

2020 Wall Street Comes to Washington Health Care Roundtable

Despite dire predictions that the COVID-19 pandemic might drive up health insurance premiums by 40 percent next year, many factors will guide health plan pricing decisions beyond direct COVID-19 treatment costs, including enrollment declines from job losses, according to panelists at the 24th annual Wall Street Comes to Washington Health Care Roundtable sponsored by the USC-Brookings Schaeffer Initiative for Health Policy. Although how the impact on premiums will play out remains unclear, the rise of telemedicine and expanded use of nonphysician clinicians sparked by the crisis are two trends likely to stick. And once the pandemic recedes, the underlying, age-old challenges related to health care costs, quality and access will reemerge as priorities for policymakers, payers, providers, patients and the public.

Predicting Post-Pandemic Premium Trends

Early predictions suggest the COVID-19 pandemic will drive hefty health insurance premium increases in 2021.¹ But Wall Street analysts gave a more nuanced forecast, saying many factors beyond direct COVID-19 treatment costs, such as job and enrollment losses and regional variation in disease incidence, will influence health plans' calculus for 2021 premiums.

Cautioning that there are a “wide range of scenarios” that could play out, Matt Borsch, managing director at BMO Capital Markets, said, “For example, it could be a scenario where the costs of COVID-19 overall are more than offset by the reductions in volume from all of the disruption to the healthcare system that’s occurred.... And then you range the scenarios all the way up to a very high level of costs, that might for example, at the upper end of the range, wipe out the earnings of the health insurers this year.”

Similarly, Ricky Goldwasser, managing director at Morgan Stanley, said that deferred medical procedures that are “benefitting the health plans early on are likely to come back” and spillover into 2021. Health plans also must be mindful of meeting medical loss ratios, which require them to spend a minimum percentage of premiums on medical claims and quality improvements, versus administrative costs and profits, or issue rebates to customers. Another factor that will shape premium decisions is geographic variation in COVID-19 incidence, which to date varies across the country. “We’re not even talking state level; we’re talking county level. So that means that if you are a regional health plan in a specific area that’s more hit by COVID-

About the Wall Street Comes to Washington Health Care Roundtable

On March 31, 2020, the USC-Brookings Schaeffer Initiative for Health Policy hosted the 24th Wall Street Comes to Washington Health Care Roundtable. Designed to bridge the worlds of Wall Street and Washington health policy, an expert panel of equity analysts, moderated by Paul B. Ginsburg, director of the USC-Brookings Schaeffer Initiative for Health Policy, discussed market trends shaping the health care system and the impact of federal policies on health care companies.

Panelists
Matthew Borsch, BMO Capital Markets
Ricky Goldwasser, Morgan Stanley
George Hill, Deutsche Bank

19, you might have to face very different realities and have to treat premium in one way, versus a health plan that's more diversified and can cross-subsidize different regions," she said.

With unprecedented job losses across the economy, health plans also must consider the other side of the cost equation—projected revenue, according to George Hill, managing director at Deutsche Bank. "I think the other part of this equation is what happens to membership, particularly as it relates to [health plans] that are exposed to employer sponsors as opposed to other payer books. And how does employment re-ramp once we get through this situation," he said.

Providers 'Blocking and Tackling' To Manage COVID-19

With almost all "high-dollar revenue, high-dollar margin elective procedures being delayed or deferred to some uncertain date," many hospitals and physicians are facing significant financial pressure, Hill said. For providers on the pandemic's front lines, however, economic and policy issues are taking a back seat, he said, as they face the "very real blocking and tackling" issues of treating patients, finding personal protective equipment to keep workers safe, and getting enough testing capability in place.

On a more positive financial note for providers, the \$2.3 trillion federal stimulus package directed significant aid to hospitals and other providers, Goldwasser noted. And longer term, "given all the focus on the hospitals and all the good work that they're doing, how likely is it that we're going to see hospital reimbursement rate cuts in the future? I think it's going to be very, very difficult for that to pass in the years, kind of like, post-post COVID," she said. Hill agreed, saying the crisis will give "hospitals the artillery to go back and demand higher prices—that they've been put under too much pressure for too long; that the infrastructure was not readily available when it was needed."

Hospital Capacity and Standby Services

Historically, hospitals have cross subsidized the cost of standby services like burn and trauma units by charging higher prices for other services. But the COVID-19 crisis has raised the question of how best to pay for hospital standby costs for critical equipment like ventilators and excess ICU capacity to handle patient surges from public health threats, observed moderator Paul Ginsburg, director of the USC-Brookings Schaeffer Initiative for Health Policy. "Should that be funded through providers getting higher prices for other services? Or should that be directly subsidized by the government? I don't know the answer, but that really is the question it brings up," he said.

At the same time, in recent years, as more and more services shift to outpatient settings, there's been a lot of discussion about overcapacity of hospital beds, Goldwasser said, with many predicting that the hospital of the future would essentially just be an ICU. In the context of the pandemic, she said, "If we think about where the capacity issue is, it is within the ICU, right—it is with the ventilators, and to me that is going to be the thing to solve for in the future."

No Turning Back on Telemedicine and Nonphysician Clinicians

Two key changes likely to outlast the crisis, analysts agreed, are the rapid expansion of telemedicine and expanded scope of practice for nurse practitioners and other nonphysician clinicians sparked by the pandemic. "Telemedicine is a clear beneficiary of this situation, and

there's an expectation that a substantial amount of that temporary conversion will outlast this crisis," Borsch said.

In recent conversations with health system leaders, Hill said a main point they make is that telemedicine can minimize risk of spreading disease. "Using their words, not mine, 'This is telemedicine's time to shine. The genie is out of the bottle. We're not going back to the way things were.' I think telemedicine would be a big part of the new normal in how beneficiaries engage with providers because it improves access, it improves outcomes, it reduces cost, and now it minimizes provider risk," he said.

Given the convenience for patients, telemedicine also may fuel a trend of patients becoming more "provider agnostic" unless they have chronic conditions that require continued contact with a specific provider, Hill said, adding that consumers "want to be served in their manner, on their terms, in a way that suits them, as opposed to walking into a primary care office, potentially waiting in the lobby for an hour, to an hour and a half, to spend \$200 to \$250 for the six and a half minutes they got with their overworked primary care provider who's trying to see 50 patients a day."

Along with gains for telemedicine spurred by the pandemic, Goldwasser also pointed to federal efforts to expand the scope of practice of nurse practitioners and other nonphysician clinicians, saying, "I think now, once this is out of the box, you can't fold it back in. So, I do think that we're going to see more localized care, nurse practitioners taking more responsibility."

Vertical Integration

Large national health insurers are continuing to integrate vertically along the care continuum to better control costs and utilization, with merger and acquisition targets tied to each firm's asset base, ranging from pharmacy benefit managers (PBMs), to retail pharmacies, to physician practices and post-acute care providers. Across the board, health plans are incorporating PBM functionalities into their operations, with a particular focus on specialty drug spending, which is growing fast and accounts for more than 50 percent of overall prescription drug spending, Goldwasser said. "From a health plan perspective, if you can control for specialty pharmacy on the front end, that overall is going to lead to lower medical cost—the back end—on the health plan side," she said.

Another health plan focus is acquiring physician practices and freestanding outpatient facilities, either outright or in joint ventures with providers. Ginsburg noted that he initially believed the acquisitions were motivated primarily by insurers' desire to prevent hospitals from acquiring practices, but he now believes health plans are really serious about harnessing the power of physicians to control costs and improve quality by aligning their financial incentives away from fee-for-service payment.

Hill pointed out that health plans need to grow to be competitive and that means taking business and market share from one another, and one way to do that is for a health plan to integrate benefit design and care delivery to bend the cost curve. "So, if you're a United, you can steer beneficiaries to your own primary care facility, you can steer them to your own [ambulatory surgery centers], you can steer them through your own pharmacy benefit design to pharmacies of your choice," he said. A United executive once told Hill that "the way the U.S. current healthcare system operates, there's enough inefficiency that small improvements create so much economic oxygen for the company, they create so much room to grow... if you can eliminate the friction, you can deliver better care at a lower cost with better outcomes, while improving financial performance, both for the beneficiary and for the company."

The CVS-Aetna deal has a different focus, in part because CVS “didn’t have the luxury of coming to the transaction not owning 10,000 pharmacies” in contrast to United’s approach with Optum and Cigna’s deal with Express Scripts, Hill said. He believes CVS is trying to be creative in using pharmacy sites to deliver primary care.

On the post-acute front, Goldwasser observed that health plans’ interest in the sector is driven by “making sure that you manage a population in all different settings in order to lower costs.”

Employer Benefit Strategies

With the repeal of the federal excise tax on high-cost health benefits, known as the Cadillac tax, Ginsburg predicted employers will slow their push for higher deductibles, and Hill agreed, saying that pushing more costs onto consumers, especially in light of the COVID-19 crisis, will be “politically unpalatable” for both employers and health plans. Instead, Hill predicted employers will focus on beneficiary engagement, saying that some plan sponsors have “cost-shifted to the point where you’ve gone beyond incentivizing good behavior and started to drive adverse outcomes, and now we want to come back a little bit from cost-shifting and figure out what is the way that we can keep the incentive alignment where it is but continue to improve outcomes, and that’s through engagement.”

Goldwasser said many employers are interested in looking at claims and other data to better understand their employee populations, citing the example of her own firm, Morgan Stanley, which now has a chief medical officer who is a data scientist. “I think that is a real change, where in the past the health plans perceived themselves as the custodians of the data, and I think at times even told employers, you don’t want the data because the data means that now... you’re taking that risk that you have that data, and you need to do something about it.”

Employers also are interested in new digital technologies aimed at helping people improve self-management of conditions like diabetes, fertility issues, and behavioral health care. For now, employers seem interested in sidestepping health plans and contracting directly with digital newcomers, but the analysts questioned how long that will last. “So, you kind of see this path of creative destruction, where you’ll see a bunch of these new companies and new ideas that come to market, but to some degree they’ll either get folded or integrated into the [health plan] offerings,” Hill said.

Drug Rebates

For brand-name prescription drugs in competitive therapeutic classes, manufacturer rebates play a big role in payer decisions about which drug to cover and out-of-pocket costs for patients.² Critics contend rebates contribute to higher drug prices, and Ginsburg noted that the Trump administration attempted to outlaw rebates in Medicare and Medicaid but abandoned the proposal back last year.

Responding to a Ginsburg question about “the value of rebates as a tool to obtain lower prices,” Hill said, “I think rebates are effective but clumsy.” Most rebate dollars now come from expensive brand drugs, often specialty drugs, or brand drugs used to treat a small patient population, according to Hill, who estimated that rebates could be subsidizing employer-level medical spending by up to 10 percent.

“The unintended consequence that has occurred is we’re basically using our sickest, most vulnerable patients to subsidize 95 percent of your beneficiaries that are healthy,” Hill said. “Again, not a planned consequence, but the flip side is now you have to turn around and go back and figure out how do you raise premium costs for your 95 percent of people who are not on these drugs.”

Goldwasser questioned why manufacturers don’t just lower prices rather than give rebates, saying, “Of course, then they’d really have to compete—then it’s efficacy, right?”

This brief is based on the 24th annual Wall Street Comes to Washington Health Care Roundtable webinar, which was held March 31, 2020. More information about the event, including a full transcript and video, is available at <https://www.brookings.edu/events/wall-street-comes-to-washington-health-care-roundtable/>.

Notes

¹ Covered California, News Release, “Covered California Releases the First National Projection of the Coronavirus (COVID-19) Pandemic’s Cost to Millions of Americans With Employer or Individual Insurance Coverage” (March 24, 2020). Accessed at <https://www.coveredca.com/newsroom/news-releases/2020/03/24/covered-california-releases-the-first-national-projection-of-the-coronavirus-covid-19-pandemics-cost/>.

² Alston, Maggie, Gabriela Dieguez, and Samantha Tomicki, White Paper, “A Primer on Prescription Drug Rebates: Insights Into Why Rebates Are a Target for Reducing Prices,” Milliman (May 18, 2018). Accessed at <https://www.milliman.com/en/insight/a-primer-on-prescription-drug-rebates-insights-into-why-rebates-are-a-target-for-reducing>.