



Managed Care's Demise



By Ed Rudin, MD

DAVID STIRES, writing in *FORTUNE*, October 14, 2002 (*HEALTH INSURANCE: The Coming Crash in Health Care*), confirms what Dr. David Gibson has been telling us for over a year: HMOs, PPOs and other managed care plans are losing their clout and their capital.

Until now, Stires says, "The healthiest way to deal with a managed care company is to own stock in it." The value of stocks in managed care giants like UnitedHealth, Wellpoint, or Aetna have doubled since the end of 1999.

Health insurers enjoyed an extraordinary five-year run of pricing power. Premiums rose 11 percent in 2001 — triple the rate of inflation — and 12.7 percent in 2002. Early estimates for 2003 show a staggering 22 percent climb on average, with some customers facing premium increases of nearly 100 percent.

Stiles tells how they got away with it. First, big firms gobbled up roughly a third of small firms in mergers that left 600 or so survivors with better pricing leverage. Second, health benefits have generally remained a sacred cow. Although employers would like to cut costs, payouts for worker health benefits are growing faster than wages.

Third, the rise in prescription drug costs is slowing, from a high of 19 percent in 1999 to an estimated 16 percent this year. If this continues, as expected, insurers would save roughly \$10 billion over the next few years.

Despite all that, Stiles agrees with Dr. Gibson that the managed care industry is on the way out.

Today's insurers are offering more of the old-fashioned, high-cost, fee-for-service insurance. Managed care did slow the increase of medical costs in the late 1980s and early 1990s, but employees never liked having their doctors' visits doled out in homeopathic doses. They wanted low prices but unrestricted access to care. In the booming economy, employers, eager to retain workers, passed those demands along and insurers loosened the strictures on access to care.

Between 1990 and 2000, the average number of doctors in each HMO nearly quadrupled, the number of hospitals per plan more than doubled, and the percentage of HMOs that paid for treatment outside the HMO's network more than tripled, to 63 percent of all plans in 2000. Employers' premiums soared.

Even then, patients thought HMO plans were too tightly managed. Over the past decade, consumers have increasingly moved to PPOs that contract with an extremely broad network of physicians and hospitals, cover all out-of-network care after an annual deductible, and reimburse doctors almost entirely on a fee-for-service basis. In 2002, PPO enrollment jumped from 28 percent in 1996 to 52 percent of all covered workers, while enrollment in HMOs fell from 31 percent in 1996 to 26 percent

Hospitals also rebelled. After years of consolidation, big chains now wield much more

negotiating power than in the early days of managed care. They are forcing price increases on insurers by threatening to walk away.

Managed care firms pushed so hard on cost containment measures that 42 states and the District of Columbia now have independent boards to review coverage decisions. These now partially or fully overturn more than half of all denials — thwarting cost containment efforts.

Medical inflation is back with a vengeance. Employers are fuming over skyrocketing medical costs and managed care companies are scrambling for a new way to cap costs yet give patients freedom of choice. Some think they've found the "miracle cure" — consumer-driven health plans.

Dr. David Gibson has been telling us this for a year. The employer pays into an annual health savings account for family medical expenses. Once the employee spends that money, additional health bills become the employee's responsibility. When an annual deductible of, say, \$1,500 to \$3,000 is reached, the employer covers all or most of the medical claims — under a managed care plan.

This shifts the financial incentive from the insurance company to the patient, hopefully encouraging the patient to shop for cheaper drugs and services — or at least to think twice about seeing the doctor for a sniffle. That, along with consumer education, exposes patients to the full cost of medical treatment and involves them in the decision-making.

Employers like Medtronic, Xerox, and Textron are signing on, hoping for instant savings, and insurance heavyweights like Aetna, Cigna, UnitedHealth Group, and Wellpoint Health Networks are rolling out products.

Last summer, the Internal Revenue Service issued long-awaited tax guidelines that did not tax money employers provide for employees' out-of-pocket medical expenses, and also allowed unspent funds in employer-funded health savings accounts to be rolled over from year to year and retained when an employee switches jobs or retires.

However, the plans are off to a very slow start. Despite aggressive marketing, estimated enrollment is below 10 percent where employers offer the plans. Aetna, the first national insurer to introduce a consumer-driven plan, has attracted only 17 of more than 4,000 of its eligible employers.

Princeton health economist Uwe Reinhardt says the product is not consumer-friendly. It heaps too much out-of-pocket cost on the employee. "Typically, managed care plans carry an annual family deductible of a few hundred dollars," says Reinhardt, "Just wait until a huge number of employees are asked to fork over \$2,500 out of their own pocket."

Many health care economists cite the problem of "adverse selection." They predict that consumer-driven plans will appeal more to healthy young workers with fewer medical bills than to older, sicker people. Healthy families on tight budgets will like the notion of piling up unused funds and rolling them over from year to year, but families facing serious illness will be scared away by the high deductibles and will choose to stay with traditional managed-care plans. As the young and healthy drop out of the traditional plans, and the plans' percentage of sick people rises, the premiums employers pay for traditional insurance will rise in what insurance experts call a "death spiral."

"Adverse selection" is no pie-in-the-sky theory. Joseph Stiglitz, former World Bank chief economist and head of Clinton's Council of Economic Advisors, won the Nobel Prize in economics last year for propounding that theory as a rationale for universal health insurance for the elderly.

Supporters deny that adverse selection has been a significant problem. Businesses that shift all of their workers to the new plans won't have a problem because the workers will have no choice. "Patient-directed?"

If consumer-driven plans fail, insurers have no Big Ideas left for reining in skyrocketing medical costs. That leaves the industry vulnerable.

Small businesses have been trying to change the law to let them band together in regional or national trade or professional groups to form purchasing cooperatives. They believe this would give small employers more leverage to fight premium increases. President Bush and a bipartisan group of more than 100 Congressmen have voiced strong support for these cooperatives, or "association health plans."

Senator John Breaux of Louisiana, an influential Democrat, is drumming up support for universal health insurance that would require every citizen to purchase at least a basic health plan, with a federal subsidy for those who can't afford one. He could have allies in CALPERS, the nation's largest pension fund, AT&T, DaimlerChrysler, and 80 other big employers, pension plans, and unions.

Even without such additional pressure, top portfolio managers at Vanguard, Longleaf Partners, and T. Rowe Price have been unloading health insurance shares in droves.

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