FamiliesUSA
The Voice for Health Care Consumers

SPECIAL REPORT

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Medicare Privatization: Windfall for the Special Interests

Introduction

The Medicare Modernization Act of 2003 (MMA) was touted as making fundamental changes in how the Medicare program works—and indeed, it did. Proponents argued that moving toward privatization of Medicare would save billions of taxpayer dollars while providing better health care for the 43 million seniors and people with disabilities who rely on Medicare. But now, nearly three years after passage of the MMA, the move to privatize Medicare has resulted in windfalls for the drug and insurance industries and huge costs to both taxpayers and beneficiaries.

The MMA is most widely known for the creation of the Part D drug program, but the law also made significant changes in Medicare's managed care option, Medicare Advantage (formerly Medicare+Choice). This report analyzes three aspects of Medicare that were affected by the MMA: 1) payments to the private managed care plans that participate in the Medicare Advantage program; 2) special funding provided by Congress to promote regional Medicare PPOs; and 3) the cost implications of offering the new drug benefit through private plans rather than through the Medicare program. In all three areas, our analysis found that Medicare is overpaying the drug and insurance industries for products and services that Medicare could provide directly for far less. Overpayments to Medicare Advantage plans and regional PPOs could easily cost more than $60 billion over the next 10 years. Billions more will be spent on overpriced prescription drugs.

Who wins? The winners are the special interests—the drug and insurance industries—that are enriching themselves at taxpayer expense. This waste of Medicare dollars is particularly troubling at a time when experts such as Medicare's trustees are raising concerns regarding the long-term fiscal health of the program. The billions wasted on subsidizing these special interests could have been invested in the Medicare program to hold down costs and enhance benefits. Instead, they will go into the coffers of the insurance and pharmaceutical industries.

Medicare Advantage Overpayments

SUMMARY

As part of the 2003 Medicare Modernization Act, Congress substantially increased payments to Medicare Advantage plans. Medicare Advantage plans are overpaid compared to traditional Medicare.

- In 2005, Medicare overpaid private plans by at least seven percent per beneficiary. Taxpayers lost $2.7 billion in 2005 to private Medicare Advantage plans and their parent insurance companies.
- In 2006, under a new payment formula, overpayments to plans are 11 percent per beneficiary (after accounting for health care status). With growth in Medicare Advantage enrollment, this amounts to at least $4.6 billion in overpayments this year alone.

Managed care plans have been part of Medicare since 1983. Managed care, it was believed, could help Medicare beneficiaries by ensuring that their care was coordinated and, at the same time, could bring down Medicare costs.[1] Medicare pays private insurance companies a flat amount for each beneficiary who joins their managed care plans. This arrangement was supposed to save money in several ways. First, most plans would limit members' choice of providers. Second, the plans would pay these providers a lower amount for beneficiary services in exchange for promising the providers a steady stream of patients. Third, the plans would coordinate members' care, resulting in better health outcomes and lower costs compared to traditional fee-for-service Medicare.

Private Medicare Advantage Plans Cost More, Not Less

Despite promises of delivering savings, in the more than 20 years since it was introduced, Medicare's privatized managed care program has never provided a better bargain than traditional fee-for-service Medicare. The privatized system, now called Medicare Advantage, has recruited and enrolled disproportionately younger and healthier members whose care is less expensive. This process is known as "cherry-picking." Healthy seniors are more willing to join Medicare Advantage plans, and tolerate limits on physicians, because they need less care. As a result, younger and healthier seniors have been disproportionately enrolled in Medicare Advantage, while older and sicker beneficiaries have remained in traditional fee-for-service Medicare.

Even though Medicare Advantage plans serve healthier, younger, and therefore less expensive, beneficiaries, they have generally been paid as if they treat the same mix of sicker, older beneficiaries as traditional Medicare. This has resulted in huge windfalls

to Medicare Advantage plans. Even worse, Congress has changed the payment formula for these private plans several times over the years. Each change has resulted in higher overpayments to plans, rather than savings to Medicare:

- 1983 to 1997: Medicare managed care plans were paid 95 percent of the average per capita cost of traditional fee-for-service Medicare.[2] This was initially believed to be a reasonable rate, because managed care was expected to cost less than traditional Medicare. In fact, because the private plans attracted younger and healthier members, the 95 percent rate turned out to be too high, resulting in windfalls to the insurance industry. Analyses by the U.S. General Accounting Office (GAO, now the Government Accountability Office) found that the payment system for these private plans was seriously flawed, with excess payments running into billions of dollars.[3]
- 1997-2003: The 1997 Balanced Budget Act was designed to expand enrollment in private plans. It created the Medicare+Choice program and implemented a complex new payment formula. Independent assessment by the Medicare Payment Advisory Commission (MedPAC, a non-partisan commission established by Congress to provide impartial advice about the Medicare program) found that, under the new system, plans were being paid, on average, 103 percent of the per capita costs for traditional Medicare.[4] Thus, even though the plans should have received lower payments compared to traditional Medicare, they actually received comparatively higher payments.

Not satisfied with the growth of enrollment in private plans despite steady overpayments,[5] Congress again sought to expand these private plans as part of the 2003 Medicare Modernization Act. It changed Medicare+Choice to Medicare Advantage and modified the payment formula again, ensuring additional payments to private plans.

- 2004-2005: A new, temporary payment formula resulted in an additional boost in payments to Medicare Advantage plans. MedPAC found that these payments reached 107 percent of per capita costs for traditional Medicare.[6]
- 2006 and beyond: Yet another new payment system will produce overpayments estimated by MedPAC to be 111 percent of per capita costs for traditional Medicare.[7] See the box on page 4 for an explanation of the current payment system and why it results in such large overpayments.

How Medicare Overpays Medicare Advantage Plans

Starting in 2006, private plans must bid to participate in the Medicare Advantage Program. The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare) established a target benchmark cost for each region based on the average cost per beneficiary in that region. Plans that bid under the benchmark can keep 75 percent of the difference in cost, and they must pay the remaining 25 percent back to Medicare. Plans that bid over the benchmark will be paid only the benchmark amount for each beneficiary and must make up the balance through charging higher premiums.

This new bidding system results in overpayments to private plans for two reasons:

1. The benchmark amount against which plans bid is set too high. It is based on the inflated payments to Medicare Advantage plans that were in place before 2006 instead of actual costs.
2. Risk adjustment is inadequate. Medicare Advantage plans have been attracting healthier-than-average Medicare beneficiaries, but their payments have not been adequately adjusted to reflect this. CMS is required to phase in a new risk adjustment payment system between 2007 and 2010 that is meant to reduce risk adjustment overpayments for that period, but this requirement expires after 2010.*

MedPAC estimates that, in 2006, the inflated benchmark cost and inadequate risk adjustment have resulted in a net overpayment to private plans of 11 percent.**

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* Deficit Reduction Act of 2005 § 5301.

** MedPAC, *Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending* (Washington: MedPAC, June 2006).

The Cost of Overpayments

A 2005 study estimated that, on average, Medicare Advantage plans were paid an excess of $546 per beneficiary. With 4.98 million Medicare Advantage enrollees at the time, this translated into a total cost of $2.7 billion.[8] Although exact figures for 2006 are not yet available, the cost has assuredly increased this year. Enrollment in Medicare Advantage has grown by more than 1 million members in the past year, to 6.04 million as of June 2006 (Table 1). Thus, MedPAC's estimate of an 11 percent overpayment translates to an overpayment to plans of $770 per beneficiary.[9] This is likely an underestimate, as it does not account for increases in health care costs this year. Overall, Medicare is paying a total of at least **$4.6 billion** in excess funds to private Medicare Advantage companies this year. And because health care costs have in fact increased since last year, this is almost certainly an underestimate of the true cost.

Table 1

Overpayments to Medicare Advantage Plans

	2005	2006
Overpayment Rate	7%	11%
Enrollment	4.98 million	6.04 million
Excess Cost to Taxpayers	$2.7 billion	$4.6 billion

The $4.6 billion overpaid to private Medicare Advantage plans is a substantial sum. And, unless CMS lowers the benchmark and institutes adequate, permanent, risk adjustment to reflect the health status of Medicare Advantage members, these overpayments will almost certainly grow over time as health care costs increase and Medicare Advantage enrollment grows. A recent independent study estimates that overpayments to Medicare Advantage plans will cost at least $23.5 billion during the five years from 2007-2011.[10] Over the next 10 years, overpayments could easily total more than $50 billion.

The PPO Stabilization Fund

SUMMARY

To encourage the growth of new regional PPOs, the MMA sets aside special additional subsidies.

- The MMA designates $10 billion over 10 years to provide additional subsidies to regional PPOs as needed to ensure access.
- In 2006, 88 percent of beneficiaries have access to a regional PPO,[11] meaning that access is already sufficient and subsidies are unnecessary.

Another costly decision Congress made when enacting the MMA was promoting the creation of regional Preferred Provider Organizations (PPOs) in Medicare. Although local PPOs were already authorized through the old Medicare+Choice program, few actually existed, particularly in rural areas. The new, regional PPOs must serve an entire region (typically one or more states), rather than just one local area, so they should cover rural as well as urban areas. Like PPOs in the private insurance market, Medicare regional PPOs contract with selected providers and obtain lower rates for beneficiary care. Members have limited cost-sharing so long as they stay within their provider network. Unlike traditional HMOs, PPOs allow members to receive care outside their network, but they generally must pay more to do so.

When it established the PPO initiative, Congress had doubts about whether regional PPOs could succeed in Medicare. Therefore, it provided special financial protection for any plans with unexpectedly high costs during 2006 and 2007. In addition, instead of creating a level playing field for the insurance companies that offer regional PPOs, proponents built into the MMA an automatic additional subsidy for PPOs called a "stabilization fund." The stabilization fund has up to $10 billion available through 2013 to make extra payments to PPOs, which is *in addition to* the help given to regular Medicare Advantage plans.

There is no evidence that a stabilization fund is needed for regional PPOs. A large number of regional PPOs have entered Medicare this year: MedPAC reports that 88 percent of beneficiaries have access to a regional PPO—before the stabilization fund has even been tapped.[12] There is no need to set aside subsidies for a program that is already growing. As MedPAC noted last year, if PPOs drop out of the system in the future, then Congress could consider whether to prop them up. In fact, MedPAC has recommended eliminating the fund.[13] In the meantime, the $10 billion could be better used to strengthen Medicare financing and help Medicare beneficiaries.

Part D Drug Prices

SUMMARY

Medicare Part D drug prices are substantially higher than the prices obtained by the Department of Veterans Affairs (VA), where the government negotiates on behalf of consumers.

- For all of the top 20 drugs prescribed to seniors, the lowest price charged by any Part D plan was higher than the lowest price secured by the VA.
- Among those top 20 dugs, the median difference between the lowest Part D plan price and the lowest VA price was 46 percent.

Securing the lowest possible prescription drug prices is critically important to Medicare Part D beneficiaries because drug prices significantly affect their premiums and out-of-pocket costs. Part D drug prices are also important to taxpayers, who pay approximately three-fourths of the cost of the Part D program.[14] Unfortunately, when it comes to achieving low drug prices, Part D is a perfect example of an opportunity wasted. Congress made a series of decisions about how to structure the new program—decisions that will impose heavy costs on beneficiaries and taxpayers.

The federal government has often used its negotiating power in other contexts to obtain good prices on purchases. The Department of Veterans Affairs (VA) uses the bargaining power of the 5 million veterans and dependents the program serves to negotiate with drug companies for reduced prices.[15] Logic would seem to dictate that Medicare, with the bargaining power of 43 million enrollees, could do even better. However, when Part D was created, Congress included provisions that explicitly prohibit the Medicare program from negotiating with drug companies. Instead, Congress handed the bargaining power to private drug plans, insisting that those plans would secure lower prescription drug prices through marketplace competition.

In order to investigate how well private Part D plans do when it comes to securing lower drug prices, Families USA has regularly analyzed price information for the 20 drugs most frequently prescribed to seniors. The lowest price for these drugs available from any Part D plan has consistently been substantially higher than the lowest price secured by the VA. The median difference across all 20 drugs this year is 46 percent.[16] But for some drugs, the difference is significantly higher (see Table 2):[17]

- For Protonix, a gastrointestinal agent, the lowest annual VA price was $214.45, while the lowest Part D plan price was $1,110.96, a difference of $896.51, or 418 percent.
- For Fosamax, a drug used to treat osteoporosis, the lowest annual VA price was $265.32, while the lowest Part D plan price was $727.92, a difference of $462.60, or 174 percent.

Moreover, these prices are the cheapest available anywhere in the Part D program. No single plan offers the lowest price on all drugs, meaning an actual senior could not obtain this combination of lowest prices in any plan available.

Table 2

Lowest Department of Veterans Affairs (VA) Prices and Lowest Medicare Prescription Drug Plan (PDP) Prices for the Top 20 Drugs Used by Seniors, April 2006

Drug Name	Strength	Dose Form	Lowest VA Price Per Year	Lowest PDP Price Per Year	Price Difference Per Year	Percent Difference
Actonel	35 mg	tab	$ 372.24	$ 703.32	$ 331.08	88.9%
Aricept	10 mg	tab	$ 1,058.69	$ 1,553.40	$ 494.71	46.7%
Celebrex	200 mg	tab	$ 632.09	$ 902.64	$ 270.55	42.8%
Fosamax	70 mg	tab	$ 265.32	$ 727.92	$ 462.60	174.4%
furosemide	40 mg	tab	$ 8.56	$ 13.44	$ 4.88	57.0%
Lipitor	10 mg	cap	$ 520.44	$ 748.92	$ 228.48	43.9%
Lipitor	20 mg	tab	$ 782.44	$ 1,068.36	$ 285.92	36.5%
metoprolol tartrate	50 mg	cap	$ 7.20	$ 12.00	$ 4.80	66.7%
Nexium	40 mg	tab	$ 848.45	$ 850.44	$ 1.99	0.2%
Norvasc	5 mg	tab	$ 315.84	$ 463.20	$ 147.36	46.7%
Norvasc	10 mg	tab	$ 490.44	$ 636.60	$ 146.16	29.8%
Plavix	75 mg	tab	$ 989.36	$ 1,283.76	$ 294.40	29.8%
Prevacid	30 mg	tab	$ 657.48	$ 862.20	$ 204.72	31.1%
Protonix	40 mg	tab	$ 214.45	$ 1,110.96	$ 896.51	418.0%
Toprol XL	50 mg	tab	$ 162.65	$ 224.52	$ 61.87	38.0%
Toprol XL	100 mg	tab	$ 250.06	$ 336.00	$ 85.94	34.4%
Xalatan	0.005 %	sol	$ 279.84	$ 555.96	$ 276.12	98.7%
Zocor	20 mg	tab	$ 127.44	$ 1,275.36	$ 1,147.92	900.8%
Zocor	40 mg	tab	$ 190.76	$ 1,275.36	$ 1,084.60	568.6%
Zoloft	50 mg	tab	$ 542.12	$ 786.96	$ 244.84	45.2%
Median Difference					**$ 257.69**	**45.9%**

Note: Annual price is calculated based on the price posted by the Medicare drug plans and the Department of Veterans Affairs in April 2006.

Source: Dee Mahan, *Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices* (Washington: Families USA, June 2006).

When it comes to achieving reduced drug prices, private Part D plans are hardly living up to the promises made by their supporters in Congress. Marketplace competition has not resulted in drug prices comparable to those secured by the VA. And although there has been no precise estimate of the additional costs foisted on both taxpayers and beneficiaries, these costs likely run into the hundreds of billions of dollars.

Consequences

Gains to the Insurance and Drug Industries

The MMA has directed billions of taxpayer dollars to inflated payments to private insurance plans and overpriced prescription drugs, benefiting the insurance and pharmaceutical industries. Early on, these industries recognized that the changes made to Medicare could yield new—and significant—profits. They have not been disappointed. Less than a year into the Part D program, insurance companies have seen sizeable growth in income and earnings (Table 3). Medicare Advantage is seen as especially lucrative, which is not surprising given the built-in profit margins stemming from the payment mechanisms discussed previously. It is likely that those companies that offer both Medicare Advantage and stand-alone Part D plans will encourage their members to move into the more profitable Medicare Advantage plans in the coming years.

The Medicare Drug Gold Rush—Profit from the Biggest New Benefit in the History of Medicare—Part D Drug!!

– Promotion for June 2005 Forum for the Managed Care and Pharmacy Benefit Manager industry.*

The three largest providers of Part D prescription drug and Medicare Advantage plans, United Health Care, Humana, and WellPoint, have all seen substantial growth in both revenue and earnings in the last year.

- United Health Care and Humana report that second quarter 2006 revenues are up by more than 50 percent compared to the same time last year, while WellPoint's revenues have increased by more than 25 percent.[18] (Table 3)
- These companies' profits have also increased substantially, with WellPoint's earnings up by more than 33 percent, United Health Care's up by more than 25 percent, and Humana's profits growing by nearly 10 percent.[19]

* Brochure available online at http://www.insurancebroadcasting.com/crg051605-2.pdf# search=%22medicare%20gold%20rush%22.

Table 3

Second Quarter Revenue and Earnings for Largest Private Medicare Plan Providers, 2005-2006

Company	Net Revenue, Three Months Ended June 30		Net Earnings, Three Months Ended June 30		Increase in Revenue	Increase in Earnings
	2005	2006	2005	2006	2005 to 2006	2005 to 2006
United	$11,388,000,000	$17,917,000,000	$770,000,000	$974,000,000	57.3%	26.5%
Humana	$3,546,000,000	$5,407,000,000	$81,000,000	$89,000,000	52.5%	9.9%
WellPoint	$11,149,000,000	$14,152,000,000	$559,000,000	$751,000,000	26.9%	34.3%

Source: UnitedHealth Group, *UnitedHealth Group Reports Record Second Quarter GAAP Net Earnings of $0.70 per Share* (Minneapolis, MN: UnitedHealth Group, July 19, 2006); Humana Inc., *2006 and 2005 SEC Quarter Two form 10-Q*, available online at: http://phx.corporate-ir.net/phoenix.zhtml?c=92913&p=irol-sec; WellPoint Inc., *2006 and 2005 SEC Quarter Two form 10-Q*, available online at: http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-sec.

Even the design of the Part D drug program has helped the drug and insurance industries. The Part D coverage gap (the "doughnut hole"), for example, is a profit-making dream for insurers. During the gap, Part D plans pay out no benefits, but they continue to collect monthly premiums. And the transfer of dual eligibles (Medicare beneficiaries who also have Medicaid coverage) from Medicaid drug programs to Medicare Part D has been a little-recognized boon to the drug industry, as well as being profoundly disruptive to beneficiaries (see the box below).

The simple fact that drug manufacturers are selling more of their products to patients who need them should be good news, not bad. The advent of Part D, even with all its problems, has helped many seniors and people with disabilities obtain prescription drugs that they could not previously afford. But the evidence is clear that, under Part D, the costs of the drugs are substantially higher than they need to be. Because beneficiaries pay a large share of drug costs, they are forced to pay much higher out-of-pocket costs while the drug companies pad their bottom lines.

The Dual Eligible Switch: Another Drug Industry Windfall

When Medicare Part D went into effect on January 1, 2006, the drug coverage of 6.4 million dual eligibles—low-income seniors and people with disabilities who are eligible for both Medicare and Medicaid—was transferred from Medicaid to Medicare.

Due to this switch, drug companies have been able to charge higher prices under Part D than they could under Medicaid. This is because state Medicaid programs, by law, receive the lowest drug prices available. Under Part D, however, Medicare is barred from negotiating with drug companies. Instead, prices are worked out between drug makers and individual Part D plans. These plans have been unable to negotiate drug prices as low as those under Medicaid. Therefore, prescription drugs for dual eligibles are more expensive through Medicare Part D than they were under Medicaid. According to analysts and health care economists, this added cost will be passed along to taxpayers because Medicare's subsidies cover most of dual eligibles' drug costs.* And though drug companies have played down the size of the expected windfall, it is clear that they are inappropriately profiting, and will continue to profit, under Part D.

* Milt Freudenheim, "A Windfall from Shifts to Medicare, " *The New York Times*, July 18, 2006.

Privatization: The Harmful Impact on Beneficiaries

Privatizing Medicare has serious consequences for the seniors and people with disabilities who rely on the program. For those enrolled in a Part D drug plan, high drug prices mean more than high out-of-pocket costs. The structure of the basic Part D benefit, with its deductible, co-insurance, and coverage gap (or "doughnut hole"), means that what a beneficiary pays is tied directly to the plans' drug costs. Even plans that offer fixed copayments generally have a coverage gap during which members pay the full price for any drugs they need, and drug prices affect how quickly members reach the gap. In future years, the size of the deductible, the point at which the doughnut hole starts, and the overall size of the doughnut hole itself will all increase. In 2007 alone, these levels will increase by nearly 7 percent. [20]

Overpayments to Medicare Advantage plans have a subtler, but still insidious, effect on beneficiaries. Continual overpayments and subsidies for private Medicare Advantage plans undermine traditional Medicare by dividing the pool of Medicare enrollees between the younger and healthier on one hand and the older and sicker on the other. Medicare Advantage companies can use their windfalls to make their premiums artificially low. This generally attracts healthier Medicare beneficiaries, who are more willing to accept the restrictions on doctors that managed care plans impose. As a result, traditional Medicare is left with a sicker population that is more costly to cover. And as costs go up, so do premiums.

Privatization: The Harmful Impact on Taxpayers

Privatizing Medicare has resulted in huge costs to taxpayers. In Medicare Advantage, taxpayers are providing ever-increasing subsidies for something that is entirely unnecessary. Congress has given an artificial advantage (and huge windfalls) to private Medicare Advantage plans compared to what traditional Medicare is paid. It has repeatedly stacked the deck to make sure Medicare Advantage plans prosper. Meanwhile, a change originally intended to save Medicare money is instead increasing costs considerably.

The costs to taxpayers from overpriced drugs in Part D are even more obvious. Medicare uses tax revenues to pay for roughly 75 percent of the Part D benefit. Higher drug prices in Part D mean greater expenditures of taxpayer dollars while profits accrue to the drug industry.

Conclusion

When it passed the Medicare Modernization Act, Congress made a deliberate decision to use public funds to support the interests of the private insurance and drug industries. Proponents of privatization argued that it would somehow save money, although there was (and is) no actual evidence to support this contention. Were privatization efficient, there would be no need to give billions of dollars in subsidies to Medicare Advantage and regional PPO plans. And Part D drug plans would see savings comparable to those obtained through bulk purchasing done by the VA.

Instead, privatization is moving Medicare away from its fundamental mission—providing the highest quality health care to America's seniors and people with disabilities at a reasonable cost. Privatization is moving Medicare toward a model in which the nation's health care dollars are used to enrich special interests. This trend should be stopped in its tracks—major changes in Medicare policy could reduce overpayments to private plans, eliminate an unneeded stabilization fund, and save the untold billions of dollars lost due to overpriced prescription drugs.

Endnotes

[1] Marilyn Moon, *Medicare: A Policy Primer* (Washington: The Urban Institute, 2006), p. 68. A small number of managed care plans participate in Medicare on a cost basis rather than a risk basis. These cost plans are not discussed in this report.

[2] Payments were adjusted by a rudimentary risk adjustment for basic demographic characteristics like age, sex, and Medicaid status of members.

[3] See, for example, *Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem* (Washington: U.S. General Accounting Office, November 1995); *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (Washington: U.S. General Accounting Office, April 1997).

[4] MedPAC, *Report to Congress: Medicare Payment Policy* (Washington: MedPAC, March 2004), p. 210.

[5] Enrollment in Medicare managed care grew steadily through the 1990s, peaking at 6.3 million in 1999. Thereafter, plans began to withdraw from some markets and to pare back their benefits packages. Enrollment dropped to 4.7 million by 2003.

[6] MedPAC, op. cit., p. 211.

[7] MedPAC, *Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending* (Washington: MedPAC, June 2006).

[8] Brian Biles, Lauren Hersch Nicholas, and Barbara S. Cooper, *The Costs of Privatization: Extra Payments to Medicare Advantage Plans – 2005 Update* (New York: The Commonwealth Fund, December 2004).

[9] Biles et al. base their estimate on a 7.8 percent overpayment rate.

[10] Brian Biles and Emily Adrion, *Payments to Medicare Advantage Plans Exceed Fee-for-Service Costs: Options for Medicare Savings from 2007 to 2011* (Washington: George Washington University School of Public Health & Health Services, September 15, 2006), available online at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Extra_Payments_2007-11_GW_Briefing_Paper_FINAL_9-15-06.pdf.

[11] MedPAC, *Report to Congress: Increasing the Value of Medicare* (Washington: MedPAC, June 2006), p. 206.

[12] Ibid.

[13] MedPAC, *Report to Congress: Issues in a Modernized Medicare Program* (Washington: MedPAC, June 2005), p. 67.

[14] Each Medicare drug plan sets its own premium. When a Medicare beneficiary enrolls in a plan, the beneficiary pays 25.5 percent of the premium, and Medicare pays the remaining 74.5 percent. Section 1860D-13 of the Social Security Act, as added by the MMA (Pub. L. No. 108-173).

[15] The VA is available to 24.6 million veterans, but only some of these veterans receive care through the system. In 2004, the system served 4.9 million unique patients (veterans and their dependents). Department of Veterans Affairs, *Geographic Distribution of VA Expenditures for FY 2004*, 2004, available online at http://www1.va.gov/vetdata/docs/GDX-FY04(000)Final.xls.

[16] Dee Mahan, *Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices* (Washington: Families USA, June 2006), p. 7.

[17] Ibid., pp. 5-8.

[18] UnitedHealth Group, *UnitedHealth Group Reports Record Second Quarter GAAP Net Earnings of $0.70 per Share* (Minneapolis, MN: UnitedHealth Group, July 19, 2006); Humana Inc., *2006 and 2005 SEC Quarter Two form 10-Q*, available online at http://phx.corporate-ir.net/phoenix.zhtml?c=92913&p=irol-sec; WellPoint Inc., *2006 and 2005 SEC Quarter Two form 10-Q,* available online at: http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-sec.

[19] Ibid.

[20] CMS Office of the Actuary, *Medicare Part D Benefit Parameters for Standard Benefit: Annual Adjustments for 2007* (Washington: Centers for Medicare and Medicaid Services, May 22, 2006), available online at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/2007_Part_D_Parameter_Update.pdf.

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