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SENIOR HEALTH PRODUCTS— MEDICARE SUPPLEMENTS AND MORE

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The moderator will review senior health products: Medicare supplement, Medicare risk, hospital indemnity policy (HIP), cancer, accidental death (AD), and employer continuance. Discussion will include product design, pricing, administration, regulation, and marketing.

MR. LUND: In this session I will give a brief overview of the senior health product market, and discuss Medicare supplements and Medicare select/Medicare risk contracting. Then I will move beyond current products to address some issues.

As a way of background, I've spent the last dozen years or so at least partially involved in senior health and the senior health market. There are several reasons for this. First, I grew up in direct marketing and Medicare supplements are perhaps the quintessential direct marketing product. We've got a well-defined, accessible market that's very responsive. Second, and I hate to admit it, but I'm getting older, as we all are. Many in this track have talked about our parents. My parents retired last year, so they're in the early stages of retirement. But I also have a grandfather who has an extremely active life in his mid-90s. Every other year, he still travels back to Norway. He travels extensively throughout this country. He still works in his wood shop and lives a very productive and healthy life. I also had a grandmother who was essentially an invalid from her early 60s until her death.

There's a great difference in quality of life between the two of them and that's what we see in the senior market. I'll get into that in a little bit and reprise the quality of life issue, but first, a few of the obligatory statistics. I'm going to concentrate on ages 65 and older. There are various definitions of seniors and senior markets. For health insurance, Medicare gives us a nice, fixed cut-off at 65, which is easy to work with.

At the turn of this century, the over-age-65 market represented 4% of the U.S. population. Today, in 1995, it represents a little over 12%. In five years, it will represent a little over 13% of the total population of this country. In fact, I moved to western New York to join Blue Cross and Blue Shield of Western New York a little over a year ago. One of the first things that I did, with the help of our marketing area, was to study the various markets in western New York. It is kind of a classic Rust Belt area. Not surprisingly, we found the only growth market in our community was the over-65 market.

Let me give two persectives of what's going on. The average senior turning 65 today has a life expectancy of about 16.5 but what's called a healthy life expectancy of only 12 years; this creates a gap of about 4.5 years. A healthy life expectancy can be defined in a number of ways. It can be measured by activities of daily living or you can look at other performance standards. There's probably no good set definition of what constitutes a healthy life, but I think most of us would prefer to live a healthy life.

While we may think that health problems are inevitable and we know that health care costs for seniors are much higher than the commercial population, the major causes of

death among seniors—that is, heart disease, cancer, stroke, pneumonia—are preventable or are controllable.

Common obstacles to a healthy life, such as arthritis, osteoporosis, and visual and hearing impairments, are controllable. What can make the difference? The answer is it's the same difference for both you and I in our active lives—cessation of smoking, good nutrition, weight control, blood pressure control, and physical activities. In fact, if we look at physical activity among seniors, what we find is that 40% of the seniors report no physical activity at all. Slightly less than a third participate in moderate physical activity and 10% in vigorous physical activity. Yet studies indicate that probably the most important piece in maintaining an independent lifestyle is vigorous physical activity.

Seniors consume more health care resources and require more periodic care to ward off life-threatening or disabling diseases. For example, mammography screening is estimated to reduce breast cancer deaths by 30% among women over the age of 65. Pneumococcal diseases are three times more prevalent among seniors than among the under-age-65 population. Therefore, immunizations are very important among seniors. Because of the greater use of prescription drugs, there is a heightened risk of drug reaction among seniors. Therefore, the monitoring of usage and dosage in total drug efficacy is very important.

Our federal government in 1990 put out a very large, very interesting report called *Healthy People 2000* [Health and Human Services Department, DHHS Publication (PHS) 91-50212 (Washington, D.C.: GPO, 1991)]. The objectives for the U.S. population were articulated in *Healthy People 2000* by Dr. Louis W. Sullivan, who was Secretary of Health and Human Services at that time. One of the objectives laid forth in 1990 to be accomplished in a ten-year period was to increase the span of healthy lives for all Americans. Another objective was to reduce the health disparities among Americans and finally to achieve access to preventive services for all Americans.

It's interesting; the goals are not to lengthen life span, but to lengthen the healthy life span. It also strikes me that the latter two goals of reducing health disparities and access to preventive services are merely a means to achieving the first goal which is increasing the span of healthy life. So I view this as really having essentially one goal—to lengthen the healthy life span. Well, how have we responded? We have responded primarily through the use of Medicare.

Medicare came about in 1966 through an act of Congress, and the insurance industry thought, "We're dead. There's going to be no market for selling insurance to seniors any more." Medicare is split into Parts A and B. Part A essentially covers hospital services and Part B covers physician services. Medicare essentially covers a basic set of services and the industry responded very nicely with products that were designed to fill the deductibles and copayments left by Medicare. Through the years, deductibles and copayments, of course, have increased. Hospitals now are essentially required to accept Medicare Diagnostic Related Group (DRG) payments as payment in full for services. So once the deductibles and copayments are met, there's no balance billing. A vast majority of physicians accept the Medicare allowable payments as payment in full. That is mandated in some states, but not all. However, about 70% of the physicians in the U.S. accept the Medicare allowable payments as payments in full for Medicare services. Again, the industry has a variety of innovative plans. There were various attempts by Congress and consumer groups to modify or limit Medicare supplements, because there is a feeling

among some that they're not necessary. Others felt that the insurance industry was ripping off the senior citizens. So we have now reached the point where, through Omnibus Budget Reconciliation Act (OBRA), there are only ten standard Medicare supplement plans available in most states—plans labeled A through J.

The general scheme of the Medicare supplement regulations, as directed by the federal government, is Plan A, a basic service which covers Part A hospital copayments, Part B copayments, and throws in a few other benefits. As you move to Plan B, you add a few benefits. C adds more and D adds more. Generally, as you move down the list, it becomes more comprehensive, until you get to J, which is quite a comprehensive program.

However, if we compare those plans to the goals of *Healthy People 2000*, we find that only two plans cover preventive services. Those are Plans E and J. Only three plans—H, I, and J—cover drugs. Only four plans provide for at-home recovery services. All of these, it appears, are parts of what would be applicable in trying to fulfill the goals of *Healthy People 2000*. I ask you, are these products achieving the goals of *Healthy People 2000*?

There exists a challenger to this. The challenger is HMOs. HMOs may approach the market two ways—through Medicare Select provisions of OBRA and through Medicare Risk contracting through the Health Care Finance Administration (HCFA). Medicare Select was a pilot program covering 15 states that was designed to allow HMOs to develop innovative programs. Medicare Select programs throughout these 15 states today cover approximately 400,000 people—not much when compared to 25 million covered by traditional Medicare Supplement. There's no set definition of a Medicare Select plan. It must be approved by the state and it's designed to add flexible or innovative benefits.

There has been a great deal of controversy covering Medicare select. The Clinton Administration advocated an 18-month extension of the pilot program limited to the 15 states. The House of Representatives recently passed a five-year extension, expanding it to all states for availability. The Senate has yet to act. The Senate is probably less likely to go along with the House and is more likely to go along with the administration in continuing a very limited pilot project.

Medicare select contracts are one limited avenue in which HMOs operate. The other avenue is Medicare risk contracts, which are essentially available everywhere. Medicare risk contracts cover about 1.4 million people; again, not a big portion. My contention is HMOs are going to take over the Medicare supplement marketplace. I'll disclose that right up front. Let's look at the under-age-65 population today.

In Buffalo about 65% of our population is currently covered by HMOs—about 25% through traditional indemnity plans and the remainder via Medicaid or uninsured. Parts of southern California, the Twin Cities, and Albuquerque, NM, have extensive HMO penetrations—in some areas approaching 100% of the commercial or under-age-65 population. What does an HMO do? An HMO was designed to provide an individual with a comprehensive set of services including preventive care, tertiary care, and home care, through the payment of a relatively nominal copayment. There may be deductibles involved with hospitalizations but, by and large, they are $5–10 copayments for services at

the physician's office or for an outpatient procedure or a $5–100 copayment for a hospitalization.

The trade-off is you only have a few physicians that you can select from and to receive service you must go through a gatekeeper. Some physician panels are small; some are larger. Either way you still have to select a primary physician and only get services through physicians as part of the panel. If we look at the HMO market in the U.S. today, there is somewhat of a dividing line at age 50. People below 50 have a strong tendency to prefer HMOs and join HMOs with much greater frequency than people over age 50.

The interesting thing is, we age as a population. What seems to be happening is every year this threshold moves up by about two years. We, in the HMO industry, and I am involved in a 200,000-member HMO, make progress as we gain acceptance. By and large, the older people in America don't have a preference for HMOs yet, which is why we see only a 5% market penetration today by HMOs. I ask you. When I retire, and I've been an HMO member for 20 years, am I going to switch out of an HMO now that I've gotten used to it? When people my age retire, are they going to switch out of HMOs and buy Medicare supplement plans? Probably not. There's a wave moving this way and it will overwhelm the traditional market.

FROM THE FLOOR: Neil, is that as true in the rural areas as it is in the urban areas?

MR. LUND: It's not as true in the rural areas. Just as an aside, one of the problems that happens with rural HMOs is that they have assumed similar utilization to indemnity plans. HMOs looked at the traditional indemnity population and they said utilization in rural areas for health services looks very similar to utilization in the urban areas, so we should be able to extend the HMO out there and assume the same level of services. It does not happen.

There is a tremendous, pent up demand in rural areas for health care services; because when you move in with an HMO, you get pasted with utilization—sometimes as much as double the utilization of what you'd find in an urban population. That tends to taper off over time, so an actuary thinks of it as antiselection.

Rural populations can't afford the yearly antiselection, so we have not made the inroads because of the way most HMOs are structured. There's also a problem with coverage. Similar to the insured population where there's a dividing line at age 50, there's the same age barrier among physicians as far as their willingness to participate in HMO panels; it's probably not quite as distinct a line, but it exists. The physicians serving rural communities are significantly older than physicians serving urban communities in the U.S. In some rural areas of the country, the average physician age exceeds 65.

FROM THE FLOOR: Haven't HMOs really achieved savings by selecting better risks?

MR. LUND: Are HMOs getting the better risks? The answer is sometimes yes and sometimes no. Sometimes you end up with poor risks and sometimes you end up with better risks. I think the real issue is the ability to control costs and utilization that are built into the HMO, and that's what we're relying on. In fact, that's what the federal government relies upon in Medicare risk.

FROM THE FLOOR: You mentioned penetration was about 65% for HMOs and 25% conventional, in Buffalo. What about for PPOs?

MR. LUND: In the Buffalo market, there is negligible PPO penetration. There are three relatively large HMOs that dominate the market and only two small PPOs. Some PPOs have characteristics very much like an HMO and some tend to be very much towards the traditional end of the spectrum. The middle ground has both PPOs and point-of-service plans, which are a combination of HMO and traditional. It's really a continuum. I'm trying to draw a relatively sharp line to be controversial. That doesn't necessarily mean that I believe that there is a sharp line and not a continuum, but that's a very good point.

Let's get back to Medicare Risk. The federal government has seen the potential that HMOs have to decrease health costs and health utilization, while at the same time bring possible improvements in the quality of care through the coordination of care and benefits. TEFRA permitted HMOs to assume the risk of providing health care to seniors. Of course, the government didn't make it easy. They never make anything easy.

Your application to assume risk has to go through HCFA, and HCFA is going to make you jump through all sorts of hoops. I'm not here to tell you all have to go through, but essentially HCFA is going to look at your marketing materials, your complaint rates, your pricing, your operations, and the network of providers you have. For anything you can think of, there's a HCFA report that you will have to file to cover it and that's just to get started. That's not the monitoring side of this. That's just to get approval.

There are, of course, rules to be followed in addition to the reports. The services must be rendered throughout the entire plan area that you're filing for. HCFA will permit county-by-county filings, so you can move forward a county at a time. We could start in Erie and Niagara County, the two urban counties, and then, if we desired, move forward to the other counties. The state of New York has problems with us doing that, but HCFA doesn't.

The services that you provide must be rendered by Medicare certified providers. That's hospitals and skilled nursing facilities. If you have non-Medicare certified providers in your panel, you either have to get them certified or you've got to exclude them. Physicians must not have been barred from serving Medicare and Medicaid payments. Again, if you've got any in your panel, they're gone.

The plan has to have at least one 30-day open enrollment a year—most have more—during which time coverage is guaranteed issued. Of course, it's done with marketing materials approved by HCFA, and you have to demonstrate an acceptable quality assurance program to them. The plan has to have at least 5,000 Medicare members, but the combined enrollment of your Medicare and Medicaid population cannot exceed 50% of your total enrollment; although there's provisions for waiver of that.

That's some of what goes on, but the key to this whole thing are five fearsome letters—the adjusted average per capita cost (AAPCC), which is done on a county-by-county basis. Essentially HCFA has said, "All right, HMOs, you think you can control costs of health care and not skim off the more favorable risks. We'll give you 95% of the equivalent fee-for-service premium." Now, that's not an easy task to calculate. Within a given county, there are 122 different cells that are age, sex, and utilization based.

In other words, if you've got someone that is institutionalized now, you get paid at a different rate than someone who is not institutionalized. HCFA calculates on an average cost 122 different cells for each county; and it's designed to approximate the average health care costs for the Medicare indemnity population in that county.

What the HMO is getting is a gross premium of 95% of the costs. There's no administrative allowances in this. If you as an HMO wanted to charge no premium rates, which does happen in some areas of the country, the 95% of AAPCC also has to cover administrative costs. Assuming that they're running about 10%, the HMO will have to deliver health care costs at 85% of the Medicare rate.

Of course, this being the federal government and recognizing it's the government's money, what if the AAPCC isn't high enough and your HMO loses money? Well, you can carry those losses forward and hopefully recoup them out of some future profits. On the other hand, if you make too much money, you've got to give some of it back to the federal government. They want half of any excess over what they classify as a reasonable profit and, if it's too big, they want it all over a certain threshold. This looks somewhat messy and there are other adjustments that come into play here, so this is complicated. Why would anyone want to do this?

It's because HMOs feel that we can provide a broad array of health care services with emphasis on preventive services—a much broader array of services than what's covered under any Medicare supplement plan. It's because we believe that HMOs can improve the quality of life, which is one of the goals of *Healthy People 2000.* It is because members of my HMO can and do turn age 65 and they want to continue in the HMO.

Now, what does this mean for you? Well, a lot of you are involved in Medicare supplements. Just as HMOs have grown in the under-age-65 population, they will also grow in the over-age-65 population and they will grow greatly. As those of my age group near retirement they will want to continue with HMOs after retirement. I do feel that HMOs, over time, not next year, or not even in five years, but certainly within the next ten years, will garner a terrific market share of the over-age-65 market. So much for Medicare, but I'm not finished yet. I do want to push this over-age-65 envelope a little further.

Let's go back to the theme that we more or less started on—quality of life. Medicine in the U.S. is practiced in a manner that is very good and very efficient at treating acute care with interventions. That's what our physicians have been trained to deal with. That's what our hospitals are designed around. If we have a well-defined condition with a well-defined onset, we can treat it well in this country. They're relatively short term. They're definable.

But let's look at the needs of the population. It goes back to quality of life. What is it that our system is not good at handling? It's chronic conditions. Neither our medical system nor we as an industry are really good at handling chronic conditions; yet with an aging population, an HMO's ability to handle chronic conditions is going to be critical to improving the quality of a healthy life for our people and its members.

As I was flying here, I finally had a chance to look at *The Wall Street Journal.* Under "Work and Family" in the second section, there's a worker's guide to finding help in

caring for an elder. It basically points out the maze that exists and the problems with finding certain types of care. Much of the care mentioned in here really deals with chronic conditions. After acute care has been taken care of, what happens in the continuing life of that patient? It's very difficult to arrange care.

Now, I'm going to describe chronic care using an example that is not confined to the senior market. In fact, what drove this example was not an incident in the senior market. I will talk a little about hospice care. Now, I choose hospice care for several reasons. It is an example of chronic type needs, even though we're dealing with death in a relatively short period of time. The need for hospice is not a well-defined medical condition. When hospice care is needed, it's a decision of the individual and his or her family. It's not a clinical decision. There's no clinical event that you can say, "That's it. Time to go into a hospice." There's a condition that is going to continue. It's a need that continues until death. We're dealing with comfort and coping in the hospice situation.

I chose the topic of hospice care because I have had some limited background in working with a hospice program and a hospice insured program. Finally, and perhaps more importantly, what drove me to this was how, in January, one of my staff members lost his wife to cancer. After a battle that went on for more than a year, the family made the decision to terminate care and move the patient into a hospice center. At that point, my company and the medical profession in the Buffalo area failed. It failed miserably. The transition was not made in a timely, convenient fashion. It did not go well. That disturbed me and really brought some issues home. We spent some time looking at the situation, trying to determine what the underlying causes were and what the problems were. We drew the conclusion that we are not a good system in making the transitions. We are not good in navigating the health care system.

Now, I promised to talk about hospice, so I will describe a program I am familiar with. It's sold as an upgrade to a cancer product. It's an add-on and very simple. Again, it's not necessarily specific to the senior market, but heavily used in the senior market. The contract provides an indemnity payment for up to six months or terminates at prior death for someone that is in an approved and licensed hospice center or uses an approved, licensed hospice home service—and those do exist—when directed by a physician as a treatment of care. That is the contract benefit.

But what is the real benefit that is provided here? It's not the dollars at all. The real service in this program was that a family member could call a toll-free number and they would be put in touch with at least one, hopefully several, hospice services within their area. The connection was made. That's the most important benefit in this product, not the dollars paid, but the connection being made.

Our next step was to make sure that the contact was followed up, that the family was comfortable with the choice. If they were not comfortable, we would steer them to another provider. The key was making the contact. The key is providing a mechanism to help people navigate through the health care system. That's where the stumbling blocks are. That's where the stumbling blocks for my staff members were. It wasn't with the hospice service that was provided once the connection was finally made. It was getting there. In this case, the oncologist and our company didn't have a clue as to how to conveniently and compassionately make this connection.

Now, not all chronic cases need hospice care. They can be elusive back pains. They can be a variety of conditions that can be involved with vision deficiencies and things like that, but the key is still making the connection, getting the member, your customer, connected to the right services. The benefit is far less important than making the connection. So if you're developing products in this market and looking at chronic care or, in fact, at any form of medical care, I've come to the conclusion that making the connections and helping your customers navigate through the system, is actually far more important than the benefits or the level of benefits.

To recap, we as an industry and as a nation center our care around Medicare and supplementing Medicare services. To meet the goals of *Healthy People 2000* is not adequate. The next step that I see is the move into HMOs. But I don't see the HMOs as a sufficient step to providing the level of care, or the level of benefits and satisfying the needs of Americans. We have to push forward, move into the area of chronic care and into the area of making the appropriate connections to services provided.

FROM THE FLOOR: People who had polio are now getting to the age where the late effects are showing up and now they have to control cholesterol. This is an example of the need for chronic care.

FROM THE FLOOR: Connectivity to chronic care really a problem of educating the public on it's value.

MR. LUND: That is a very valid observation. People don't think of connectivity until they need it. Most chronic conditions aren't going to go through an acute stage first. There has to be some sort of connectivity. The marketplace is not recognizing the value of connectivity but perhaps with articles like the one in *The Wall Street Journal*, awareness will increase. It's the sort of things that HMOs do have the capability of addressing relatively seamlessly and in a relatively cost-effective manner. But I agree about where we stand today. I don't think the public really perceives the value of that until they need the connectivity from an acute situation into a continuing situation of some sort.

We've got an educational job to perform. We've got to provide a set of services. Although the cancer program that I spoke of, which was an add-on, marketed very well; it was sold only as an add-on. The initial mailing garnered over a 20% response rate, so there may be some hope. Again, it was very specific and tied to cancer.

MR. PHILIP J. BARACKMAN: As HMOs move into providing services for chronic conditions, be it long-term care or whatever, have you thought about issues relating to the financial side in terms of getting into long-term claims and the need to prefund active life reserves? I wonder if you could discuss or anybody has any observations on how that may pose some issues for the current structure of HMOs in terms of how they're regulated and what their mandates are under the current regulatory framework.

MR. LUND: Phil, you've asked a real challenging question. Regulation varies from state to state as to what the adequate financial standards are for an HMO. Interestingly, a number of those issues were part of what Clinton's health care reform plan was trying to do. Part of what it attempted to do was create a level playing field. Despite the plan's

flaws and the shortcomings, the Clinton plan attempted to create the same financial standards for HMOs and indemnity plans. In my estimation, that is really needed.

FROM THE FLOOR: Do you think that Medicare risk contracts have been or will be affected by any willing provider with legislative initiatives?

MR. LUND: Any-willing-provider legislation is something that HMOs fight like mad. Yes, any willing provider has a huge impact on the ability of any HMO to select and control its panel of physicians, hospitals, and ancillary providers. In order to control cost effectively, the HMO needs to be able to exert some level of control over its provider panel. Any-willing-provider legislation runs just counter to that.

FROM THE FLOOR: Do the HMOs have any problem with their enrollees maybe wanting to do something different from what their primary care physician does? With the Medicare benefits, they are not subject to the normal HMO disciplines and they can go any place for the Medicare paid coverage.

MR. LUND: I can only speak for my company. No, we keep them in the panel. We try to educate enrollees on the need to work within the panel, plus our panel is relatively large. We have 1,800 doctors out of approximately 2,600 in western New York.