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The Managed Care Market - Current Status, Future Direction

by Kevin M. Dolsky

A snapshot of the rapidly evolving managed care market is a difficult concept. However, several key factors that characterize its current status can be identified. This characterization, along with consideration of newly developing influences, provides insight to the markets' likely future direction.

Consolidation Industry consolidation continues at a rapid pace. National players have largely replaced local and regional plans in the last five years. The factors driving this, weak balance sheets, a desire for growth, pessimism about future industry prospects, and the belief that large technology investments are necessary, will continue to fuel consolidations.

One byproduct of the consolidations has been a substantial reduction in the cyclicality of underwriting results. The former pattern of growth thru pricing and marketplace operations has been replaced with national companies, and BCBS consolidators' top line growth is the result of acquisitions rather than same store enrollment increases.

Capital Markets

The investment community has more influence on the managed care market than historically and is generally not enthusiastic in company valuations. Weak and inconsistent profit margins, consumer backlash, Medicare exposure, and the treat of litigation have provided negative pressure. The investment community is poised to reward (and managements have taken notice) companies with strong underwriting discipline, low operating costs, innovative products, a strong market position, and low exposure on the negative pressures.

Consumer Backlash

The managed care industry has lost the public relations battle, and its legitimacy as a concept is somewhere between severely damaged and destroyed. The general population seems to believe medical management units are staffed and managed by accountants. The industry is not willing or able to defend itself. The result has companies running away from a substantial reason for their economic basis for existence, namely, managing cost. Companies are rapidly trying to remake themselves into customer friendly advocates for good health.

Who Will Manage The Cost ?

A typical health plan mission five years ago would sound something like this. We finance health care. How we provide value and gain competitive advantage to grow and make money is to negotiate the best deals with providers and eliminate unnecessary utilization of services. We will send patients to lower cost providers and not allow higher cost ones to participate with us. Often statements are added about quality, access, and customer focus.

Contrast this with the typical health plan mission today. We will be nice to consumers. We will help them achieve good health. We will develop services to make it easy for them to get health care. We love everyone and are not nasty.

Providers, after widespread moves into risk and capitation, have in many cases decided they do not want responsibility for the cost and are insisting on fee or service-based reimbursement.

Employers for the most part are paying the expense. However, they are not equipped or in business to be able to do much to control it.

The change in emphasis away from managing medical expenses can be perplexing to actuaries, whose contribution often deals with financial aspects of competitiveness and maximizing ROI.

Rapidly Increasing Costs

Health plans' lower standing on the food chain is not lost on providers in many negotiations over terms and fees. The reduction in inpatient utilization, which covered increases in other categories of medical service, has leveled off for many plans. Pharmacy costs are increasing at 20% per annum or more for most plans. Government reimbursement for services has been constrained as a result of the Balanced Budget Act of 1997.

Particularly affected are hospitals and to a greater degree in non-metropolitan areas. This reimbursement is generating pressure to raise fees to private-pay patients. Additionally, inflation in the economy has gone from under 2% to nearly 4% in the last two years.

In addition to the increase in medical cost is the desire for the industry to improve profitability by lowering their medical loss ratio. The result is rate increases averaging in excess of 10% for the industry for CY2000. Many increases for individual customers or business segments are 20% or more.

Pharmacy Costs

Health plans are experiencing annual increases in per member per month (pmpm) cost ranging from 15% to 30%. Evidence of pharmacoeconomic benefit is anecdotal at this time. An analysis of the drug pipeline indicates increases in the high teens can be expected for the next four years, without adding additional breakthroughs that may occur. Despite the cost increase, there is great hope that

biotechnology will provide better health, better outcomes, and less invasive cures. Genetic therapy is on the horizon, but is not affecting costs or treatments today or in the near term.

Regulatory and Legal

Govermnent will be asked, through the elective process, to continue to incrementally increase their involvement in managed care and the health care system. Despite a budget surplus, the government has more attractive items to spend money on than adequate health care reimbursement rates.

There were 21 class action lawsuits filed against the industry in the four months following the 9/30/99 announcement by the tobacco lawyers of their intention to target the managed care industry. The Carle case decided by the Supreme Court in June 2000 provided the industry some relief from concern over liability. The consensus is that the legal challenges will be mitigated when a national patient protection bill is passed.

Future Direction of the Managed Care Industry

Consumerism

Consumers are convinced they are entitled to medical care — presently through a system where someone else pays for it. The industry has learned THE CONSUMER IS KING — PERIOD! Managed care companies learned this the hard way when their efforts to contain cost interfered with consumer desires for freedom and access. The industry is scrambling to be friendly to consumers. Plans are developing ways to be advocates for consumers. It remains to be seen whether they will be successful at being advocates for health, access to quality services, and cost effectiveness all at the same time.

Technology

Information about medical care, treatment options, quality, cost, and providers can be gathered and provided to consumers in fulfilling managed care companies' advocate role. The Internet will provide the medium for communication of such information.

Technology and the Internet will also provide the ability and medium for more efficient claims and eligibility processing, and better communication with customers on claims, inquiry, and other service issues.

Defined Contribution

There is admittedly a debate over how fast employers may move to limiting their financial and legal obligation through moving away from promising health benefits to providing a defined contribution for employees use in paying for health care selected by the employee. I believe the change will occur rapidly and extensively, meaning in the next five years, as much as half of the market will be through a defined contribution.

Providers and managed care companies have demonstrated they do not want the risk or are willing to pass it on through rate increases. Employers have been largely paying for this because of employment shortages and strong earnings. I expect large rate increases to continue for the next several years because of pharmacy, government reimbursement, lack of ability to aggressively manage costs, consumerism, and medical cost inflation.

Of the four parities involved in health care, individuals, employers, health plans, and providers, the employers have the least ability to manage cost or affect medical decisions. It is not in employers' business interest to provide benefit guarantees, and they continue to do so based only on tradition and tax benefits (the latter of which can be obtained in other ways).

It is for these reasons that I believe once a certain momentum is achieved toward defined contributions, it will accelerate. This does not mean managed care companies will be shut out, but rather will be consistent with their desire to be close to consumers.

Group underwriting (eligibility) and pricing will still be provided through the employer grouping with more individual choice and consequence for decisions.

New Competition

In a world where managed care companies' value is derived from their ability to be advocates for health, access, and information concerning medical care, new competitors will spring up. Companies such as Vivius that sell over the Internet health care coverage designed as personalized health care systems can provide for much of the advocate responsibility. Positive brand image and trust will be valuable assets for health plans in succeeding against this competition.

Government Programs

It is unlikely that managed care company involvement in at-risk programs for Medicare and Medicaid will be profitable in the near future. For this reason, plans will reduce their exposure to this in the near term. Opportunities on the horizon may be in government-sponsored programs for prescription drugs and the uninsured.

Conclusion

The managed care market has changed from one of aggressively managing costs to one reflecting consumerism. The author's view is the change is a permanent shift rather than a pendulum that will swing back in a few years.

Consumers have expressed their desires and exercised their authority through backlash and through their elected officials. It remains to be seen if the consumerism will also entail an adoption of responsibility by individuals. If consumers become financially responsible for their medical care, they will be much more incented and receptive to managing their health as a result. This will provide an opportunity for a pendulum swing of a different type where companies can provide value and thrive as health maintenance organizations rather than the maligned managed care companies.

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