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Wall Street Analysts Add Market Insights to Healthcare Reform Debate

7/10/2009
by Hazel Becker

WASHINGTON, D.C. – The question of the day at the 14th annual Wall Street Comes to Washington conference July 8 was: "What effect will healthcare reform legislation have on the market for health insurance, and how will hospitals and providers figure into the picture?" The answer, of course: "The devil is in the details." Although some broad parameters of the legislation are taking shape, no one yet knows what the details will be.

The conference, sponsored by the Center for Studying Health System Change (HSC) and funded by the Robert Wood Johnson Foundation, pairs Wall Street analysts covering the healthcare industry with policy experts from Washington think tanks. The idea, according to HSC President Paul Ginsburg, is to have equity and bond analysts "bring their understanding of market forces to bear on questions that those involved in health policy have on their minds."

This year's panelists are following every twist and turn of the debate in Congress over how to reform the nation's broken healthcare system, which is costing too much of our economic resources (estimated at 16.7% of gross domestic product in 2008) and providing too few people with quality, insured care. Panelists expressed concern that the debate is focusing on inclusion of a "public plan option" in the legislation at the expense of looking for ways to stem increases in healthcare spending.

The two panel discussions — one focusing on health insurance market trends and the other on provider trends — highlighted the deep frustration felt by policy analysts who are active in the healthcare debate. In a nutshell, it seems that the current U.S. healthcare system is fundamentally flawed, and there is too much to accomplish — there are too many competing policy imperatives in play — to fix it all at once.

In the words of Goldman Sachs Vice President Matthew Borsch, "I am surprised at sophisticated economists who think this health reform push is about cost containment. It's not about cost containment, it's about universal access, and you can't address them both at the same time." Christine Arnold, managing director and healthcare analyst at Cowen & Co., agreed that in the current debate, legislators are not paying enough attention to measures that could bring the overall cost of healthcare down because "they are lost in the debate over the public plan."

Marketplace Backdrop

As the concept for this conference highlights, it is important to look at the legislative debate in the context of what's happening in the marketplace. Arnold offered some insights into what's going on in the primary health insurance market segments. In general, she noted, enrollment is down because of the downturn in employment. "There's much more price sensitivity in small employers, and much more churn," she observed. "At the same time, cost trends have ticked up, and so pricing is up about 100 basis points [1%] in the individual and small-group market." Arnold noted an increase in benefit changes for 2009 in the individual and small-group markets, including higher deductibles and out-of-pocket costs, which she expects to filter into the large-group market this year as employers set their benefits for 2010. "For next year we're expecting large employers' uptake [of benefit

changes] to be much steeper, and they will have to bear the price increases they didn't get in 2009 because they had made their benefit design changes and locked in premium rates before the downturn in the economy," she said.

Also in the large-group and self-insured markets, "they are putting a lot out to bid and threatening to change carriers, but of course they won't change carriers because that's very expensive." Self-insured employers are trying to get medical trend guarantees written into their administrative services only (ASO) contracts to insure their medical costs, she said.

Premium increases and benefit changes stem from two primary causes: medical spending inflation and cost shifting, panelists said. As hospitals' payments from government insurance plans are cut, they pass along more costs to private insurance carriers, and in turn, employers are passing along their cost increases to their employees in higher premium contributions, copays and out-of-pocket maximums. In that environment, more workers — particularly those who are young and healthy — decide not to sign up for employer-subsidized insurance. This puts even more pressure on a system skewed to have those who are insured absorb the cost of providing necessary care to those who are not.

The Universal Care Debate

In the current legislative debate, as the panelists noted, the main thrust is how to insure as many people as possible within the scope of a free-market system. Policymakers have all but ruled out a single-payer system in which the government pays for everyone's care, but they have agreed to mandate that a government plan be available to those who choose that option over commercial insurance.

As Ginsburg summed up after the conference, some healthcare analysts believe having a public plan option that pays providers at or near Medicare reimbursement rates will lower overall healthcare expenditures and that these costs savings would be passed along in lower premiums. Analysts who don't agree are frustrated that introducing a public plan option won't bring overall healthcare expenditures down, and we are missing this opportunity to institute some measures that have a better chance of reforming the system and reducing costs.

The analysts expressed concern about the disruption that a public plan would cause in the health insurance marketplace, predicting that a public plan that paid providers approximately what they get from Medicare would have a strong price advantage and wind up taking market share from commercial plans. According to Joseph Antos, healthcare and retirement policy scholar at the American Enterprise Institute, such a plan could become a "default insurer," further disrupting the marketplace.

Insurance Exchanges

One potentially positive effect of providing universal coverage might come from the introduction of insurance exchanges or cooperatives to help individuals and small groups purchase insurance. Panelists suggested that a system that allows exchanges to offer a few standardized policy options, with guaranteed issue and no policy rescissions, would reduce insurance costs by cutting out the hefty broker commissions that plague the individual insurance market.

The analysts noted that insurance brokers generally earn commissions of between 20% and 25% of the premium in the first year and then half that amount in each renewal year, adding substantially to the cost of individual insurance. They are needed in a system that requires people to make difficult choices about which policy is best for their needs, Christine Arnold said. Matthew Borsch cautioned, however, that on this issue, as with others, the devil is in the details. "If there is a mechanism where benefit offerings are standardized and set up in the right way, where you no longer need as much of an intermediary system, it could work — but if you set it up in the wrong way it could increase costs," he said. He envisioned a system with set offerings, similar to the Medicare Supplement market, but suggested that fewer options be available. "The system would be more competitive if you restrict offerings to Gold, Silver and Bronze," he said.

The Medicare Advantage Model

Analysts on both panels looked to the current Medicare system as a test of what the resulting marketplace might be like. In the current system, most people are signed up for traditional Medicare benefits, and the government pays for all covered services. Given the choice of commercial insurance plans offering varying levels of care management and supplemental benefits, almost a quarter of the people eligible for Medicare benefits have signed up for commercial Medicare Advantage (MA) plans.

Borsch noted that in looking at MA results in terms of cost savings, this test has had mixed results. "There were areas where MA plans could drive cost savings," primarily urban areas with lots of providers, he noted. However, reducing expenditures and lowering the cost of insurance in sparsely populated areas with few providers was an elusive goal. Robert Berenson, senior fellow with the Urban Institute, noted that success in pursuit of this goal has depended on the level of care management provided. Medicare health maintenance organizations (HMOs) with the highest levels of care management are delivering services at 98% of the cost of traditional Medicare, he said, while preferred provider organizations (PPOs) with a lesser degree of care management spend on average 105% of original Medicare's costs per member.

Introducing a public plan into the under-65 marketplace would be different in this respect, Ginsburg told us after the conference: "we would start from the opposite situation, with most people now in private insurance and adding the public option for those who don't have insurance or want to switch."

It's possible that individuals' plan choices might be driven by the lower premiums, but based on the MA test, Berenson believes that managed care organizations would hold their own in this new marketplace. "The Medicare HMOs and some other managed care plans are relatively competitive, and I assume that is what would happen if there is a public plan," he said, adding that he believes the cost advantage assigned to a public plan has been exaggerated in the current policy debate.

MA Market Disruption

Christine Arnold objected to proposals to pay for healthcare reform in part by cutting the subsidy paid to MA plans, which are costing the government about 112% of the expense of providing traditional Medicare benefits. Cutting the reimbursement rate would likely cause commercial plans to reduce or eliminate the incremental benefits they now provide to MA members, including memberships in weight reduction and physical fitness programs as well as supplemental dental and vision coverage. "I object to the idea that we are going to take these things away from old people so we can provide coverage for people under 65," she said.

Borsch said this would cause "a very painful transition for people in MA plans." Further, he predicted, if that happens, the MA marketplace "will go back to looking a lot like it did in the 90s. It will be much more concentrated in the urban areas, in areas where there is significant provider competition and significant overutilization." While some people argue that this would be a rational conclusion and managed care belongs in areas where it will help reduce costs, the disruption should not be ignored, the analysts said.

Cost Reduction — the Other Debate

One question left at the end of the conference was how to move beyond the current debate over the public plan and get on to discussing solutions that might bring the nation's healthcare expenditures down. American Enterprise Institute scholar Joseph Antos said, "The idea that there are magic bullets, that there are easy ways to get out of these problems — these are classic Washington."

"There are plenty of good ideas out there," Antos said. "But there are also the biases against action, and the problem is the same. A lot of what we do is optional, and a lot of what insurers do doesn't address the cost structures in their own plans, and employers pass costs on to employees in ways employees don't understand."

Analysts on both panels want to see the debate shift to serious proposals that would help reduce overall healthcare expenditures, and they advocated systems with more integrated care. Berenson, for example, hopes for measures that would move hospitals toward reducing their readmission rates by working with community physicians to follow up with patients after discharge. Arnold wants a system where providers make better use of technology so they can shift their focus from doing paperwork and instead spend their resources on helping people manage their health.

On both panels, the analysts were sincere in their desire for an integrated healthcare delivery system that provides better care to more people at lower costs. Whether the current debate will lead to such a system remains to be seen.

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