

Luring Customers From Medicare

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<http://select.nytimes.com/mem/tnt.html?tntget=2006/09/22/business/22medicare.html&tntemail=y&emc=tn&pagewanted=print>

For years, private insurers have offered alternatives to the federal Medicare program that are meant to give patients lower-cost options than the government coverage provides. More than 7 million people now subscribe to such plans, out of a total Medicare population of 42.5 million.

But suddenly a type of private insurance plan is gaining ground that looks very similar to the basic coverage long available to anyone with a federally issued Medicare card.

And the government is paying the private insurance industry a subsidy of 11 percent per patient, on average, to provide it.

Since the government substantially increased the subsidies two years ago for these most basic private industry plans — known as private fee-for-service — enrollment in the plans has grown tenfold to 820,000. About 18,000 people signed up in August alone, Medicare said yesterday in its latest update. And some analysts expect enrollments to double or even triple by 2009.

The \$7 billion that Medicare will pay private industry this year to provide this fee-for-service coverage is at least \$770 million higher than the government would spend covering those patients itself, based on the 11 percent calculation.

Critics see the trend as further evidence that the government is paying private industry to take Medicare off its hands.

It is a “back-door way of trying to privatize Medicare,” said Dr. Jack Lewin, the chief executive of the California Medical Association, a physicians’ group. But the Bush administration’s Medicare chief, Dr. Mark B. McClellan, insisted yesterday that the trend “is definitely not a ‘push to privatization,’ ” but simply a way to give people with Medicare more choices. “The original Medicare program is and remains an option for those who prefer it,” said Dr. McClellan, who plans to step down next month.

Private insurers can offer more choices and cost breaks to patients, he said, while providing overall better health care that will end up saving the government money.

The 11 percent calculation comes from the Medicare Payment Advisory Commission, an independent federal research body that advises Congress. And some insurance executives say the figure is an exaggeration. But there is little dispute that federal subsidies are encouraging the insurance industry to recruit members for the plans.

And while the current industry coverage can be a good deal for some patients, critics worry that Medicare patients reliant on private insurers could be left stranded if the federal money is eventually cut.

“We are very concerned that Congress is going to pull back on the funding,” Dr. Lewin said, “and we will be left with a private system that offers fewer benefits and is going to be influenced by Wall Street.”

Critics say the growing transfer of the nation’s \$342 billion Medicare program to private industry has already been playing out through other means, like the new Medicare Part D drug program and various Medicare-linked managed care plans and H.M.O’s offered by private insurers.

Providing Medicare coverage in all its guises has become a \$60 billion-a-year business and one of the few profitable growth areas for insurers. Medicare enrollees look especially attractive to insurers, as the

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industry's other main clientele — corporate America — struggles to meet the growing cost of providing health benefits to working people.

The fee-for-service plans, the focus of the current controversy, are in many ways similar to the government's own Medicare. Under the industry version, patients have the right to choose their own doctors and hospitals — as they have long been able to do with their federally issued Medicare cards.

And as with the federal program, enrollees in the private fee-for-service plans typically pay a monthly \$88.50 premium to the government.

Under the industry plans, moreover, the hospitals and doctors receive the same rates as when they are paid through the basic federal Medicare program.

Experts say that because the administrative costs of providing the private policies are minimal, they represent easy income for the insurance companies, with profit margins of 4 percent or so.

But many see the private fee-for-service Medicare plans as mainly a feeder program in which insurance companies hope to gradually convert members into even more complex, more profitable private Medicare offerings that the government also subsidizes.

The more lucrative plans, like Medicare health maintenance organizations or doctor-network managed care programs, which have been available longer, can yield profits in the 10 percent range, analysts say.

The more basic private fee-for-service plans, around for less than a decade, were authorized through an amendment to the 1997 balanced budget act as a way to ensure that elderly people could obtain adequate health insurance. Now the plans are envisioned as primarily for rural Americans who typically have few medical choices.

The insurance industry largely ignored the fee-for-service plans until the insurers' subsidies were increased by \$14 billion over 10 years by the 2003 Medicare overhaul legislation. Insurance lobbyists had argued that expanding private Medicare programs would eventually lower the government's costs.

But insurers "are not really being asked to do anything for additional subsidies," said Marilyn Moon, a longtime Medicare researcher who served as a public trustee of the program — a watchdog role — during the Clinton years. She is now at the American Institutes for Research, a nonpartisan research center in Washington.

Insurers, though, say they provide benefits that basic Medicare does not cover.

The leader by far in private Medicare fee-for-service, with more than half the total members, is Humana. UnitedHealth and WellPoint are also big players.

John M. Bertko, a Humana vice president, says benefits included having nurses stay in touch with discharged hospital patients with chronic diseases to make sure they were following doctors' orders.

Other selling points for the private insurance plans include predictable out-of-pocket co-payments — typically \$5 to \$20 for doctor visits. That compares with the uncertainties patients face under traditional federal Medicare, in which they are responsible for 20 percent of whatever the doctor charges.

Martin Smith and his wife, Donna, of Bristol, Ind., chose a fee-for-service plan from UnitedHealth's Secure Horizons Medicare unit earlier this year.

The monthly premiums of \$12.50 each for Mr. Smith, 68, and Mrs. Smith, 70, are in addition to their government Medicare premiums of \$88.50 each. But the Smiths say the private plan is paying off.

Mrs. Smith recently had heart bypass surgery. And though the bill has not yet arrived, she knows that the hospital deductible for her Secure Horizons plan is \$600, compared with the \$952 she would be responsible for under traditional Medicare.

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And instead of 20 percent of the approved doctors' fees in traditional Medicare, the Smiths pay only \$10 to a primary care doctor and \$20 for specialists. Secure Horizons pays the rest out of its subsidies from Medicare — which are \$692.29 a month, on average, for each fee-for-service member in that part of the country.

The Smiths chose to sign up for Medicare Part D drug coverage from a separate insurer, Humana.

Like the Smiths, more than half of the private fee-for-service enrollees so far have also chosen drug coverage, and many are choosing a plan that combines both.

One is Cathy Watts, 58, of Decatur, Ill., a former nurse who says she had to retire four years ago because of Parkinson's disease and partial paralysis. Last January she signed up for a fee-for-service offering from Humana that included Part D drug coverage.

Other than the government's \$88.50 Medicare premium that is deducted from her monthly Social Security check, Ms. Watts pays no premium to Humana.

She says the drug coverage was the main lure for her because her drug bill last year was \$6,000.

"I will probably pay \$3,600 this year" for drugs, she said. "So that will be better." And she can still see the doctors of her choice.

While insurers do run a risk of losing money on a patient if he or she has unexpectedly large health costs, the companies can consult county-by-county Medicare cost data and decide where to offer coverage and which high-cost areas to avoid.

In southern Illinois, where Mrs. Watts lives, the average monthly rate the government is paying an insurer to provide Medicare fee-for-service is \$692.29 — the same as in Mr. Martin's town in Indiana.

Under Medicare's complicated rules, though, the amount actually paid to a company for a patient can vary. Around the nation, depending on local medical costs and the health profile of Medicare-eligible residents, the monthly federal subsidy to the insurance company can range from \$400 to \$2,500, said Dr. Scott Latimer, a Humana executive based in Tampa, Fla.

Enrollments in the fee-for-service plans are still primarily, though not exclusively, concentrated in rural and small cities. Before the Medicare subsidies were increased in 2003, insurers had little incentive to focus on such places. With few doctors and sometimes only one or two hospitals in such areas, insurers typically have little bargaining power. And the health care providers have often balked at accepting the lower fees and second-guessing often associated with managed care insurance networks. But when enough patients in a local area have been enrolled in the private fee-for-service plans, the companies say local health care providers may have little choice but to join the insurers' Medicare networks.

Rick Jelinek, the chief executive of UnitedHealth's Secure Horizons Medicare business, acknowledged that the company's strategy was "in the longer term, to build networks around our programs."

With such networks in place, he said, the company could help manage patients' health — and the insurer's costs — through techniques like having nurses provide telephone health counseling aimed at helping keep patients with heart disease and diabetes avoid hospitalization.

Dan Mendelson, a former Clinton administration health official who is now the president of Avalere Health, a Washington research and consulting firm that advises insurance companies, said the private fee-for-service trend "should save money for Medicare by improving patient care."

But Ms. Moon, the Medicare researcher, said she was "unconvinced by the logic that says, 'If we are overpaying the health plans now, they will save us money later.' "