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Roundtable Discussion

Health System Change: The View From Wall Street
by Paul B. Ginsburg and Joy M. Grossman

Wall Street analysts are more sober than other health observers are about the prospects for rapid change in the U.S. health care system. Consumers’ desire for a wide choice of providers and high-technology services will inhibit the ability to slow growth in health spending, these analysts predict. They agree with others about the importance of supporting physicians with tools to practice effectively and providing the right incentives to use them, but they believe that major progress in this area is some ways off. Medicaid beneficiaries will experience the greatest degree of change, especially if pending legislation to turn the program into a block grant is enacted. The strongest managed care systems will be those with a large regional presence, not those that attempt to cover the entire nation.

These are the views of an expert panel of five securities analysts who follow the health care industry for major Wall Street investment houses.1 The analysts met in July 1995 to discuss health system changes at a roundtable convened by the Center for Studying Health System Change. The center is pursuing a number of research initiatives to track changes in the U.S. health care system.2 As part of this process, the center sought out a group of analysts respected by their peers for their understanding of health care markets. The analysts collectively cover a broad range of companies, including insurers, managed care organizations, hospitals, physician management companies, and suppliers.

In this paper we present highlights of the panel discussion, focusing on the analysts’ perspectives on the shape of change; the role of managed care; relationships between health plans and providers; role of capital markets; and controlling health spending.

The Shape Of Change

The analysts generally agreed on the pace of change and its direction. They rejected predictions that health system change would accelerate rapidly through the remainder of the decade, believing that change is likely to continue at the pace it has shown over the past few years. They also were conservative in their estimates of the magnitude of particular changes, such as the shift to managed care. They pointed out the many exaggerated predictions of change in the past: “The people that predict the death of indemnity coverage . . . are the same people who predicted the death of the hospital industry and the massive closures of hospitals in the early '80s . . . that really never happened.” They also emphasized that resistance to change by consumers, especially the elderly, and some physicians inevitably would slow the pace of change. In managed care, demands by consumers for a wide choice of providers may slow the pace at which medical practice is made more effective through tight linkages between managed care companies and

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providers. Consumers’ insistence on the latest in technology also will force managed care providers to proceed cautiously in limiting access to procedures for which evidence on effectiveness is lacking.

The analysts did not accept the oft-stated notion that different markets will proceed linearly through stages of development. In contrast, they referred often to the fact that health care is local and that change in any particular market depends on the existing organization of the system and the relative market power of the actors. This implies that even if the health care systems in different communities face similar pressures from the outside, such as pressures by purchasers for cost containment, their responses are likely to differ based on these factors. One analyst supported this point by noting that, while the point-of-service product was developed as a transitional product to move people into managed care, the demand for choice of providers has spurred its growth in the California market, which has had high managed care penetration for a long time.

The Role Of Managed Care

For this discussion the analysts defined managed care to include plans that are actively involved in care management—for example, health maintenance organizations (HMOs) and point-of-service plans. They excluded traditional preferred provider organizations (PPOs), which have involved less control over the delivery of care. They agreed that growth in managed care market share will continue, at a minimum, at the current rate of about one to two percentage points per year. With the possibility of Medicaid block grants and policy changes in Medicare in mind, some predicted an acceleration in enrollment growth so that half of the population would be in managed care by 2005, but this is still below the predictions of other analysts.

A large proportion of privately insured persons in managed care plans will enroll in a point-of-service plan that uses gatekeepers but also covers out-of-network care, albeit at reduced rates. One analyst suggested that enrollment in more restrictive HMOs will continue to shrink. It was their judgment that there would continue to be a sizable market for indemnity policies that incorporate utilization management but do not restrict choice of providers. “There will be a core of the population,” another analyst said, “that maintains much more of the traditional kinds of financing arrangements than you would imagine [because] there is a high degree of resistance on the part of many people against any infringement on choice of providers.”

Three potential growth areas for managed care are the small-group market, Medicaid, and Medicare. Small groups represent an underdeveloped market segment that provides opportunities for growth, particularly with the availability of point-of-service products. Much of the growth in managed care over the next few years is expected to come from Medicaid enrollees, as more states adopt this approach to lower costs and improve their ability to budget expenditures. The analysts expect that the proportion of Medicare beneficiaries enrolled in managed care will increase from the current level of less than 10 percent but that the share will not exceed 25-30 percent within the decade. Medicare’s managed care enrollment growth rate will vary across the country, since HMO investments in this market are very sensitive to the relative level of Medicare’s capitation rate, which is tied to Medicare’s fee-for-service experience. The rate of growth could be greatly affected if there are major changes in payment rates, direct incentives for beneficiaries to enter plans, or the “fifty-fifty” rule, which limits any plan’s market share of Medicare enrollees.

Entry of managed care companies into new geographic markets is expected to continue at a rapid pace. Heavy capital requirements will favor for-profit firms, which have greater ability to raise capital. Purchasers increasingly are demanding a range of insurance products that vary with respect to provider choice and other dimensions of managed care. Firms can increase their market share by providing total replacement capability (offering purchasers the opportu-
nity to buy a combination of indemnity, point-of-service, PPO, and HMO plans from a single vendor).

Successful managed care companies are also likely to be large and to be concentrated regionally. “Size, regionally defined, gives you market presence. It also gives you leverage,” one analyst said. The analysts were uncertain about the ability of national companies with a broad geographic base to balance the benefits of marketing products to large nationwide employers with the need to maintain sufficient market share in any one region. One analyst pointed to Maxicare Health Plans as an example of a company that did not succeed in emphasizing national coverage at the expense of regional market share. Recently, most consolidation has been at the regional level. However, the merger of United HealthCare and Metra-Health will be a strong test of whether broader national expansion can succeed.

**Relationships Between Health Plans And Providers**

The analysts anticipate little vertical integration between health plans and providers. Instead, these parties will rely on a broadening array of contractual arrangements rather than ownership. They were skeptical of the ability of hospitals and physicians to organize successfully to bear risk: “The efforts to link providers together with an insurance-underwriting function have really been quite faulty. Even Kaiser, which is the ultimate tripartite organization-the docs, the hospitals, and the insurance-is having an increasingly tough go of it.” There have been few successful models of provider-based health plans, in part because of the potential for conflicting incentives between maximizing the use of providers and controlling costs. The analysts attributed the success of PacifiCare, started by a hospital management company, to the fact that the managed care company was set up as a separate entity with its own management and board so that the HMO would not be used as a vehicle for filling hospital beds. Humana, in contrast, was unable to merge the two businesses and eventually spun off its hospitals from the managed care organization, to the benefit of both companies.

Given current excess capacity, health plans can negotiate large discounts from hospitals while avoiding the fixed costs of purchasing and maintaining facilities. Although the trend of downsizing of hospital beds and consolidation will continue at current rates, the analysts do not expect the demise of the traditional hospital in the near future. They noted that many hospitals continue to be highly profitable on a cash-flow basis. “Twelve years ago, everybody was predicting [this],” one analyst said. “Excess capacity not withstanding, this industry has shown resilience under price pressure.” Hospitals still have the major portion of the health care dollar and a large share of the rapidly growing outpatient market. Physicians still earn a major portion of their income from hospital-based services. There will be a continued need for inpatient acute care, particularly cardiac care, as the population ages. The role of hospitals as a major employer in local communities also is likely to help ensure their continued existence.

Health plans are using two opposing strategies in contracting with physicians; which will be the winning approach is uncertain. Some plans are establishing wide physician networks to respond to consumers’ preferences for provider choice. In markets where major competitors have more restricted networks, plans that have broad networks can differentiate their product and may command a premium. But in markets where most major competitors sell plans with wide networks, health plans are less differentiated, and competition becomes more focused on price. Other plans are limiting the size of the network and developing closer relations with the affiliated physicians. These affiliations provide better opportunities to control costs. Some plans also may be able to differentiate their product on the basis of the reputation of network providers.

Many new types of contractual relations between health plans and providers are being developed that fall in between full ownership and an agreement on a price discount.
For example, plans may guarantee a higher capitation rate or volume of patients to physicians who commit a substantial portion of their practice to the plan. There is an increasing emphasis on long-term exclusive relationships with physicians, with a variety of compensation options. Health plans may enter into joint ventures with physicians to own and manage practices.

The analysts emphasized that individual physicians have distinct attitudes toward these new kinds of relationships. Some physicians are willing to work as employees of managed care companies or contract with a plan on an exclusive basis, but a majority are more comfortable working with their peers than under the direction of either health plans or hospitals. This is driving more physicians to join larger group practices or to associate with physician management companies. They are willing to sacrifice some independence to reduce their costs and to gain leverage in contracting with health plans. There will continue to be a core group of physicians who prefer more traditional autonomous arrangements.

The analysts predicted that the use of specialty care networks may grow in the short run but that their role will be transitional. These networks of physicians and other providers focus on a specific disease, such as cancer, and manage those cases under a capitated payment arrangement. The networks are attractive to managed care plans that have not developed management expertise in a given specialty. But over time, these plans are likely to seek to develop their own management expertise, to avoid the complexities and expense of dealing with separate networks for specialized services.

The analysts cited the example of hospitals that initially contracted for specialty services, such as respiratory therapy and rehabilitation, but have tended to develop internal capabilities to provide them. Specialty care networks formed around tertiary care providers may have a more lasting role because they offer an opportunity to enhance a plan’s reputation for quality. Who controls the process of care—health plans, hospitals, or large physician groups—will differ by market. How the system has historically been organized will affect which players are well positioned to manage care effectively. For example, in most markets physician groups are too small to be the organizers of the delivery system. However, in certain markets where large physician groups have been important for some time, they have become key players. In general, providers-hospital and physician groups are more likely to control the system in smaller, more concentrated markets. Dominant parties are likely to have capital to consolidate market power by acquiring competitors and to invest in information systems and management expertise.

One analyst suggested that in some markets where major teaching hospitals are key players, these institutions might parlay their role in providing high-technology tertiary care and their access to clinical data and research funds into serving as central providers in a hub-and-spoke system. The analyst also speculated that pharmaceutical companies may be possible contenders. With the highest margins in the health care industry, these firms have the most to lose from health care markets becoming increasingly competitive. Just as they have been purchasing pharmaceutical benefit management companies, they have incentives to purchase specialty care networks, HMOs, or large providers that control prescription drug use. These firms, especially foreign companies, have large quantities of cash and the lowest cost of capital, which can enable them to buy into a market quickly.

The Role Of Capital Markets

The changes in health care markets envisioned imply substantial capital requirements. Builders of health care systems will need funds for expansion, funds to purchase other organizations as markets consolidate, and funds to invest in information systems. Nevertheless, the analysts did not see capital as a constraint. Their view is that capital is plentiful for enterprises with good prospects. But nonprofit health plans may be hindered by their inability to raise equity capital other than through reinvestment of surpluses.
This explains the trend toward Blue Cross and Blue Shield plans’ converting to for-profit status. On the other hand, reserves and traditional debt-financing sources are likely to be adequate for the many nonprofit hospitals, including some that wish to form vertically integrated systems. Others may find it necessary to convert to for-profit status to obtain the capital they need.

Controlling Health Spending

The analysts believed that most cost containment is now occurring through discounts from providers and reductions in hospital use. They disagreed about the potential for additional savings through these mechanisms but agreed that it varies a great deal across markets. They pointed out that the level of discounts also varies over time with purchaser pressure. For example, in response to recent efforts by the California Public Employees Retirement System (CalPERS), a large purchasing cooperative in California, to reduce premiums, health plans have put renewed pressure on providers to reduce their prices. This has led at least one health plan to change the nature of its relationships with providers—entering into more exclusive arrangements, whereby price reductions are granted in return for increased volume.

The analysts stressed that to achieve additional savings, health plans and providers need to develop new approaches to reduce the volume and intensity of services, for example, by focusing on the effectiveness of treatment. They felt strongly that success in controlling costs ultimately lies in developing clinical information systems, effective tools to use the data, and appropriate incentives for physicians, as the key clinical decisionmakers, to integrate the information into their practice. As one analyst put it:

Information . . . is another key success factor. Doctors are very sensitive to what their peers are doing in every regard, whether that’s professional status or utilization. If you give doctors information and they’re way out of bounds on either side, half the time you don’t even have to say anything to them, they’ll correct it . . . . HMOs are actually information database companies.

Over time, competition on the basis of implementation of clinical management tools would become more important than the current emphasis on developing market power to reduce payments to providers. However, development of these clinical data systems and management tools is only in its initial stages. There are, at present, no ideal models for how to provide the appropriate incentives for physicians to integrate the information. The analysts believed that the basic data on effectiveness developed by the federal government is an important resource for health plans in developing their own methods for improving outcomes.

In contrast to their confidence that health plans and providers eventually will be successful in implementing such strategies to improve the efficiency and effectiveness of care, the analysts were less sanguine about the overall ability to control the rate of growth in costs. They felt that consumers, resistant to narrow provider networks and demanding high-tech medicine, will be a force against rapid slowing of health care cost increases. In all, the analysts expect that although the recent slowing in the rate of health spending growth will be maintained, spending will continue to grow faster than gross domestic product for the foreseeable future.

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NOTES

1. The participants were Joyce Albers-Schoenberg, Deerfield Asset Management; Geoffrey Harris, Smith Barney; Margo Vignola, Merrill Lynch; Roberta Walter, Goldman Sachs; and Patricia Widner, Warburg Pincus Counsellors, Inc. Thanks to all of them, especially Margo Vignola, who hosted and helped to organize the session.