Then Oprah turned to the audience and said she finally "got it" when in the film Moore points out that we don't charge for the services of firemen or think profit should have anything to do with firefighting. Then she told her audience to go out and see the film.

It's not surprising to find commentators noting, as Oprah did, that this film is less political than Moore's previous offering. It's less caustic, less outraged. But to call it less political than *Fahrenheit 9/11* is a category error. *Fahrenheit* was an intensely partisan project, focused with laserlike precision on building a damning brief indicting the Bush Administration. And like a lawyer, Moore was only too happy to grab whatever argument he could find, even if it was at the expense of internal consistency. The film, while effective as propaganda, suffered a bit from this ad hoc approach, like the old law school chestnut about "arguing in the alternative": The kettle was in perfect condition when I returned it; it was broken when I borrowed it; and I never borrowed the damn kettle in the first place.

Sicko is far, far less partisan than *Fahrenheit*, but much more ideological. And as such, it is more consistent in what it offers—with one major caveat. The film's final half-hour, in which Moore takes 9/11 rescue workers to Cuba, serves only to reinforce the decades-old slander that equates social democracy with repressive socialism. It's a major miscalculation and nearly squanders the first hour and a half of the film in which Moore so deftly guts arguments that socialized medicine represents the vanguard of Marxism. But that final section aside, the film functions as a compelling advertisement for an alternative way of ordering society, one in which, as in France, there's vacation, paid sick time, doctors who make house calls and even, amazingly, a state-supplied nanny who will come to your house and do your laundry after you've had a child. Who wouldn't want that?

The healthcare industry, for one, and it's betting that itcan once again persuade Americans not to want it either. At a press conference after the American premiere, Moore said that in response to the film we should expect to see all the old chestnuts rolled out by the health insurance industry: "Canada's bad, they've got long lines they wait in, you know, blah, blah, blah," said Moore. "In the Canadian system, there is no wait if you have an emergency situation, if it's a life-and-death issue. The wait to see a specialist or if it's elective surgery, I think the most recent statistic I saw was that it was down to four weeks. But you know, sometimes that's what you have to do when you share with everyone—you have to wait."

Moore continued, "When you share the pie, sometimes you have to wait for your slice. Sometimes you get the first slice, sometimes you get the third slice, sometimes," Moore chuckled, "you get the last slice. But the important thing is that you get a slice, everybody gets a slice of this pie. That's not what happens in this country."

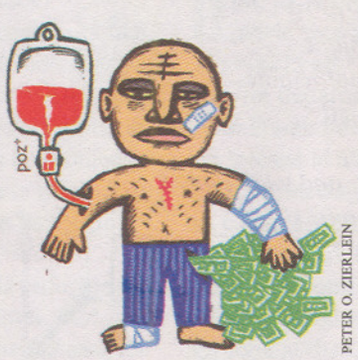
"There are no easy answers," Reagan once said, "but there are simple answers." Social democracy as pie. The Gipper himself couldn't have said it better. ■

UNDER THE GUISE OF 'CONSUMER CHOICE,' CONGRESS IS SLOWLY DEFUNDING MEDICARE.

The Medicare Privatization Scam

TRUDY LIEBERMAN

In the next few weeks Congress will decide whether to cut $54 billion in overpayments to Medicare insurers, igniting a battle that may well determine whether the program survives. On one side are Medicare supporters, who want it to continue as a successful social insurance program. On the other is the insurance industry, which is spending millions and lobbying hard to put Medicare on a fast track to privatization, a goal long sought by fiscal conservatives and their allies in right-wing think tanks.



PETER O. ZIERLEIN

The seeds of the conflict were sown in 2003, when Congress passed the Medicare Modernization Act (MMA), which gives seniors a prescription drug benefit that is sold and administered by private insurers, not the government. This drug benefit, known as Part D, opened new markets for insurers, some of which have profited handsomely from the government's gift. The story of one of those companies, Humana, a forty-six-year-old carrier based in Louisville, Kentucky, shows what's at stake.

Before 2003 Humana, a regional company peddling health insurance, including HMOs, was hardly a household name. One of its policies had been a big money loser, and the company was struggling to dig its way out of a financial hole. Vice president Steve Brueckner called the MMA "an unprecedented opportunity to establish relationships," and his company made the most of it. Humana gained 4 million new policyholders and reported to stockholders in April that it had amassed "record breaking revenues." What's more, Humana has become a national brand poised to sell policies in the non-Medicare market, where people will increasingly be forced to buy their own health coverage, especially if an "individual mandate" becomes

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a solution for the country's healthcare woes. "Part D transformed the company," says Bridget Maehr, an analyst for A.M. Best, an insurance rating service.

Humana's game plan centered on the options the MMA gave seniors for obtaining their benefits. They could keep traditional Medicare, in which the government provides the benefits, and buy a "stand-alone" drug benefit; or they could get the new drug coverage plus regular Medicare benefits provided by one of the Medicare Advantage plans, which include HMOs, the less restrictive preferred provider organizations (PPOs) and private fee-for-service plans, which usually offer traditional Medicare benefits, drug coverage and benefits for extras like dental, vision and chiropractic care. There are no limits on specialist referrals, and seniors can choose any doctor who accepts the insurer's fee schedule.

Humana saw gold in Medicare Advantage plans and embarked on a strategy of government-sanctioned bait and switch.

Some Medicare Advantage plans were not new. Medicare HMOs had been around since the 1970s. But by the late 1990s, conservatives had seized on HMOs, as well as new options such as medical savings accounts and PPOs, as ways to speed up privatization. Under the guise of "consumer choice," always a popular concept, Congress authorized four new kinds of plans, in the 1997 Balanced Budget Act, that would compete with traditional Medicare.

In theory, private plans, particularly managed care, would reduce the program's escalating costs. Government payments, it was argued, would allow these plans to offer both standard and extra benefits and encourage efficient, low-cost care. However, after 2003 the government began shoveling huge sums of money into the Medicare Advantage plans to entice seniors to leave the traditional program—in effect subsidizing privatization even more and bringing right-wing think tanks like the Heritage Foundation closer to their objective of ending Medicare as social insurance. The ultimate goal, of course, is to make seniors bear future costs, sparing their benefactors the need to pay more taxes to keep Medicare afloat. This year the government will pay insurers on average 12 percent more than it costs to provide the same benefits to people who stay in the traditional program, according to the Medicare Payment Advisory Commission (MedPAC), an independent group that advises Congress. HMOs will get 10 percent more, but private fee-for-service plans will get a whopping 19 percent more, a subsidy that lets them offer rock-bottom premiums and lots of extras—at least for now.

An unlikely player in the 1997 debate was the National Right to Life Committee. Worried that Medicare HMOs would euthanize old people, the committee lobbied Congress to allow private fee-for-service plans in the 1997 law as an alternative to managed care. Carriers were slow to market them, and in December 2005 only about 200,000 Medicare beneficiaries had signed up. But thanks to the federal honey pot, all that has changed. By February of this year 1.3 million [illegible]

put the finishing touches on a catch-all bill late last year, Hastert got the House Rules Committee to insert a provision that gives sellers a larger window of time to sell these plans. They can be sold all year, not just between November 15 and March 31, the only time other Medicare Advantage plans can be sold. According to the *New York Times*, Aon, a large Chicago-based carrier, pushed for the change to help its subsidiary Sterling Life, the first carrier to market private fee-for-service plans in 2000. Aon recently told stock analysts that its health insurance business had a strong first quarter with good growth, "driven primarily by Sterling." According to the Center for Responsive Politics, Aon is the twentieth-largest insurance contributor to political campaigns. It has given generously to the Illinois Republican Party and to Hastert. In the 2003–04 election cycle, Hastert received a run-of-the-mill contribution of $5,000; in 2005–06, as fee-for-service plans were becoming more important, Aon and its affiliates gave Hastert $23,900.

From the start, Humana saw gold in Medicare Advantage and embarked on a strategy of government-sanctioned bait and switch: Offering the lowest premiums in most counties across the United States (some as low as $1.87 per month), and selling through agents stationed in Wal-Mart stores, Humana signed up more than 3 million seniors just for its stand-alone drug benefit. It was willing to trade off smaller profits for the prospect of eventually switching seniors to the more lucrative Medicare Advantage plans. On average, seniors pay about $100 a year for Humana's stand-alone plans, versus about $800 for its other Medicare Advantage plans. To get people into those other plans, Oklahoma regulators say, it paid agents commissions that were five times higher than commissions for stand-alone plans. This spring Humana announced that 100,000 people had moved to Medicare Advantage plans, and most chose private fee-for-service options. "It reflects good value for seniors and their preferences," says Humana's outgoing chief actuary, John Bertko. It's also good value for Humana. Says one Washington insurance consultant: "An additional 100,000 people contributing to top line revenue is not insignificant—it's an extra billion dollars."

Private fee-for-service plans are also catching on with United Healthcare, Aetna and Blue Cross Blue Shield, the country's insurance giants, which like these plans not only because of generous government payments but also because they are easy to administer. There are no cumbersome networks of doctors and hospitals to police and little oversight of the quality of treatment delivered to beneficiaries. So insurers are prospecting for new markets, selling fee-for-service plans to employers obligated to provide health benefits for their retired workers. The Michigan Public School Employee Retirement System, for example, just moved 115,000 retirees into a fee-for-service plan sold by Michigan Blue Cross Blue Shield.

All that, of course, depends on what happens in Congress. When the Congressional Budget Office estimated the bill for the overpayments at $54 billion for five years and $149 billion over ten, cuts seemed likely. After all, Medicare's chief actuary, Richard Foster, has said that overpayments shorten the life of Medicare trust funds by two years and raise premiums that all beneficiaries pay for doctor and outpatient services. MedPAC has recommended giving all Medicare Advantage plans no more than it costs the government to provide benefits under the traditional program. "I don't see any possible defense for the overpayments," says Robert Berenson, MD, a senior fellow at the Urban Institute. "Managed care has been ineffective at controlling costs in the commercial sector. Why would we want to turn Medicare over to private plans and abandon traditional Medicare, where if we wanted to, we could actually manage costs?" For example, Congress could lift the MMA prohibition on negotiating lower drug prices with pharmaceutical companies. But earlier this year the Senate refused to do that, bowing to lobbying pressure from Big Pharma, which believes government negotiations will lead to the dreaded price controls.

AHIP has turned the usual industry/consumer lobbying dynamic on its head, casting legitimate consumer groups as bad guys for wanting cuts.

Some HMOs have not been particularly good at improving care. A 2005 study by The Commonwealth Fund found that beneficiaries enrolled in for-profit health plans received significantly lower-quality care than those belonging to not-for-profit plans when it came to certain procedures like giving patients appropriate medications after heart attacks. (Most Medicare beneficiaries belong to for-profit HMOs.)

Despite convincing evidence for cutting payments, America's Health Insurance Plans (AHIP), a trade association of insurance companies and HMOs, has managed to marshal strong support in Congress for continuing them; many legislators see nothing wrong with seniors reaping extra benefits from private fee-for-service plans, which they argue bring more choice to constituents, especially in rural areas without managed care. "It's absolutely brilliant how this has been orchestrated," says Bonnie Burns, a training and policy specialist with California Health Advocates. AHIP has turned the usual industry/consumer lobbying dynamic on its head, casting legitimate consumer groups like California Health Advocates and the Medicare Rights Center as bad guys for wanting cuts and the insurance industry as good guys for wanting more money poured into the program. Consumer groups generally advocate more money for social programs, but in this case they see the overpayments as a strategy to destroy Medicare.

To confuse legislators even more, the industry has called on its own sham "consumer" group, the Coalition for Medicare Choices, to push its agenda on the Hill. AHIP founded the group back in 1999 and still provides administrative support, according to spokesman Mohit Ghose. The address on the coalition's website turns out to be the same one as Democracy & Data Communications, a public relations counseling firm whose clients include AHIP, Humana and United Healthcare, another carrier riding the Part D gravy train with [illegible]

now has 400,000 members, in every state; and the group has gained 140,000 new members in the past sixty days. Its main purpose seems to be ginning up letters and calls to members of Congress "to protect choices and additional benefits provided through the Medicare Advantage program." Sterling Life's website, for instance, tells visitors about the Coalition for Medicare Choices and urges them to send letters—sample included. Nowhere does it say that the coalition is a creature of the industry's trade association.

AHIP has also played the race card, forming a minority advisory committee of community leaders "to protect low-income and minority seniors from Medicare cuts." According to its press release, members, including representatives of the NAACP, Latino and Korean groups, and churches, will "reach out to members of Congress and provide guidance as the Coalition for Medicare Choices conducts grassroots efforts in their communities." This spring Hilary Shelton, director of the NAACP's Washington bureau, and Rosa Rosales, national president of LULAC, the League of United Latin American Citizens, sent letters to Congressional leaders arguing that minority members would be hurt by the cuts. They cited statistics from a study done for the Blue Cross and Blue Shield Association by Emory University health economist Ken Thorpe showing that more low-income and minority Medicare beneficiaries obtain supplemental coverage from private plans than from other sources, so cuts would hurt them. (A Center on Budget and Policy Priorities analysis says Thorpe's study is misleading because it inflates the importance of Medicare Advantage plans by excluding those who get coverage from retiree plans and from Medicaid, which is the primary source of coverage for low-income seniors.) United Healthcare has hired former Ohio Congressman Louis Stokes, a founder of the Congressional Black Caucus, to add lobbying heft to the effort. AHIP has targeted for special attention fifty legislators, primarily Democrats and members from rural areas where a lot of private fee-for-service plans have been sold.

Enmeshed in this political clash are the demands of doctors, who are facing a mandated 10 percent cut in their Medicare fees; the need to reauthorize and expand the State Children's Health Insurance Plan (SCHIP); and the consequences of tax cuts over the years. The fate of Medicare's overpayments may well be decided at this intersection of healthcare and budget politics. Under Washington's budget neutrality rules, new programs or expansions must have a "pay for," that is, money coming from an existing pot of revenue or new taxes, which isn't likely. Medicare overpayments are the juiciest target.

The American Medical Association, a large donor to political campaigns, is eyeing the overpayments as a way to redirect money to its members, who are threatening to withhold services from Medicare beneficiaries if their fees are cut. The Center on Budget and Policy Priorities, a far less powerful voice, argues that a substantial portion of the money now going to insurers [illegible]

SCHIP, setting up a confrontation between old people and children. Without savings from the cuts, the center says, it may be impossible to allocate anything close to the $50 billion over the next five years to expand SCHIP. Such an expansion would move the country closer to universal insurance coverage, which presidential candidates say they want. Of the Senate Democrats who will vote on the issue, Barack Obama and Hillary Clinton both say they support cutting the Medicare overpayments.

If AHIP wins, however, Medicare beneficiaries will lose in the long run. Some have already started to lose. "There's an explicit decision to create a funding crisis for Medicare predicated on overpayment to private plans," says the Urban Institute's Berenson. MedPAC chairman Glenn Hackbarth has warned that the overpayments weaken Medicare financially and threaten the government's ability to sustain it. Overpayments raise overall costs, and the program's trustees have already signaled looming financial troubles for the trust funds. A little-publicized provision in the MMA requires that if the trustees estimate in two consecutive reports that more than 45 percent of Medicare's budget in the next six years will come from general revenues (which partly finance doctor and outpatient services), the President must propose legislation to bring costs below 45 percent. Trustees say that point will be reached in 2013.

With some of the Medicare Advantage plans, seniors may end up paying more out of pocket than they would under traditional Medicare.

That means benefits could be drastically cut and more costs shifted to beneficiaries, hastening the conversion of Medicare from a social insurance program to a defined contribution or voucher plan, under which the government would give seniors a set amount of money each year to buy coverage from private carriers. If the money is insufficient over time, the cost of ever-rising medical care will shift to beneficiaries, who will have to pay more out of pocket for insurance or foot the medical bills themselves. "It's a very scary thing," says Marilyn Moon, vice president of the American Institutes for Research, a large social science research nonprofit, and a former Medicare trustee. "What looks good today could look pretty terrible in five years. If you get to the point of a defined contribution, people will be hurt." Those hurt the most will be the low-income beneficiaries that minority groups doing the bidding of AHIP want to protect.

Beneficiaries who flock to Medicare Advantage plans because of the low premiums and the promise of extra benefits may be hurt long before full privatization becomes a reality. Marketing abuses and hidden traps in policies, reminiscent of the Medicare supplement market two decades ago, are starting to pinch. With some of the Medicare Advantage plans, seniors may end up paying more out of pocket than they would under traditional Medicare. Take hospital copayments, for example. Most private fee-for-service plans have them, but if policyholders are unlucky enough to stay in the hospital for seven days—a not-unreasonable stay for heart-valve surgery—they could spend more than the $992 hospital deductible, which (if the copay is $150–$200, the typical range) is all they would pay had they stayed in traditional Medicare.

panies and are discovering that some carriers make it hard to access benefits; others change the rules, dropping some benefits altogether. Maureen Doyle of South Weymouth, Massachusetts, listened to the government and advocates who urged her to take advantage of the new drug benefit. But ever since, she has tussled with her insurer, WellCare. Several times last year, WellCare refused to authorize prescription refills. Each time she went to the pharmacy to pick up medicine, she was told she had no coverage. Each time, after numerous phone calls and correspondence, the company admitted a mistake and allowed the prescriptions. "Our government assured us that private insurers would provide the most efficient drug coverage," says Doyle. "The casual, go-to-hell attitude of this private insurer belies this promise." After other problems with WellCare's marketing surfaced this spring, it announced enhanced oversight measures.

Early in the game Humana promoted its "Complete" stand-alone drug plan, which provided brand drug coverage in the so-called doughnut hole, where consumers with high prescription use have no government-subsidized Part D benefit. Humana dropped the brand drug coverage this year. It had underpriced the policy, and too many sick people were hurting the bottom line. Humana customer service representatives contacted thousands of customers who had bought the Complete plan, explained that brand coverage was being cut and suggested they seek similar coverage from a competitor, Sierra Health. Sierra, which is also dropping brand drug coverage in the doughnut hole next year, says that as many as 7,000 of its customers may have come from Humana. Humana spokesman Dick Brown says the company supports "a continuing public-private partnership with Medicare amid mounting evidence that private-sector Medicare plans are the right choice."

State insurance regulators and advocates cite industry marketing abuses. A report issued earlier this year by California Health Advocates and the Medicare Rights Center found that agents had misled beneficiaries about private fee-for-service plans. Although agents told them they could go to any doctor, many have had trouble finding doctors who would accept their coverage. In June seven insurance companies said they would suspend the marketing of private fee-for-service plans until they can prove to Medicare officials that agents understand the policies and their sales materials are accurate, a voluntary move unlikely to hurt the bottom line. Humana released a statement saying the suspension would affect 2007 earnings by no more than 2 cents a share. The move, of course, is a ploy to deflect attention from the real issue of overpayments. Pete Stark, who chairs the House Ways and Means Committee's health subcommittee, said the move "will do virtually nothing to protect Medicare beneficiaries and is a pathetic attempt to pre-empt Congressional action."

The story of Humana is emblematic of a major transition in healthcare, to a more privatized system in which insurance companies can discard policyholders when they are no longer profitable. This raises a question: If the private market doesn't provide long-term, effective and efficient care, why does the government