Managed Care At A Crossroads

A Wall Street view of managed care's mistakes and misfortunes, and a prognosis for survival in an increasingly hostile environment.

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For the first time in roughly four years managed care companies appear to be reversing the negative fundamental trends that have punished earnings in recent years. Commercial pricing is in a sharp upward trend, medical loss ratios (MLRs) are improving, returns on equity (ROEs) are moving higher, and earnings estimates have been largely stable for the large market capitalization players. Unfortunately, the corresponding stock-price momentum evident in late 1998 and early 1999 suffered a dramatic reversal in late 1999, as a result of the growing intensity of societal, political, and legislative forces that threaten the managed care industry's earnings prospects and perhaps even its very existence. In fact, it would not be an exaggeration to suggest that the managed care stock universe suffered a “free fall” of virtually unprecedented proportions. In the space of several weeks the managed care universe lost roughly 20–25 percent of its value.

While the immediate impact of these forces has been on investors' perceptions and on stock prices alone, analysts are concerned that recent events could delay or even derail the fragile fundamental recovery that could improve earnings and stock-price performance. The issues confronting the industry and investors go well beyond current fundamental trends and valuation levels. What happens to managed care and financing for health care in the United States has both near-term and long-term implications for the broader health care marketplace.

Managed Care: Unfairly Punished?

By most objective measures, the managed care industry has been a huge success. Health care cost trends have moderated in recent years, health care as a percentage of gross national product (GNP) has leveled off, and the overall health status of the U.S. population, as reflected in growing life expectancy and reductions in infant mortality, has continued to improve. Furthermore, managed care has increased access to the health care delivery system by expanding coverage for pharmaceuticals, alternative medicine, preventive care services such as health screening, and primary care services.

Despite this track record, the industry has not only failed to capture any credit for its successes, but has consistently received bad press and has become a societal, political, and legal target. When the Health Care Financing Administration (HCFA) reduced Medicare risk rate increases as part of the Balanced Budget Act (BBA) of 1997 and some health plans responded by exiting the business, the popular press ran stories about health plans’ “abandoning” seniors. No mention was made of the rate reductions as the root cause. When health plans introduced reminder cards and first-dollar coverage to increase the frequency of prenatal care, cancer screening, and basic physical examinations, the press ignored these beneficial programs. In 1996, when nearly 60 percent of plans reported that they

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had implemented at least one of the three most popular disease management programs (for asthma, diabetes, and congestive heart failure), the media failed to applaud them. And as health plans began to use various review programs to reduce clearly inappropriate care (such as cesarian sections and hysterectomies, driven more by income and malpractice considerations than by medical necessity), they were accused of interfering with the physician/patient relationship.

The industry’s failure to earn credit for its positive contributions is the result of several factors, including (1) public-relations ineptitude; (2) fierce ideological opposition by advocates of a single-payer system; (3) clever maneuvering by the health care industry’s other constituents; (4) the ongoing reluctance of our society to recognize health care as an economic resource rather than a “right”; (5) the lack of economic connection between the payer for and the user of medical services in an employer- and government-financed health care system; and (6) the large spread in industry ideology.

Public relations failure. While the managed care industry has been credited in the business community with reducing medical inflation, the industry systematically has failed to achieve recognition for the value it has delivered to patients. First-dollar coverage (no deductible and no copayment) has led to a dramatic expansion in coverage for and consumption of pharmaceuticals, alternative medicine services, prenatal care, immunizations, screenings, and primary care services. In fact, most of the cost savings achieved by managed care techniques have come from reductions in medically unnecessary hospital and specialist services, price concessions from providers and suppliers, and administrative efficiencies.

The fact that managed care has vastly increased access to health care has received little or no press attention. Rather, the industry has earned an image of profiteering by denying needed health care services and erecting obstacles between patient and physician. Ironically, 56 percent of U.S. health maintenance organizations (HMOs) lost money in 1998, and managed care companies have lower levels of profitability and returns on investment than many other health care industry participants have.

The view that managed care companies deny services is not totally surprising, given that many managed care techniques such as utilization review, gatekeepers, and formularies clearly involve an intervention between provider and patient. Thus, the member may have the impression that cost control is more important than high-quality patient care. In addition, the industry blundered by using often poorly educated staff to carry out many of its medical management tasks. Physicians frequently complain that the utilization review person on the other end of the phone can’t begin to understand his or her rationale for a given course of treatment. This frustration with the payer is then passed on to the patient with whom the physician, not the payer, has the personal history.

Managed care companies also have failed to create any relationship or brand awareness with their members. Oxford Healthplans probably came the closest. Managed care companies have failed to create any relationship or brand awareness with their members.
niques equally across its membership base instead of isolating them to chronically and critically ill persons, who typically account for 70–80 percent of total medical expenditures. Thus, healthy members often were subject to the same annoying interventions as high-severity patients were but with little financial benefit to the plan and at great cost in terms of lost goodwill.

In some cases, health insurers simply stole defeat from the jaws of victory. For example, when actor Christopher Reeve sustained his horrifying injury, his health insurance company reportedly abandoned him once his lifetime benefit cap was reached, thus creating a high-profile industry enemy. Suppose instead that his insurer had helped him to identify and secure additional health funds from other sources: The insurer could easily have played the role of hero and made a friend for life.

Finally, most of the cost savings achieved through the use of managed care techniques have accrued to employers instead of employees. Had employers and the industry been willing to share more of the cost savings, consumers might have taken certain inconveniences more in stride. Also, to the extent that consumers have shared in the cost savings either directly through lower premiums or indirectly through enhanced benefits, employers and health plans have not communicated these benefits to consumers very well.

The dangerous allure of single-payer systems. In addition to suffering from its own missteps, the managed care industry, along with the entire private-sector health care financing system, has come under constant assault from advocates for universal coverage administered through a government-run single-payer system. Single-payer advocates, while largely driven by ideology, point to the fact that other nations have lower per capita health care expenditures than the United States has, without any measurably adverse consequences to health status. In fact, many European countries (the United Kingdom, Germany, and the Netherlands) have longer life expectancy and lower infant mortality than the United States despite significantly lower health expenditures as a percentage of gross domestic product (GDP).

These traditional measures, however, do not adjust for the enormous demographic, socioeconomic, and value differences between the United States and other developed countries. The United States spends enormous sums of money on patients during the last months, weeks, days, and even hours of life when there is often little statistical evidence of medical benefit. In many other countries such patients would simply be made comfortable in their final hours, and the expense of a heroic procedure would be avoided. In the United States we don’t let people die if there is even a remote chance of survival. While this ethic is costly, it has also resulted in major advances in medicine. Also, traditional aggregate measures of health status do not take into account quality-of-life measures. In 1997 in the United States $2.1 million was spent on reconstructive joint replacement, which might have little impact on overall life expectancy but can clearly improve quality of life.

The current trend toward discrediting private-sector cost containment initiatives could serve to bolster the voice of single-payer advocates. In fact, if the Democrats win the next presidential election, we believe that a single-payer system could once again surface as a seriously considered policy solution to the new crisis in health care.

Public relations in other health care sectors. In sharp contrast to the managed care industry, other health industry participants have done a far better job at public relations.
ton administration in the early 1990s, the pharmaceutical industry has successfully repositioned itself in the public’s and politicians’ eyes as a research industry. No politician would ever suggest that we should spend less money on research, regardless of the high profit margins and returns enjoyed by pharmaceutical companies. Emphasizing the political appeal of generously funding research, the president’s budget for the National Institutes of Health called for an unprecedented increased investment in medical research of $1 billion in 1999, and there is sentiment in Congress to increase spending even further.

Even physicians have regained some ground by positioning themselves as victims alongside their managed care patients, notwithstanding median annual earnings of $164,000 in 1997 versus $34,674 for the average working male and $24,973 for the average working female. This is not to say that these constituencies do not deserve their popularity, profits, or high incomes, only that the managed care industry has missed an opportunity to achieve the same status in light of its contributions.

Unfortunately, these other sectors also have positioned themselves as adversaries to managed care. Many physicians have publicly expressed their anti–managed care sentiments, and the pharmaceutical industry has been a silent bystander while Congress debated the Patients’ Bill of Rights. Their stance, however, is understandable, given that managed care companies initially created pressure on pricing, margins, and incomes in many segments of the health care system.

However, if managed care is dismantled, the likelihood of a national health insurance system administered and financed by government will increase. It is somewhat surprising and shortsighted, therefore, that the pharmaceutical industry, the American Medical Association, the Federation of American Health Systems, and others have not yet come to the defense of managed care. A single-payer, government-financed system would surely reduce profitability and returns across the entire spectrum of health care participants as it has elsewhere in the world.

In the United Kingdom, under a nationalized health care system, the pharmaceutical industry absorbed a 4.5 percent government price reduction in mid-July 1999 for drugs sold in the United Kingdom. As a result, the Warburg Dillon Read Pan-European pharmaceutical team expects only low single-digit growth in Pan-European pharmaceutical sales during the next three years, versus growth in the mid to high teens in the U.S. market. U.S. pharmaceutical EBITDA (earnings before interest, taxes, depreciation, and amortization) margins average 29.24 percent, while the global average excluding the United States is 23.3 percent. In addition, a national health system could have a direct negative impact on infrastructure spending and on research and development and overall capital flows into the health care sector.

- **An economic resource.** Americans still have not come to terms with the fact that health care is an economic resource that must be rationed like other resources. We have put the managed care industry in the unfair position of having to make resource-allocation decisions that should be made by consumers, the government, or medical ethicists. Unfortunately, universal coverage and indemnity-style insurance are often viewed as being the same as unlimited access to health care. However, a national health insurance system would simply substitute a government rationing system for a market mechanism. A return to old-style indemnity insurance would likely result in higher medical premiums, and lack of affordability would then act as a rationing mechanism.

- **Disconnect between payers and users.** There is little direct economic linkage between consumers, providers, and financiers in our third-party payment system. As a result, consumers do not have any economic incentive to watch how the health care dollar is spent because it is not “their” money. Similarly, providers have little incentive to be sensitive to the consumer’s demand curve, because they recognize that the consumer usually is not footing the bill. Attempts to better align consumers’, providers’, and payers’
interests through vehicles such as medical savings accounts have met stiff political resistance from those who believe that such plans would benefit only the healthy rich. However, in our opinion, creating a structure in which the consumer has a financial incentive to spend wisely would act as a significant deflationary force on today’s medical cost trends without compromising quality.

**Large spread in ideology.** Managed care plans do not share a common legacy, and they still operate with very different ideological and strategic approaches to the marketplace. These differences have made it difficult for the industry to join ranks to gain public and political support. Tension within the industry is illustrated by the fact that the nation’s largest managed care companies do not belong to a common trade group. Although heterogeneity is not a surprising characteristic in a young and challenged industry, more unity probably would serve the health care industry well in political and public-policy circles.

**Legislation, Litigation, And Investigations**

The failure of the managed care industry to capture credit for its accomplishments has led to a significant societal backlash. Ironically, it is precisely the industry’s success that has shifted the health care debate back to access and quality and away from costs. Playing on the growing public discontent with managed care, politicians and class-action lawyers have chosen their next target after tobacco: the managed care industry.

The managed care industry is under attack. Anti–managed care consumer groups are lobbying for significant regulatory and legislative changes aimed at curbing alleged managed care abuses. Politicians and legislators have responded by proposing and enacting anti–managed care legislation at both the state and federal levels. Three states—California, Georgia, and Texas—have passed laws enabling people to sue their health plans for medical malpractice with compensatory and punitive damages, and twenty-eight states have passed prompt-payment and anticapitation legislation. Many states have passed legislation mandating specific practice guidelines such as minimum lengths-of-stay for maternity care, restrictions on the application of pharmaceutical formularies, and hospital staffing ratios. Finally, sixty-eight Republicans in the House of Representatives crossed party lines to pass the Norwood-Dingell Patients’ Bill of Rights that includes liability as one of its key components.

These legislative mandates are systematically removing the very tools that managed care companies and others have used to manage costs. Ironically, these techniques have yet to be proven to be detrimental to health plan members on a widespread basis. The industry has recently been hit with a number of class-action suits alleging that managed care techniques represent a breach of fiduciary duty under the Employee Retirement Income Security Act (ERISA) and fraud under the Racketeer Influenced and Corrupt Organization (RICO) Act. Fear of litigation is likely to lead managed care companies to reduce the use of medical management techniques such as utilization review and gatekeepers, which could cause the medical cost trend to rise again.

**The Future Of The Industry**

Given the growing hostility toward traditional managed care techniques, the industry clearly will be forced to change. The question is whether it will have to abandon the innovations of the past decade and revert to indemnity insurance practices, or whether it will innovate again and find new ways to meet the health care needs of consumers while managing medical cost trends for employers and the
government. Another key consideration is whether the industry will have the time and continued access to capital needed to innovate and to change its image, given the speed with which the legislative and legal systems are moving against current industry practices.

We believe that all constituents would be better served if health plans were to focus on the creation of efficient markets for health care services. Under such a model the health plan would no longer be viewed as an obstacle to care or as interfering in the physician/patient relationship. Rather, the health plan would be viewed as a facilitator of care, a purveyor of useful information, and a provider of helpful services. In their ultimate form health plans would no longer need to create networks or even specific insurance products. Rather, through the use of “smart cards” (credit and identification cards that are embedded with medical and financial information and have “read/write” capabilities) and the Internet, plan members would essentially create their own individualized virtual networks and products through their own choice.

The naysayers will undoubtedly say that patients are not sophisticated enough to participate this aggressively in their own medical decision making, that accurate outcomes data are too hard to collect and to interpret, that physicians will not cooperate, and that application of market forces to health care simply will not work. We acknowledge that this new paradigm would involve significant changes in attitudes among all constituents in the health care delivery system and sizable capital and innovation in information systems. However, we believe that it represents an option more consistent with American values of free markets, consumer empowerment, and choice than the alternative of a health care system that is heavily controlled and regulated by government.

Given the importance of innovation and capital investments to this outcome, we hope that policymakers and the public will not overreact to the shortcomings of the existing system with legislation that results in diminished access to capital. Clearly, a rush to a single-payer system would not only kill innovation in the organization and delivery of health care services but would undoubtedly have a negative impact on the future of the entire health care industry as well, including the pharmaceutical, biotechnology, and medical technology segments that offer such a bright future for the treatment and eradication of disease. If politicians and the public are able to avoid a “rush to judgment,” we believe that a number of existing managed care companies can help to solve the problem.

Assessing The Managed Care Companies

**Large companies.** Based on our near-term view that the threat of litigation and the implementation of specific practice guidelines at the state level could lead to an acceleration in utilization and overall cost trends, we are using a selective approach to recommending stocks. It will be difficult for stocks to move higher if the fragile margin recovery that began last year is derailed by accelerating cost trends that outstrip today's rising rate increases.

We have positive investment ratings on a number of industry participants because they are large and therefore have the financial ability to invest in next-generation managed care systems. A number of these companies are already creating and implementing next-generation managed care techniques and thus are less likely to be subject to legal action or a substantive rise in costs. Companies that fall into these categories are Aetna for scale; CIGNA and WellPoint for scale and lower probability of legal action; and UnitedHealth Group for scale, lower probability of litigation, and next-generation managed care. We believe that companies that have used a fee-for-service model of reimbursing providers are generally less vulnerable to RICO and other suits.

**Other companies.** We are concerned about the prospects for most other managed care companies in light of recent earnings results and the points articulated here. These other companies lack either the scale, the financial resources, or the vision to accomplish...
the changes necessary to succeed in the future. Additionally, some of these companies are experiencing near-term operational and financial problems. We believe that the only real long-term hope for these companies is to sell to one of their larger peers.

We have articulated for some time now our belief that premium increases today are beginning to outstrip medical cost increases for the majority of the publicly traded managed care organizations. The result has been a downtrend in MLRs for the universe of publicly traded companies. Historically, relative stock-price performance has had an inverse correlation with MLR trends. That is, stocks have outperformed the market when MLRs were declining and underperformed the market when MLRs were increasing. Given ongoing capacity withdrawals and an attempt by the industry to improve profitability, we expect premium trends to continue a sharp upward acceleration over the next several years. In addition to improving MLR trends, earnings estimates have been stable to rising for the larger players, returns of equity appear to have bottomed out, and the ratio of operating cash flow to net income appears to be improving, which suggests a rebuilding of reserves.

Unfortunately, we believe that recent legislative and legal events could delay or derail the fragile industry recovery by creating an upturn in medical utilization. The capital investment that companies will need to transform themselves into next-generation managed care entities will be substantial.

Only the large managed care players will thrive, because they have the ability to invest in systems and adapt to the changing operational paradigm. In our opinion, small companies will have less opportunity as the industry changes, because of their lack of scale and size, unless they are able to leapfrog the competition through tremendous innovation. This could contribute to another round of consolidation as companies try to preserve franchise value and membership.

NOTES

2. Reeve's difficulties with insurance are documented in a variety of places, including “Dana and Chris Reeve,” Ladies’ Home Journal, November 1999, 240.
8. Ibid., 7.