at managing care depends largely on how much of the care continuum they themselves provide and manage. It is particularly important for a hospital to have a solid working relationship with physicians. "A hospital accepting global capitation when it does not have salaried physicians is opening up a can of worms that it cannot possibly control," commented one analyst.

As the relationships change—and no matter how they change—physicians, hospitals and health plans will have to figure out how to share information. Because their needs are different, each has its own information systems to support clinical management and other functions. There has to be "a common highway," one analyst said, and it is expected that outside vendors will do the linking.

Ownership and Contractual Arrangements. Providers and plans are exploring new types of relationships as they try to determine how best to position themselves. Intricate contractual relationships are the wave of the future. In some markets, the largest and most desirable plans, hospitals and physicians will find themselves aligning more closely through these arrangements.

The analysts agreed, however, that the "delivery system will remain largely separated from the payment system in terms of ownership."

Scavenger hunting is the term one analyst used to describe the current state of consolidation activities among health plans. This typically happens during times of weakness in an industry.

Combining provider and payer functions in one organization creates conflicting incentives that are difficult to resolve internally. There are noteworthy examples of providers that have tried unsuccessfully to enter the payer arena. Large payers, including Prudential, Aetna and Cigna, have likewise been largely unsuccessful at owning and managing delivery systems. The analysts expect even Kaiser to divest itself of facilities in some markets.

CONSOLIDATION AND ITS CONSEQUENCES

Scavenger hunting is the term one analyst used to describe the current state of consolidation activities among health plans. Most recent health plan consolidations have been instigated by strong companies taking over weaker ones. "Almost every company that has agreed to be acquired in the past 12 months is a company that stumbled badly," one analyst observed. Among the examples cited: Cigna's acquisition of Healthsource, PacifiCare's purchase of FHP International and Foundation Health's sale to Health Systems International. Analysts agreed that this trend will continue and will result in some surprising combinations.

Despite the rapid pace of these activities, there is still significant room for further industry consolidation and plan growth. "Notwithstanding the size of these companies, they still represent a relatively small percentage of their markets," one analyst noted, who predicted that Americans ultimately will be served by 40 to 50 large plans that are either national or regional. Smaller players may continue if they have critical mass in their markets and comprehensive service capabilities.

At the same time, many of the larger health care companies—both plans and providers—will strive to develop branded identities and promote public awareness of these identities. Several already are working to create brand images in their markets, including Oxford Health Plans and Columbia/HCA.

The Securities Analyst Perspective

Wall Street securities analysts who follow publicly held health care companies offer a unique and useful perspective on health system change. To forecast the earnings of these companies, they need to have a thorough understanding of the markets in which the companies operate.

Analysts monitor general economic trends, government policies and sector-specific trends relating to the activities of purchasers, health plans, providers and suppliers as well as consumer issues and advances in medical technology. As a result, they are in a good position to provide a broad picture of the changing health care marketplace.

Despite a lot of merger activity in the hospital industry, there has been little reduction of excess hospital bed capacity. The reasons are both political and financial.

In most communities, people strongly object to the closure of their local hospitals. "Nobody likes to see his or her community hospital close down," one analyst said. Hospitals have high visibility, and their directors, administrators and physicians are often prominent within their communities. In addition, elderly people in particular, who wield considerable political power, do not want to travel far for their health care services.

In financial terms, the high level of profitability that many hospitals are now enjoying shields them from competitive pressures. "If you look at the cash flow margins at hospitals, excluding depreciation charges, hospitals are actually far more profitable than HMOs in many cases," one analyst noted. In many respects, the hospital industry has responded shrewdly to demands for lower costs. For example, it has taken inpatient service capacity and redirected it to control outpatient service delivery. More than 80 percent of outpatient surgeries in the United States are performed in hospitals.

This combination of political and economic clout is extremely powerful. As long as these forces are in play, hospitals are unlikely to act aggressively to reduce excess bed capacity.

PUBLIC POLICY

Although the managed care backlash movement has resulted in the passage of several state and federal length-of-stay laws for childbirth and mastectomy, such laws will have little effect on costs, the analysts said. While other proposals pose serious risk to the market's ability to control costs, they have not been enacted yet. The analysts expect that purchasers will oppose those laws vigorously because of their concerns about costs.

Managed care plans are adopting a "wait and see" attitude about proposed changes in Medicare capitation rates. If Medicare does slash rates, plans will have several choices. One is to raise premiums; another is to reduce benefits. Since rates for Medigap insurance are increasing, HMOs will still be a relatively attractive option for those deciding between an HMO and the traditional Medicare program supplemented with Medigap coverage.

A third option is to abandon Medicare for more profitable business. Currently, managed care plans have a fairly low stake in Medicare. Only 12 percent of Medicare recipients are enrolled in HMOs. One analyst observed that policy makers might be wise to wait until HMOs are more heavily invested in Medicare before trying to cut their reimbursement. Currently, Medicare is not a sufficiently powerful purchaser of managed care services to dictate the prices it will pay, this analyst noted. If Medicare does cut rates, the analysts believe beneficiaries will bear the brunt of the impact of any of those scenarios—higher premiums, reduced benefits or less choice.

Publicly held managed care companies have been serving the Medicaid market in some states, but significant cuts implemented by a number of Medicaid programs have reduced profitability, with at least one company facing major financial losses. A number of companies have abandoned the market altogether in response to what they perceive as "policy instability."

The analysts concluded that the health care industry has evolved rapidly during the two years since they first convened. The direction of change, while slightly different in some respects than predicted two years ago, has not altered substantially. But the net effect of two years of change has definitely altered the system. It should be noted, however, that there are significant variations in the changes taking place in the health care system across regional and local markets, and that these variations will continue. ■

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