UNITEDHEALTH VS. UNINSURED KIDS

Wednesday night, the House voted 225–209 to pass a bill that would, in the words of a *Wall Street Journal* editorial, "steal nearly $50 billion from Medicare Advantage, the innovative attempt to bring private competition to senior health care" in order to beef up the State Children's Health Insurance Program (SCHIP), a program that delivers health care to poor children.

SCHIP is scheduled to expire September 30; the House bill would renew the program while expanding it to include another 5.1 million children at a cost of an extra $50 billion over five years. The bill's backers propose to fund the legislation by increasing the federal cigarette tax by 45 cents while simultaneously paring the premium that Medicare pays private insurers who provide Medicare to seniors. The goal of the bill, reformers say, is to ensure that all children in the United States have health insurance. *The Wall Street Journal's* editors see things otherwise: "Democrats apparently want to starve any private option for Medicare," the editorial concluded.

Rupert Murdoch hasn't yet weighed in, so I decided to take a look at the proposal. Would the legislation really make it impossible for private sector insurers to continue to offer needed benefits to seniors?

I began by looking at insurers' finances only to discover that the health care insurance industry is, in fact, facing rough weather ahead. While the cost of providing health care continues to climb, more and more employers are backing away from providing health care benefits for their employees. Others are raising premiums and co-pays to a point that some workers can't afford to participate in the plans. This means that insurers are losing customers.

As a result, one might expect that insurers' profits would be falling. One would be wrong.

Just last week, Bloomberg reported that in the second quarter of 2007 profits at UnitedHealth Group, the largest health insurer in the United States, climbed by 22 percent. On the heels of that happy announcement came the news that Humana's earnings more than doubled. They are not alone. Aetna posted a 16 percent jump in earnings while WellPoint, the second-largest U.S. health insurer, saw profits rise 11 percent over the same span.

This is not to say that Wall Street broke out the champagne. In recent years, investors have come to count on rich returns from insurers, and many sniff at numbers like 11 percent. To give you an idea of what investors expect, consider the fact that Humana's stock has climbed 26 percent in the past

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seven months. Over five years, UnitedHealth Group's shares have gained 125 percent, while WellPoint's investors have reaped a 130 percent return. Granted, some insures have had a tougher time, but still, as of the end of July, the six-member managed care index showed a 13 percent gain in just seven months.

Meanwhile, just as one would expect, many insurers have been losing business in the employer-based market: Humana, for example, saw the number of customers in employer-sponsored health plans fall by 10.7 percent in the second quarter, while UnitedHealth reports that, in the year ending June 30, it lost 10,000 customers in employer programs. WellPoint explains that its health-plan membership declined by 108,000 from the first quarter, in part because of declines in employment in the automobile, home-building, and mortgage industries.

Health care inflation also is taking its toll. In April, Aetna's stock dropped sharply after the company confessed that its spending on patient care has climbed from 77.9 percent of its revenues to 79.4 percent.

In the midst of so much bad news, how have insurers continued to maintain double-digit earnings growth? Bloomberg explains: "UnitedHealth's profits rose 22 percent on gains from government-sponsored medical programs." Here Bloomberg is referring to what it describes as "the boon UnitedHealth has seen from increasing the profitability of its Medicare programs for the elderly and adding 290,000 members in state Medicaid programs for the poor in the 12 months through June 30."

Aetna also got a boost from the government; in the second quarter, it raked in Medicare premiums of $677.8 million, up from $436 million a year earlier. WellPoint President Angela Braly echoes the theme, announcing that her company's profits were driven by "expanded enrollment in government-funded programs" as well as "tighter control of costs." As for Humana, it "reported its strongest quarterly result in recent memory on the back of stronger-than-expected performance in the government segment," according to Gregory Nersessian, a Credit Suisse analyst in New York.

In fact, "Humana derives more than 50 percent of its 2007 earnings from Medicare Advantage alone," Justin Lake, an analyst with UBS Investment Research, recently pointed out to his clients. The company is forecasting Medicare profits margins of 5 percent for 2007—up from 4 to 5 percent in earlier statements.

Just how is it that Medicare Advantage has turned out to be such a lucrative business? It may have something to do with the fact that Medicare is paying insurers an average of 12 percent more (or about $1,000 more, per beneficiary) than Medicare would spend if it covered those same seniors directly.

This may seem counterintuitive. After all, isn't the private sector supposed to be more efficient than the government? Shouldn't competition among for-profit insurers mean that they would be able to provide Medicare for less?

When Congress passed the Medicare Modernization Act of 2003, it decided to sweeten the deal for the insurance industry because the program's backers wanted to make sure that a large number of Medicare patients would switch to private plans. After all, the majority of seniors were quite satisfied with regular Medicare. They would need encouragement to leave a program they knew—particularly since so many had been badly burned by private insurers in the late 1990s when Medicare began giving seniors a choice between standard Medicare (with the government paying medical bills

directly) and Medicare+Choice (a program that paid HMOs to provide Medicare benefits to seniors).

The architects of Medicare+Choice hoped that managed care plans might find creative ways to cut Medicare's costs while enhancing benefits. Indeed, American Association of Health Plans' president Karen Ignagni told Congress that insurers could do a splendid job if they were just paid the same amount that Medicare was spending on seniors. All Ignagni wanted was "a level playing field." (Testimony before the Senate Finance Committee, May 27, 1999.)

Unfortunately, it didn't work out that way. From the beginning, insurers started shunning the sickest seniors by charging high-co-pays for items such as hospital care, chemotherapy, radiation therapy, oxygen, and dialysis. At the same time, HMOs offered extras that would appeal to robust seniors. Thus, insurers wound up with a relatively healthy pool of customers. Meanwhile, Medicare paid the companies a lump sum per enrollee—which meant that it was shelling out roughly 4 percent more per beneficiary than it would have spent if those pink-cheeked seniors had remained in traditional fee-for-service Medicare where they would have used fewer services.

Even so, many insurers groused that Medicare payments were not keeping up with the soaring cost of health care, and HMOs began bailing out of the program, blindsiding seniors. Insurers that didn't abandon their Medicare patients drove them away by hiking both co-pays and deductibles.

Mindful of that experience, legislators who pushed Medicare Advantage through Congress in 2003 decided to pay insurers more so that they could offer more benefits (including prescription drugs, sometimes at no extra charge), enroll more patients—and make more profits. The government has "pretty much given up on the argument that the HMOs save money," Lori Achman, a research analyst at Mathematica Policy Research, an independent research center, told the *New York Times.*

How much more is Medicare paying insurers? According to the Congressional Budget Office, over the next five years, Medicare will be paying for-profit companies $54 billion above and beyond what it would cost traditional Medicare to serve the same beneficiaries. Over ten years, the bonus will total $149 billion.

A portion of that premium does go to seniors in the form of extra benefits and lower cost-sharing. But the remainder of what critics call the "overpayment" covers the insurer's administrative costs, marketing—and profits.

The amount that goes into profits varies by plan and by region, but overall, if the Wall Street reports and earnings announcements quoted above are to be believed, the government's largesse is making a big difference in helping to offset insurers' losses in other areas. Or as one analyst put it, insurers are achieving double-digit profits "on the back of" stronger-than-expected performance in their Medicare business.

To put it bluntly, at a time when some customers are deserting private insurers (because they find premiums too high), the government is subsidizing the industry. But is this Medicare's job? Are we to view UnitedHealth as another Chrysler? Are the taxpayers who fund Medicare responsible for making sure that UnitedHealth's shareholders continue to make 125 percent on their investment every five years?

The idea of subsidizing for-profit insures does not sit well with many members of Congress. Indeed, even UBS analyst Justin Lake thinks this is a bit much: "It is likely inevitable Congress will be forced

to act [to cut the 'overpayment'], given the competing priorities and long-term solvency issues facing Medicare," Lake wrote in a July 23 note to clients.

And now House Democrats are threatening to do just that. Under the SCHIP legislation that is being considered this week (The Children's Health and Medicare Protection Act, H.R. 3162), lawmakers would equalize payments between Medicare Advantage plans and traditional Medicare over five years, reducing federal reimbursements by nearly $50 billion in order to help fund health insurance for children.

MedPAC, the independent committee that advises Congress on Medicare spending, also has recommended "leveling the playing field" between the private plans and regular Medicare over a five-year period. President Bush has promised to veto the bill.

Ironically, in the late 1990s, private insurers themselves were calling for a "level playing field," but now they are adamantly opposed to the idea that they should be expected to compete with Medicare on equal terms. America's Health Insurance Plans (AHIP) is leading the protests with a national television advertising campaign warning seniors that some lawmakers are plotting to rob them of their Medicare Advantage benefits.

On the other side of the debate, the chief actuary at the Centers for Medicare and Medicaid Services has testified that the overpayments mean that the Medicare Hospital Insurance Trust Fund will become insolvent sooner—in 2012 instead of 2019. ("CMS Actuary Says Medicare Funding Warning Likely Not Needed if Managed Care Pay Cut," BNA Health Care Policy Daily, April 26, 2007.) And, because of the overpayments, restoring solvency will require substantially larger benefit cuts and/or tax increases than would otherwise be needed.

At that point the only alternative would be to eliminate Medicare and let it become a private sector, for-profit program. This is in fact what some who back Medicare Advantage hope will happen. From the beginning, they saw the Medicare Advantage program as an opening salvo in the battle to privatize Medicare.

Meanwhile, in testimony before the Health Subcommittee of the House Ways and Means Committee earlier this year, MedPAC chairman Glenn Hackbarth warned that Medicare faces "a very clear and imminent risk from this overpayment that will put this country in an untenable position." ("Growth of Managed Care Plans Threaten Program's Finances, MedPAC Chairman Says," BNA Health Care Policy Daily, March 2, 2007.)

Nevertheless, while Medicare Advantage may be overfunded, there is one huge up side to the Medicare Advantage program—the prescription drug benefit, which is not available under traditional Medicare. Nearly everyone agrees that seniors need help paying for drugs. No one wants to see private insurers cut back on those programs. But those who back the House bill say insurers don't need a premium that averages 12 percent per beneficiary in order to cover drugs.

Others argue that just because many insurers have seen profits rising in recent years doesn't mean that they don't face hard times down the road, when the so-called "insurance cycle" turns. The so-called "overpayment" provides a buffer. But many industry-watchers say that the boom and bust pattern in health insurance markets (three years of profitability followed by three years of losses) is, to a large degree, a thing of the past. "The pattern of insurer profitability changed greatly in the nineties," they say, "but it will be even more muted than it was in the 1990s because of changes in industry structure and forecasting improvements." (Joy M. Grossman, Paul B. Ginsburg, "As the

Health Insurance Underwriting Cycle Turns: What Next?" *Health Affairs*, November/December 2004.)

Moreover, even if the industry is still subject to booms and busts, is it the government's job to bail out insurers during low points in the cycle? Isn't it up to the industry to try to continue smoothing out those cycles through better management?

Finally, if insurers say that they can't—or won't—cover seniors and provide a drug benefit unless they are paid a rich premium, then why not let Medicare provide the drug benefit directly? As an editorial in the *Atlanta Journal-Constitution* observed in the fall of 2005, "Forty years after its creation, Medicare has proved itself to be a well-administered and cost-effective government program. . . . Extending the basic model to include prescription drug coverage would have been comparatively simple, cheap, and efficient."

"Unfortunately, though, we can't bring ourselves to acknowledge Medicare's success," the editorial continues, "because doing so would mean challenging the accepted wisdom" that health care financed through the government "must always be a disaster. Apparently we would rather design a complex, largely unworkable and hugely expensive Rube Goldberg machine that diverts huge profits to private industry, because that's exactly what we've done."

Who needs the $50 billion more, children who are either uninsured or underinsured—or an industry that is already racking up double-digit profits?

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