Seniors flock to private Medicare plans

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By Jane Zhang and Vanessa Fuhrmans,
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Hundreds of thousands of seniors are signing up for a type of privately run Medicare plan that delivers traditional benefits without the usual restrictions on access to doctors and hospitals. In turn, some of the nation's biggest health insurers are launching more such plans and marketing them in more areas.

The plans, called private fee for service, are a type of privately run Medicare alternative known as Medicare Advantage. Advantage plans wrap physician and hospital services in one, some with additional benefits. Instead of paying beneficiaries' claims directly, the federal government pays insurance companies to manage the care, with the hope of reducing Medicare spending. To entice seniors to sign up, costs for private plans are cheaper on average than those for traditional government-run Medicare.

But recently such plans have become an even better deal. As part the sweeping law that created the new Medicare prescription-drug benefit, Congress raised the government's reimbursement rates to companies offering Medicare Advantage plans to about $10,000 per enrollee per year. That has led insurers, eager to bring in the new business, to offer Advantage plans with lower premiums but often more benefits, such as vision or prescription drugs.

Laura Cummins of Des Moines, Iowa, switched to a private fee-for-service plan offered by Humana several months ago. It covers her prescription drugs and allows her to see doctors or hospitals without network restriction -- but it doesn't charge either a premium or a deductible. Out-of-pocket charges include $180 per hospital stay up to five days and $15 or $30 for a doctor visit.

"I thought I'd give it at least a year and see how it works out," says Mrs. Cummins, 69 years old. With diabetes and some heart problems, she has already been hospitalized a few times this year. "So far, I've been glad that I did this."

Of all the private Medicare options, it is private fee for service that is seeing the most explosive growth. These plans accounted for about half of the recent growth in Advantage-plan enrollment, according to Avalere Health LLC, a health-care advisory firm that analyzes Medicare data. As of July, more than seven million people were in some form of Advantage plan, or about 17 percent of all Medicare beneficiaries, says Avalere, up from 14.3 percent in December. Enrollment in private fee-for-service plans alone jumped to 802,068 as of Aug. 1 from just 20,000 three years ago, says David Lewis, acting director of the Medicare Advantage Group at the Centers for Medicare and Medicaid Services.

The reason, for many seniors, is freedom of choice. Most Advantage policies are managed plans -- such as HMOs and PPOs, or preferred provider organizations -- that provide no coverage, or lesser coverage, if patients go outside of a plan's network of doctors and hospitals. Private fee for service (known as PFFS) was created in 1997 as an alternative, especially for those living in rural areas where some hospitals and doctors don't want to join restricted networks. PFFS plans operate with only an informal assemblage of providers willing to accept Medicare rates paid through the private plans.

The PFFS plans had been relatively obscure. But as increased government reimbursement made Advantage plans more lucrative for insurers, many are touting the plans more aggressively and retooling their offerings. In some areas of the country, PFFS plans are the first Advantage plans that have become available.

WellPoint has said it plans to offer them in all 50 states in 2007, up from 650 counties in 15 states this year. Humana Inc., which sells the private fee-for-service plans in 35 states this year, and WellCare Health Plans Inc. also plan to expand, though they won't say exactly where until the fall.

Typically, the greater degree of choice makes these plans more expensive than Medicare HMOs or PPOs. But in many counties, the generous government reimbursements allow companies to market some private fee-for-service plans at prices near or even below the premiums of managed-care plans with restricted networks.

For example Humana, with 460,000 enrollees, is the largest provider of PFFS plans. In Sarasota, Fla., where insurers have longstanding Medicare networks, Humana's PFFS option carries a monthly premium of $64, compared with zero to $39 for the more-popular PPO plan.

But in Raleigh, N.C., reimbursement rates allow Humana to sell its private fee-for-service "Gold Choice" for no additional monthly premium. Its PPO plans there range from $10 to $71. Both options include coverage for prescription drugs, comprehensive medical care and even fitness club membership, the biggest difference being that private fee-for-service members pay a $180 co-pay per hospital day while members in most of Humana's PPO options pay $165, plus a $100 deductible.

Next year Humana expects to sell even more PFFS plans, many of them to the millions of seniors it signed up this year in stand-alone drug plans. "We have 3.4 million drug-plan members we didn't have a year ago," says Scott Latimer, Humana's market president for central and northern Florida. "The opportunity to market other products to customers with whom we already have a relationship is that much greater."

As with most Advantage plans, premiums are often lower than the combined premiums for government-run Medicare benefits for physician and hospital services and drugs. Advantage members must still pay the Medicare part B premium for physician and

outpatient services, which is $88.50 a month. But Advantage plans may wrap in other benefits such as additional days in the hospital and drugs.

As insurers expand their private fee-for-service offerings, the plans will see "dramatic growth" next year, says Dan Mendelson, president of Avalere Health.

But some wonder how long seniors can take advantage of this program. The Medicare Payment Advisory Commission, which advises the government on Medicare, has warned that the government pays 11 percent more on average to Medicare Advantage plans for physician and hospital services than the traditional ones.

Without network restriction, private fee-for-service plans don't have as many tools to restrict spending. If a member, for instance, doesn't have one primary-care physician, it can be more difficult to monitor care or ward off a costly hospital admission. "A health plan may not know about a high-risk case until the claim is paid," says Richard Jelinek, head of UnitedHealth's Secure Horizons division, which administers its Medicare Advantage plans.

But some insurers are implementing programs to identify members with multiple chronic conditions and better coordinate care. UnitedHealth, for instance, is implementing 24-hour nurse hotlines and a disease case manager program for PFFS plans; Humana has similar programs.

Some insurers say that as they sign more people in rural areas into PFFS plans, the concentrated number of members will allow them to form doctor-and-hospital networks. In turn, they'll be able to also sell HMO or PPO Medicare plans with lower costs or richer benefits there. With the added savings that come with extracting greater discounts from network providers, Mr. Jelinek says, "we can pass on those benefits to enrollees."

Medicare Advantage

Some privately run Medicare alternatives:

HMO: Generally require use of doctors and hospitals in the network.

PPO (Preferred provider organization): Some out-of-network coverage.

PFFS (Private fee for service): No networks, though may cost more than Medicare HMO or PPO plans.

Special Needs Plans: Cover people eligible for both Medicare and Medicaid, those in nursing homes and with chronic conditions.