

Medicare Privatization:

**The Case Against Relying on
HMOs and Private Insurers to
Offer Prescription Drug Coverage**



**Congress Watch
September 2002**

Acknowledgments

The principal author of “Medicare Privatization: The Case Against Relying on HMOs and Private Insurers to Offer Prescription Drug Coverage” was Public Citizen’s Congress Watch Legislative Representative Benjamin Peck, Ph.D. Congress Watch Director Frank Clemente made significant editorial contributions to the report. Research was done by Legislative Assistant April Greener. Executive Assistant Tamar Scialo was responsible for the lay-out of the report. Assistance with statistical analysis was provided by James Meehan, Public Citizen’s Manager of Information Systems.

Technical Reviewer

Public Citizen would like to acknowledge Marilyn Moon of the Urban Institute who reviewed this report. Whatever errors of omission or commission remain should be attributed to Public Citizen.

About Public Citizen

Public Citizen is a 150,000 member non-profit organization based in Washington, D.C. representing consumer interests through lobbying, litigation, research and public education. Founded by Ralph Nader in 1971, Public Citizen fights for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.



Public Citizen’s Congress Watch
215 Pennsylvania Ave. S.E.
Washington, D.C. 20003
P: 202-546-4996
F: 202-547-7392
www.citizen.org

©2002 Public Citizen. All rights reserved.

Public Citizen
1600 20th Street, N.W.
Washington, D.C. 20009

Table of Contents

Executive Summary	1
I. Background	4
II. HMOs Are Unreliable and Inefficient	5
Figure 1 Number of Medicare Beneficiaries Affected by Plan Withdrawals by Year and State	6
Figure 2 States without Medicare+Choice HMOs Offering Rx Drug Coverage	7
Figure 3 Medicare HMOs Overpaid \$5.2 Billion in 1998	10
Figure 4 Percentage of Beneficiaries with Health Conditions, by Type of Condition and HMO Status, 1997	12
Figure 5 Health Spending per Medicare Beneficiary by Health Impairment Status, 1997	13
III. Problems with Drug-Only Private Insurance	14
Figure 6 Sources of Prescription Drug Coverage for Medicare Beneficiaries, Fall 1999	15
IV. Private Plans Won't Guarantee Benefits – A Feature Medicare Beneficiaries Highly Value	16
Figure 7 Change in Average Additional Premium for HMOs Offering Rx Drug Coverage 1999 & 2002.....	19
V. Lower Drug Prices Need Not Stop New Drug R&D	20
Figure 8 Profitability of Fortune 500 Drug Industry and All Fortune 500 Industries 1970 to 2001.....	22
Figure 9 Fortune 500 Drug Companies Were Far More Profitable in 2001 Than All Fortune 500 Industries.....	23
VI. Conclusion	24
V. Endnotes	25

Medicare Privatization:

The Case Against Relying on HMOs and Private Insurers to Offer Prescription Drug Coverage

Executive Summary

In the U.S. Congress there has been a major push by the Republican Party, a handful of Senate Democrats and the prescription drug and HMO industries to begin to privatize the Medicare program. Their proposal: subsidize HMOs and private insurers to offer beneficiaries prescription drug coverage, rather than providing it directly through the traditional Medicare program as hospital and physician services are now. Privatizing a Medicare drug benefit has many problems, not the least of which is that it is the first step towards privatizing the entire Medicare program.

Politicians who once supported privatizing some portion of the Social Security program have been running away from their past position this election season in the face of corporate scandals and a sliding stock market.

Ironically, the country has no practical experience with Social Security privatization. On the other hand, there is a great deal of experience with some forms of Medicare privatization. And it is not a pretty picture.

This Public Citizen report uses recent authoritative research on the Medicare program and its beneficiaries' experiences with HMOs (Medicare+Choice plans) and private indemnity insurance to demonstrate why it would be a mistake for Congress to rely on private plans, rather than the Medicare program, to offer prescription drug coverage. A proposal relying on private plans passed the U.S. House of Representatives largely along party lines in June 2002. Fortunately, a similar proposal was defeated in the Senate in July, but it will certainly be back for consideration, if not this Congress then in the next one.

The following are the report's major findings:

- **HMOs offer unreliable coverage.** Real-world experience in recent years shows that beneficiaries cannot rely on HMOs to provide reliable coverage. From 1999 through the beginning of 2002 a total of 2.2 million Medicare beneficiaries have been forced to look for new providers after their HMO reduced or ceased to provide service to them as part of a contract with the Medicare program. That number will increase to 2.4 million next year when HMOs will drop 200,000 more beneficiaries. Also, the number of states that had *no* Medicare HMO offering prescription drug coverage jumped from 9 to 14 from 1999 to 2002— a 56 percent increase.
- **The 10 states with the highest number of Medicare+Choice enrollees dropped from their plans since 1999, including recently announced figures for withdrawals in 2003, are:** Texas: 313,767, Florida: 264,170, California: 184,578, New York: 179,941,

Pennsylvania: 154,519, Ohio: 144,400, Maryland: 116,273, Connecticut: 110,783, Washington: 85,265, New Jersey: 79,733

- **For-profit insurers are particularly unreliable.** The managed care industry argues that HMO withdrawals from Medicare are due to low government payments. But a major study found that the greatest effect on plan withdrawals had to do with whether a plan was a for-profit. Private plans that are for-profit, as opposed to non-profit, and owned by a large national corporation, as opposed to locally owned, are *two-and-a-half times* more likely to withdraw from Medicare+Choice.
- **HMOs are overpaid but demand still higher payments as the price for providing coverage.** HMOs are withdrawing from the Medicare program despite the fact they are overpaid, according to government investigators. From 1998 to 2000 federal payments to Medicare HMOs exceeded by 13.2 percent the costs the program would have incurred for by paying providers directly for care. In one year – 1998 – Medicare HMOs were overpaid \$5.2 billion. Even the private plans that withdrew from the program from 1998-2000 had, on average, 22 percent excess payments with which they provided extra benefits, such as prescription drug coverage.
- **HMOs are much less efficient than the Medicare program.** The Medicare program spends a mere 2 percent on administrative costs. By contrast, HMOs on average spend 15 percent of their revenue on administrative costs, rather than on health care. Some HMOs spend as much as 32 percent of their revenue on administration. This is a tremendous waste of resources that could provide health care. For example, government investigators found that if all HMOs participating in the Medicare program had been held to a 15 percent ceiling on administrative costs in 2000 this would have freed up \$500 million that could have been used to provide additional health care to beneficiaries. If the same health care provided by the plans were provided through traditional Medicare directly, with its 2 percent administrative overhead, many more millions if not billions of dollars could have been saved.
- **Private indemnity insurers are much less efficient than the Medicare program.** Private insurers that now offer supplemental insurance to Medicare enrollees (Medigap policies), and who would be the carriers that would offer drug-only insurance if a privatization proposal becomes law, spend an average of more than 20 cents out of each premium dollar on agents' fees, marketing, advertising, administration and profits – not on health care. In contrast, Medicare spends just 2 cents out of each dollar on administrative costs.
- **HMOs are not viable in much of the country.** In 2002 only 61 percent of beneficiaries had access to enrollment in an HMO. This represents a significant decline from 1998 when 74 percent of beneficiaries had access to an HMO. Although one of the stated goals of the 1997 Medicare+Choice program reforms was to make HMOs available to more beneficiaries, certain areas of the country have proved inhospitable to HMOs. This is particularly the case in rural areas where there may be few health care providers, and

providers have little incentive to contract with an HMO to offer services for a cut-rate fee.

- **HMOs cherry-pick the healthiest beneficiaries.** In order to make money HMOs target their membership promotions to the healthiest seniors and try to avoid people with disabilities. For example, one major study found that in 1997 13.8 percent of Medicare beneficiaries enrolled in the traditional Medicare program had both cognitive and physical difficulties; but only 6.6 percent of Medicare HMO enrollees reported such problems. The cost differences in caring for beneficiaries with cognitive and physical problems compared to those without such problems was dramatic that year – \$20,332 vs. \$5,037. HMOs and insurance companies who would agree to provide prescription drug coverage would likely continue such behavior in order to reduce their exposure to costly beneficiaries.
- **HMOs dump sick beneficiaries onto the government program in order to avoid the cost of treating them.** From 1991 to 1996 the Department of Health and Human Services found that Medicare paid hospitals \$224 million for inpatient services furnished to beneficiaries within three months of their disenrollment, whereas Medicare would have paid the private plans just \$20 million in capitation payments if the beneficiaries had remained in the private plans – a difference of \$204 million, or more than 1,000 percent!
- **Health problems among seniors make proposals relying on choice unworkable.** Nearly a quarter (23 percent) of Medicare beneficiaries have health (e.g., poor hearing or eyesight) or cognitive problems. One national survey found that 44 percent of adults over the age of 60 are functionally illiterate. Such problems would make it difficult for beneficiaries to evaluate the important differences between prescription drug coverage offered by various HMOs or insurance companies. It would be much better to guarantee them a comprehensive benefit package through the traditional Medicare program.
- **Beneficiaries are more concerned about whether they have access to health care coverage that offers them reliable and reasonably priced benefits than they are in having a great number of plans to choose from.** A survey of beneficiaries in 2000 found that 44 percent had **never** seriously considered their choices of health care coverage, and 14 percent last thought about it when they first became eligible for Medicare.
- **Private insurers are *not* able to negotiate drug price discounts that are as deep as what the federal government gets.** Today, the federal government’s Veterans and Defense departments negotiate price cuts of 52 percent off the price paid at the pharmacy. HMOs and other private sector purchasers negotiate discounts of only 12 to 40 percent. It seems appropriate that since Medicare currently negotiates hospital and physician fees it should do the same for the purchase of prescription drugs on behalf of its 40 million beneficiaries.

I. Background

As we approach the November 2002 elections, the issue of Medicare prescription drug coverage for seniors and people with disabilities is being hotly debated on the campaign trail. This issue has been driven to the top of the political agenda by a combination of the needs of seniors and the needs of candidates for their votes. Not only do senators up for re-election know that about a third of seniors lack prescription drug coverage. They also know that seniors vote, and that they are often part of a group of so-called “swing” voters – voters who do not reliably cast their ballots for either major party and often determine the outcome of tight elections.

This year, just like the 2000 Congressional elections, the candidates are debating rival prescription drug proposals and weighing their votes in Congress based on how they will play on the campaign trail. The pressure of upcoming elections appears to have been powerful enough to force some Senators to side against their party in close votes on the issue. For example, a tight race for re-election most likely played an important role in Sen. Gordon Smith’s (R-Ore.) decision to work with Democrats and sponsor compromise legislation with Senator Bob Graham (D-Fla.). That legislation was opposed by every other Republican except one – Senator Tim Hutchinson (R-Ark.) – who is also in a tight re-election race.

Electoral pressures also affected the vote of incumbent Sen. Tom Harkin (D-Iowa), who voted against the Graham-Smith compromise. Harkin felt that supporting the legislation would have opened him up for criticism by his opponent, Rep. Greg Ganske (R-Iowa), in his re-election bid who would have portrayed the measure as weaker than legislation that Ganske voted for and that passed the House.

Throughout this year’s debate on prescription drug legislation there has been one bright line that has differentiated the position of the Democratic leadership from the Republican leadership. The Democrats have authored, and most Democrats have supported, legislation that would offer coverage for prescription drugs through the traditional Medicare program. Republicans, on the other hand, have authored legislation favored by the drug industry that would subsidize HMOs and private insurance companies to offer prescription drug coverage.¹ One of the principal objections that Republican leaders and the drug industry have raised to Medicare providing a drug benefit is the concern that the government will drive a hard bargain with the drug companies and get deep price discounts.²

This report examines the experience to date of the Medicare program and its beneficiaries with private insurers and HMOs. This real-world experience strongly suggests that we should not rely on them to be the foundation of Medicare drug coverage. Instead, a drug benefit ought to be made available through the Medicare program directly, because the program’s reliability and efficiency is unmatched by the private sector.

II. HMOs Are Unreliable and Inefficient

Unlike the traditional Medicare program, which guarantees coverage to all beneficiaries no matter where they live, coverage through private plans would be unreliable because plans can and will back out of the program. Today, Medicare's 40 million beneficiaries can choose to have doctor and hospital services covered by the traditional fee-for-service Medicare program, in which they retain freedom to see the doctor and use the hospital of their choice. Or, they can elect to be covered by a Medicare+Choice plan (M+C).³ Under the Medicare+Choice program HMOs are paid a set amount to provide coverage to each Medicare beneficiary. If an HMO spends more on a particular beneficiary than it is paid for the year, it takes a loss on that beneficiary, which it must make up from the total payments it receives for all Medicare beneficiaries under its care.

HMOs Have Proven to Be Very Unreliable

HMOs providing health care coverage to seniors and people with disabilities under the Medicare program is a concept that has not fared well in practice. Many parts of the country are unattractive for HMOs, and millions of Medicare beneficiaries have been affected by private plans' on-again, off-again relationship with the program:

- Since 1999 a total of 2.4 million Medicare beneficiaries will have been forced to look for new providers after their HMO reduced or ceased to provide service to them as part of a contract with the Medicare program. This includes recently announced withdrawals by plans for 2003. (See Figure 1)
- In 2002, only 61 percent of beneficiaries had access to enrollment in an HMO.⁴ This represents a significant decline from 1998 when 74 percent of beneficiaries had access to an HMO.⁵ Although one of the stated goals of the Balanced Budget Act of 1997 was to make HMOs available to more Medicare beneficiaries around the country, certain areas of the country have proven inhospitable to HMOs. This is particularly the case in rural areas where there may be few health care providers, and therefore providers have little incentive to contract with an HMO to offer services for a cut-rate fee.
- In 1999, nine states and the District of Columbia had no Medicare+Choice plan offering prescription drug coverage; the number of states that do not have a Medicare+Choice plan offering drug coverage jumped to 14 in 2002 – a 56 percent increase.⁶ (See figure 2) In seven other states there are regions where there is no HMO offering prescription drug benefits to Medicare beneficiaries (Idaho, Indiana, Mississippi, New Hampshire, New Jersey, North Carolina, and South Dakota).⁷

Figure 1
Number of Medicare Beneficiaries Affected by HMO
Withdrawals by Year and State

State	1999	2000	2001	2002	2003	Total
Alabama	N/A	N/A	2,530	2,733	N/A	5,263
Alaska	N/A	N/A	N/A	N/A	N/A	N/A
Arizona	3,307	30,887	24,327	10,909	N/A	69,430
Arkansas	N/A	2,389	284	16,841	N/A	19,514
California	8,744	12,984	52,464	83,634	26,752	184,578
Colorado	14,526	14,574	4,454	9,250	N/A	42,804
Connecticut	12,175	8,638	51,185	38,785	N/A	110,783
Delaware	11,031	N/A	3,560	815	451	15,857
District of Columbia	2,362	N/A	932	N/A	3,451	6,745
Florida	62,206	29,292	87,727	59,348	25,597	264,170
Georgia	6,080	1,432	19,689	348	N/A	27,549
Hawaii	N/A	N/A	N/A	2,666	N/A	2,666
Idaho	1,356	N/A	N/A	N/A	N/A	1,356
Illinois	18,321	2,001	18,144	40,539	200	79,205
Indiana	N/A	N/A	9,081	4,017	4,919	18,017
Iowa	N/A	1,433	N/A	N/A	101	1,534
Kansas	N/A	1,416	N/A	6,765	11,945	20,126
Kentucky	N/A	N/A	9,153	12,041	N/A	21,194
Louisiana	14,336	33,959	25,131	N/A	5,760	79,186
Maine	N/A	N/A	1,632	N/A	N/A	1,632
Maryland	34,595	15,521	53,038	N/A	13,119	116,273
Massachusetts	18,296	5,621	21,781	12	600	46,310
Michigan	N/A	N/A	146	31,446	3,683	35,275
Minnesota	4,052	2,955	14,278	N/A	325	21,610
Mississippi	N/A	N/A	N/A	1,042	N/A	1,042
Missouri	124	1,897	10,112	4,965	14,922	32,020
Montana	N/A	N/A	N/A	N/A	N/A	N/A
Nebraska	N/A	5,413	N/A	N/A	N/A	5,413
Nevada	N/A	9,592	N/A	N/A	N/A	9,592
New Hampshire	3,911	13,412	498	N/A	N/A	17,821
New Jersey	8,172	5,707	12,411	53,144	299	79,733
New Mexico	128	16	15,810	N/A	N/A	15,954
New York	54,642	38,703	64,329	15,590	6,677	179,941
North Carolina	N/A	N/A	3,872	N/A	11,347	15,219
North Dakota	15	N/A	N/A	N/A	N/A	15
Ohio	24,775	13,031	65,617	13,993	26,984	144,400
Oklahoma	N/A	1,190	7,216	2,518	N/A	10,924
Oregon	7,011	3,089	5,767	442	500	16,809
Pennsylvania	6,198	844	89,641	54,561	3,275	154,519
Rhode Island	781	2,036	1,694	N/A	N/A	4,511
South Carolina	N/A	1,060	N/A	N/A	N/A	1,060
South Dakota	N/A	N/A	N/A	N/A	1,596	1,596
Tennessee	N/A	652	19,865	N/A	94	20,611

Texas	28,554	31,707	180,749	45,977	26,780	313,767
Utah	18,562	N/A	N/A	N/A	N/A	18,562
Vermont	N/A	N/A	N/A	N/A	N/A	N/A
Virginia	9,259	16,655	14,618	N/A	7,722	48,254
Washington	30,515	11,673	32,177	10,900	N/A	85,265
West Virginia	N/A	N/A	N/A	18	130	148
Wisconsin	N/A	6,796	1,410	10,366	N/A	18,572
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL	404034	326575	925,322	533,665	197,229	2,386,825

Source: Public Citizen analysis of data from Centers for Medicare & Medicaid Services.

Figure 2
States without Medicare+Choice HMOs
Offering Rx Drug Coverage

1999	2002
Alaska	Alaska
Delaware	Arkansas
District of Columbia	Delaware
Iowa	Kentucky
New Hampshire	Maine
South Carolina	Montana
South Dakota	Nebraska
Utah	North Dakota
Vermont	South Carolina
Wyoming	Utah
	Vermont
	West Virginia
	Wisconsin
	Wyoming

Source: Public Citizen analysis of Centers for Medicare and Medicaid Services data.

Managed Care Companies Withdraw Because They Are For-Profit — Not Because of “Low Payments”

The managed care industry has argued that HMO withdrawals from the Medicare program are the result of low government payments to private plans. Proponents of offering Medicare beneficiaries drug coverage through private insurers and HMOs argue that adequate payments to private plans will assure that private plans that initially choose to participate will continue to do so. The Medicare program’s current experience suggests that this position is rather spurious. There is a considerable body of evidence that indicates Medicare+Choice plans are overpaid, not underpaid. (See section below, “Medicare HMOs Are Overpaid”). Moreover, a recently released study by the Henry J. Kaiser Family Foundation,⁸ and an earlier report by the General Accounting Office (GAO),⁹ have found many other factors contributing to withdrawal decisions besides payment levels.

The Kaiser study came to the startling conclusion that private plan characteristics, not payment levels, had the single greatest effect on HMO decisions to withdraw between 1999 and 2001. The Kaiser report found that if private plans were for-profit, as opposed to non-profit, and owned by a large national corporation, as opposed to locally owned, they were two-and-a-half times more likely to withdraw from the program. This appears to indicate that private plans for whom participating in the Medicare program is strictly a business decision, as opposed to a decision rooted in a desire to serve the Medicare population, are particularly likely to withdraw from the program.

The Kaiser report also confirmed earlier work by the GAO¹⁰ finding withdrawals to be the result of HMOs that have recently entered a market being unable to recruit an adequate number of providers to offer benefits – a particular problem in rural areas.

Further evidence that the cause of HMO withdrawals is linked to the dynamics of the market, not solely to payment levels, can be seen in the Federal Employees Health Benefits Program's (FEHBP) experience with HMOs. FEHBP also has experienced a sharp drop in the number of HMOs contracting with it from 1996 to 2000. During that period, the program experienced a decline from 476 plans to 277. Many of the private plans withdrawing, a GAO report concluded, in part, were new participants in the program and were simply unable to attract sufficient enrollment. The report found, in part, that “the number of HMOs participating in FEHBP is declining because of a natural weeding out of those that cannot compete in the marketplace.”¹¹

The FEHBP program is often held up as the model for reforming the Medicare program by those who would like to see Medicare turned into a system where seniors and people with disabilities would get a set amount of money to purchase coverage on the private market. Proponents of this sort of reform have argued that because premiums in the FEHBP are set through a market-like competitive bidding process, instead of by government regulation, a Medicare program modeled after it would be better at retaining HMOs than the existing Medicare program. This is why it is particularly ironic that, according to the GAO, one of the leading causes of HMOs dropping out of the FEHBP program is the very market dynamics the supporters of privatization celebrate.

Private businesses fail and often decide to change the products they offer for a variety of reasons. The GAO's explanation for HMOs leaving the FEHBP, attributing it to “a natural weeding out of those that cannot compete in the marketplace,”¹² could just as easily be said about the reasons HMOs withdraw from Medicare+Choice.

Instability is fine if we are creating a system to make deodorant or hairspray available to consumers. But when we are designing a health care system for the most vulnerable in our society, seniors and people with disabilities, that is a different matter. Here, continuity must be assured. Congress created the Medicare program in 1965 precisely because private insurers were failing to offer affordable health insurance to seniors. Today, only by creating a drug benefit as part of the traditional Medicare program can we guarantee that seniors throughout the country will have access to reliable prescription drug coverage.

HMOs Are Much Less Efficient than Medicare

The Inspector General of the Department of Health and Human Services (HHS) has found that HMOs that contract with Medicare, on average, spend 15 percent of their revenue on administrative costs, rather than on health care.¹³ Some HMOs spend as much as 32 percent of their revenue on administration. By contrast, the Medicare program spends only 2 percent of its budget on administrative overhead.¹⁴ This HMO administrative inefficiency is a tremendous waste of resources that could be used to provide health care. The HHS Inspector General has found that if all HMOs participating in the Medicare program had been held to a 15 percent ceiling on administrative costs in 2000 this would have freed up \$500 million that could have been used to provide additional health care to beneficiaries. If the health care provided by the plans were provided through Medicare directly, with its nominal administrative overhead costs, many more millions if not billions of dollars could have been saved.

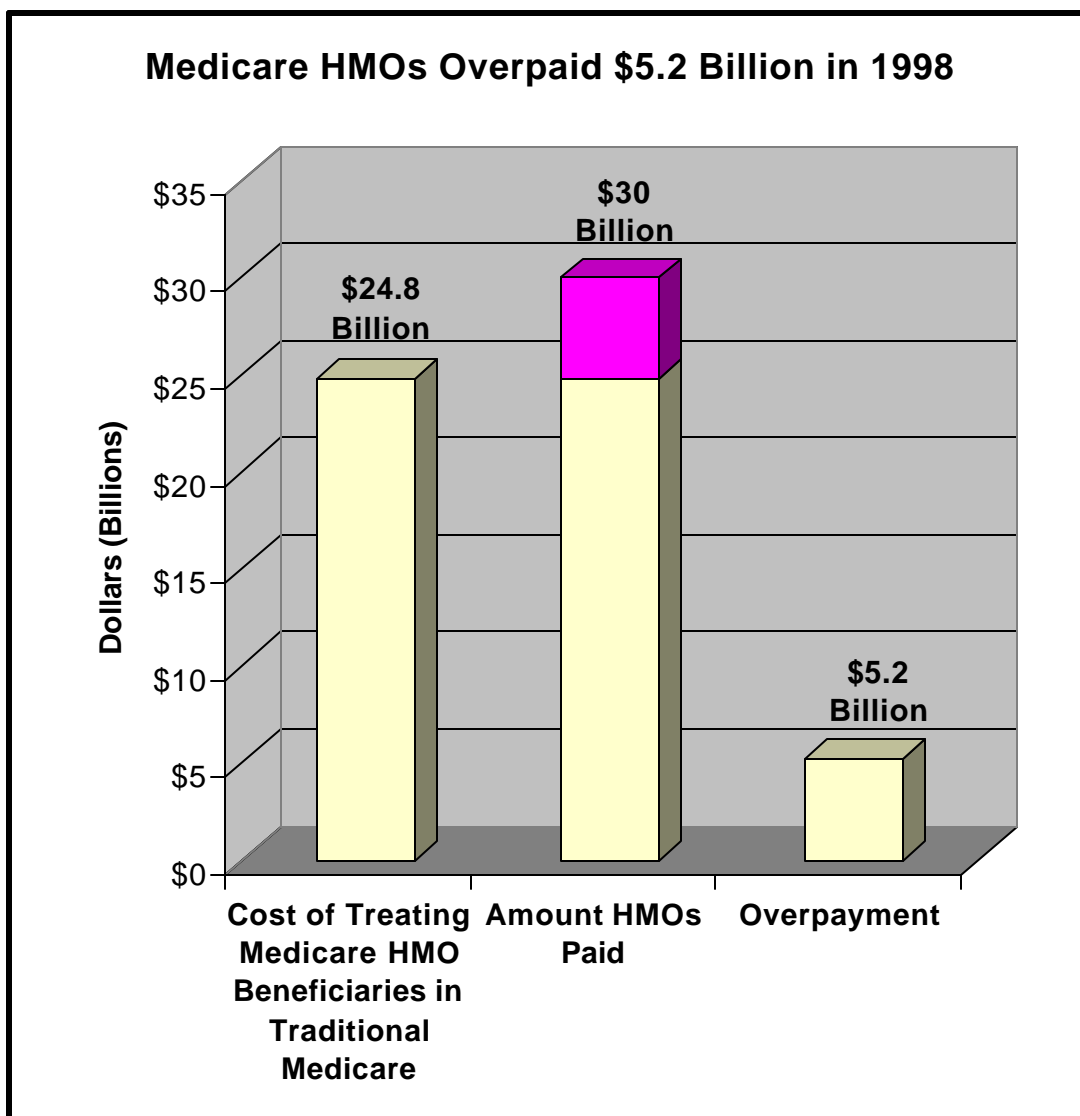
Medicare HMOs Are Overpaid

Under the Medicare+Choice program, HMOs contract with the Medicare program to offer Medicare covered services for a set per-enrollee payment from Medicare. Originally the notion was that the Medicare+Choice program would be a way of controlling costs. However, that is not what has happened. Instead, it has cost the Medicare program more to pay HMOs to provide services required by Medicare than it would have cost for traditional Medicare to have paid providers directly for beneficiary care. This is because the private plans attract healthier than average Medicare beneficiaries, but are paid based on the average of what it costs for Medicare to deliver services to the sicker enrollees who remain in the traditional fee-for-service program.

From 1998 to 2000 federal payments to Medicare HMOs exceeded the costs the program would have incurred for treating patients directly by an annual average of 13.2 percent.¹⁵ In one year, 1998, HMOs were overpaid to the tune of \$5.2 billion. (See Figure 3) Not only were payments greater, but HMOs received cumulative rate increases that were larger than the growth in per capita spending in the fee-for-service system from 1999 to 2000.

It is worth noting that even the private plans that withdrew from the program reported having, on average, 22 percent excess payments available to provide extra benefits, such as prescription drug coverage, over and above allowed profits. Far from being underpaid, as the managed care industry has claimed, Medicare HMOs are overpaid.

Figure 3



Source: U.S. General Accounting Office, "Medicare+Choice Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000.

HMOs reduce their costs and increase their profits in large part by enrolling the healthy and avoiding the sick:

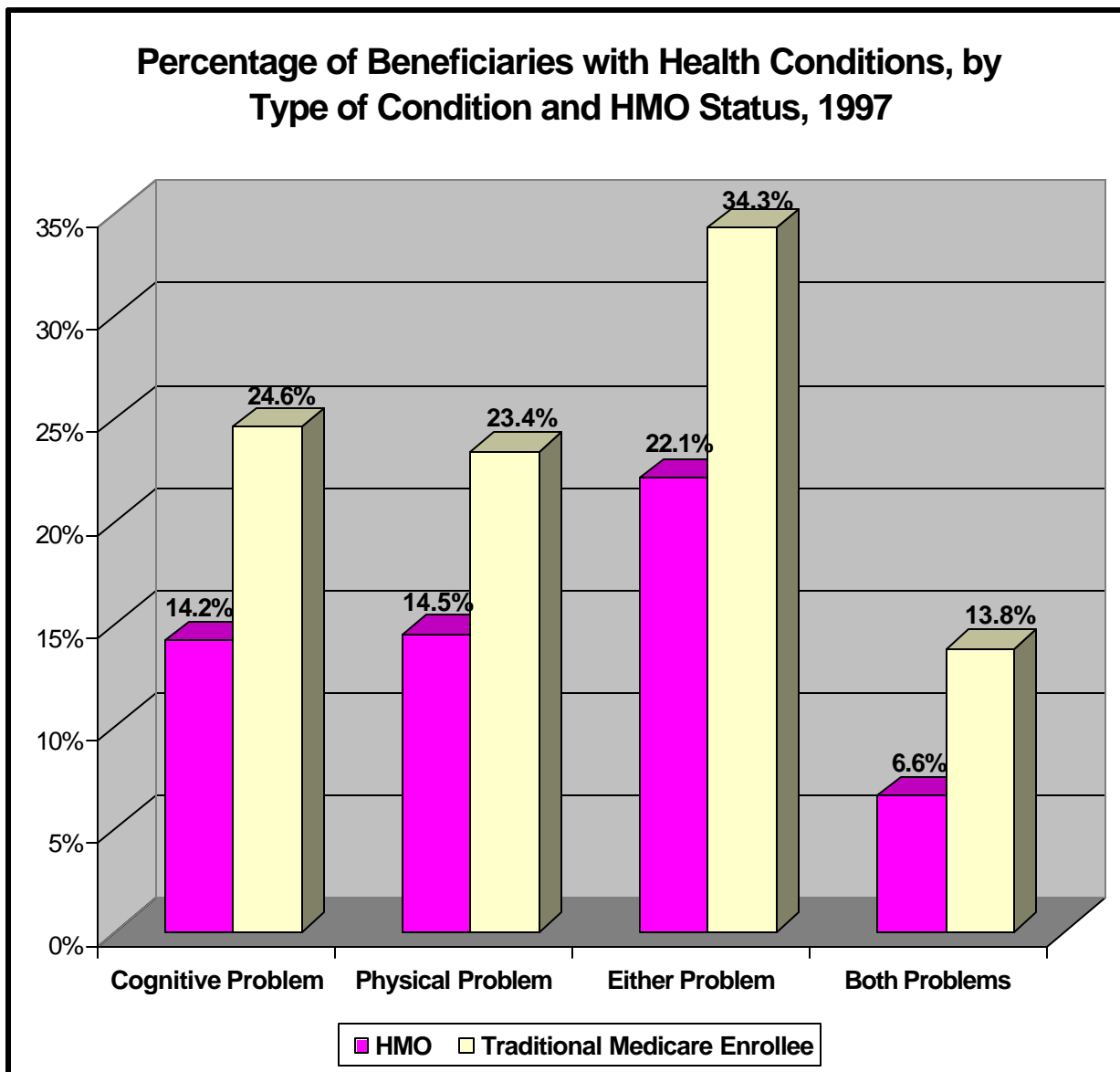
- **HMOs cater to the healthy in order to avoid the expense of treating the sick.** A study by the Kaiser Family Foundation of the marketing practices of HMOs that participate in the Medicare program found that private plans deliberately target the healthy as opposed to the sick.¹⁶ More than half of the television ads examined in the study portrayed seniors engaged in "physical or social activities such as running, biking, swimming, snorkeling, riding amusement park rides, and playing with grandchildren." None of the visuals in either newspaper or television ads showed people in hospitals or

using wheelchairs or walkers. More troubling still was the fact that nearly one-third of the 21 HMO marketing seminars attended by researchers were not wheelchair accessible – an indication that enrolling the infirm was not a high priority for these HMOs. Although Medicare has 5 million beneficiaries who are under 65 and disabled, none were pictured in any of the television or newspaper advertisements examined for the study. Many newspaper ads fail to mention that disabled beneficiaries are eligible to apply and 8 out of 70 incorrectly stated that beneficiaries had to be 65 or older to enroll.

- **HMOs have attracted more healthy – and less costly – beneficiaries.** In 1997, 13.8 percent of Medicare beneficiaries enrolled in the traditional Medicare program had both cognitive and physical difficulties; but only 6.6 percent of Medicare HMO enrollees reported such problems.¹⁷ (See Figure 4). Health care spending for enrollees with both physical and cognitive difficulties was more than four times what it was for those with neither of these problems (\$20,332 vs. \$5,037) in 1997. (See Figure 5) Moreover, those with both types of problems account for only 12 percent of the Medicare population but over 30 percent of total Medicare spending. Given these facts, it is a rational business decision on the part of managed care plans to avoid these sicker enrollees. Not only do private plans have an incentive to avoid the sick, but the sick are likely to be particularly hesitant to join such a plan, which limits their choice of provider, because they will need to see doctors and specialists often.¹⁸

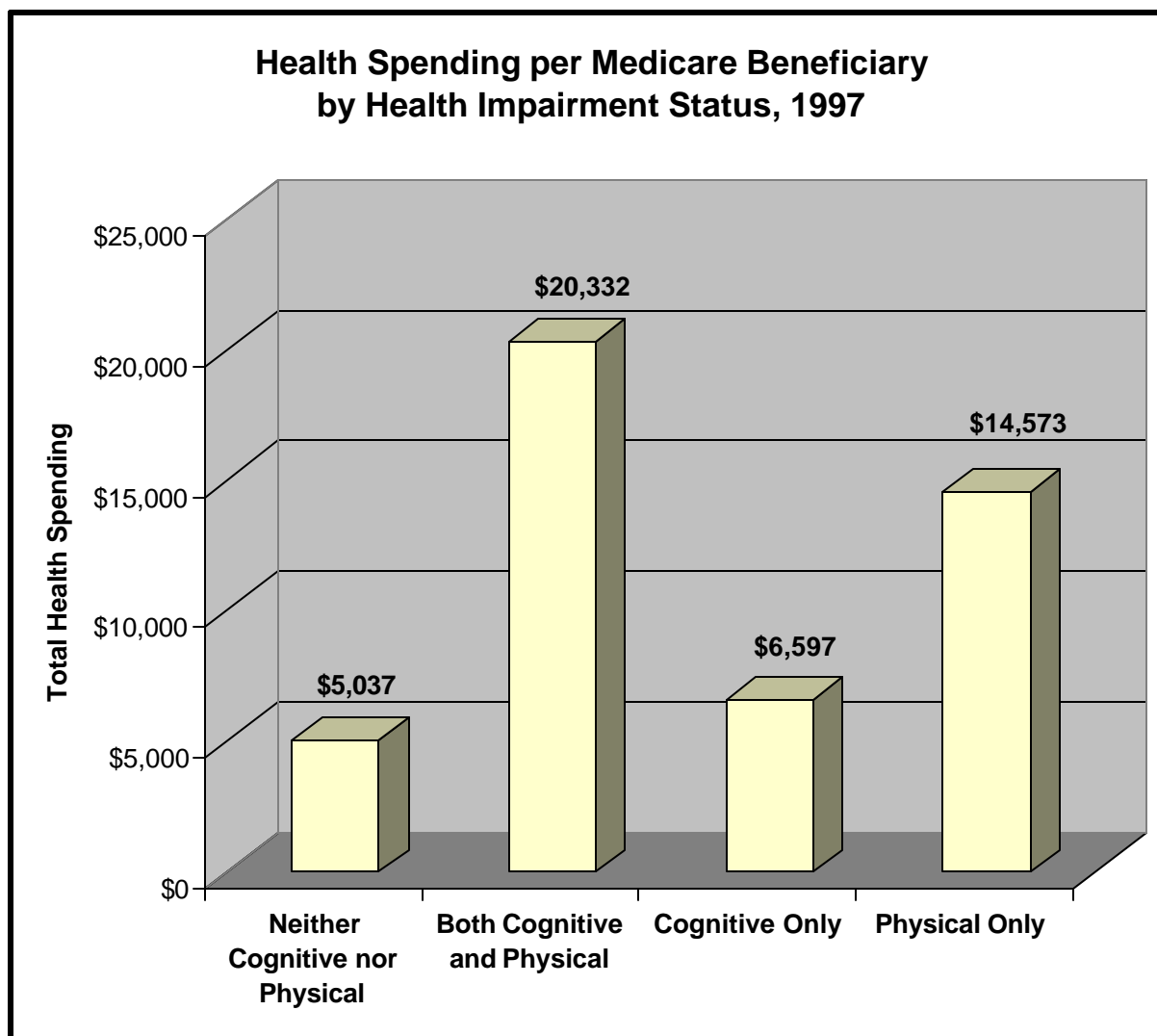
- **HMOs dump sick enrollees onto government programs.** The HHS Inspector General has found that managed care organizations’ avoidance of paying high health care costs appears quite deliberate. The IG found that private plans have, in the past, avoided the expense of treating their sickest patients by having sicker beneficiaries disenroll, in order to have expensive hospital care delivered through the traditional Medicare program, and then reenroll beneficiaries when they are healthy again. From 1991 to 1996 the IG found that Medicare paid hospitals \$224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment. Medicare would have paid the private plans just \$20 million in capitation payments if the beneficiaries had remained in the private plans, a difference of \$204 million, or more than 1,000 percent.¹⁹

Figure 4



Source: Marilyn Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.

Figure 5



Source: Marylin Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.

HMOs Demand Overpayment to Stay in the Medicare+Choice Program

If private plans are to attract enrollees, they know that they must overcome beneficiaries' resistance to joining HMOs, which often limit patient choice of doctor. The way they do that is by offering additional benefits, particularly coverage for prescription drugs. In order to finance those additional benefits they must receive resources over and above what it costs to offer the services Medicare covers.²⁰ This is part of what leads HMOs to demand to be overpaid in order to stay in the Medicare program.

However, there is another reason that Medicare will have to overpay private plans if it is to keep them in the program, a reason private plans do not advertise. They are not as effective at

controlling costs as the Medicare program. One study looking at this found that for services covered both by Medicare and private insurers, average annual per enrollee spending by Medicare increased less quickly than for private insurers.²¹ Specifically from 1970 to 2000 private insurers posted a 10 percent increase per year as opposed to 9.4 percent increase for the Medicare program.

III. Problems with Drug-Only Private Insurance

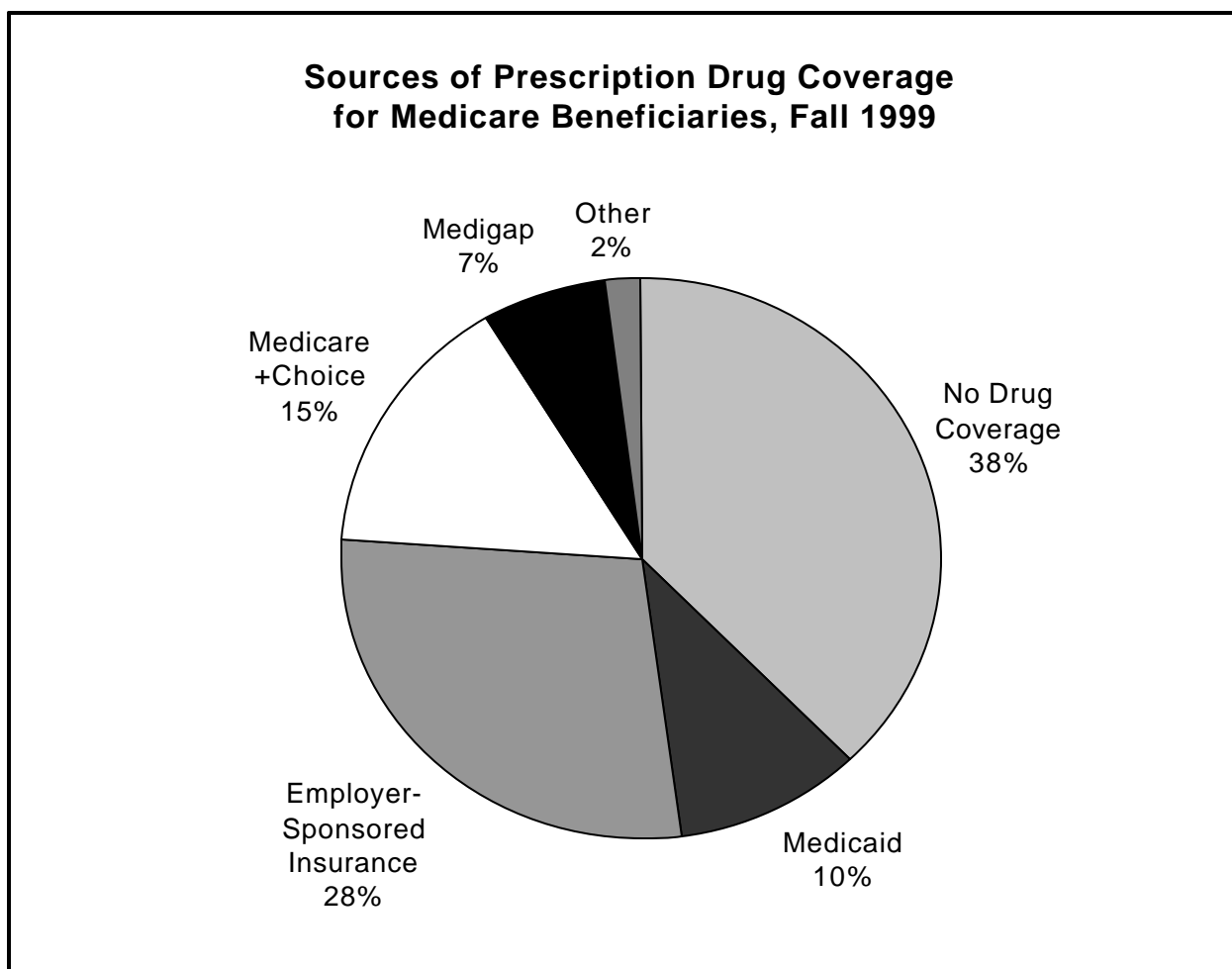
In addition to HMOs, proponents of a private-sector approach to Medicare drug coverage envision insurance companies offering drug-only indemnity insurance. This would be similar to the Medicare supplemental policies (Medigap) already offered by insurers, except these new policies would be for drugs only and would be subsidized with federal dollars, lowering their premiums.

Private Insurance Is Inefficient

Medigap insurance is one of a range of options that seniors currently have to get coverage for some of the gaps in Medicare. Most seniors who do not join an HMO generally have some form of supplemental insurance to help with the costs of prescription drugs, which Medicare does not cover, and the high deductibles and coinsurance amounts for the doctor and hospital care that Medicare does cover. (Payment for care by doctors is subject to a \$100 deductible and 20 percent coinsurance. There is a \$792 deductible on coverage for hospital care.) For many low-income people this supplemental coverage is provided by Medicaid. The more fortunate obtain coverage through a present or former employer. Approximately 7 percent seek coverage on the private market and purchase a Medigap policy that offers coverage for the costs of prescription drugs. (See Figure 6).

The companies that would offer drug-only insurance policies as part of a privatized drug coverage program would be many of the same companies that now offer Medigap policies. These policies would be subsidized by federal dollars – resulting in lower premiums and greater participation than is found in the current Medigap market for drug coverage. However, like current Medigap policies, they would be extremely inefficient. Medigap policies on average spend over 20 cents out of each premium dollar not on health care but on agents' fees, marketing, advertising, administration, and profits.²² This compares very unfavorably to Medicare, which spends less than 2 cents out of every dollar on administrative costs.²³ This means that seniors and the federal government will not get good value for the resources they put into this program.

Figure 6



Source: Laschober, Mary et al., *Health Affairs Web Exclusive*, February 27, 2002

Recipe for a Boondoggle

The supporters of a private insurance model claim that a market-based approach will be more efficient and more nimble than a government-run Medicare program. That is the rationale they have offered for creating a program in which private plans would compete with each other to offer drug coverage at the lowest possible cost to beneficiaries and the Medicare program. Yet, a close analysis of their proposal shows they have not stuck by their free-market convictions. This is because when the Republican leadership put forward a proposal two years ago that would have relied on private companies to offer drug-only insurance under a truly market-based system, the companies said they would not participate. The reason – it would be too risky financially!

So in 2002 the Republican leadership drafted a proposal that sweetened the pot enough for private insurers to say that they would offer coverage under the program.²⁴ What did the

leadership have to do to get the insurance industry to agree to participate? It had to guarantee the industry's profits at taxpayers' expense.

Under the Republican leaderships' proposal, private plans can pick and choose where and when to offer drug coverage. And 67 percent of the costs they pay out will be repaid by the federal government, leaving them at risk for only 33 percent of those costs. If they are unwilling to offer drug coverage in a particular area the federal government is authorized to do whatever it takes to lure them into offering coverage, including assuming virtually all of a plan's financial risks and guaranteeing a plan's profitability.

This is a clear recipe for a boondoggle, since Medicare could be forced to pay not only for the cost of the drugs covered by a private plan but for the plan's administrative costs and profits – which based on experience with the Medigap market are likely to amount to at least an additional 20 percent on top of the cost of the prescription medications covered. Given that Medicare offers coverage and only uses 2 percent of its resources for administrative costs, relying on private plans will lead to significant resources being wasted that could have gone to providing additional benefits to seniors and people with disabilities.

IV. Private Plans Won't Guarantee Benefits – A Feature Medicare Beneficiaries Highly Value

Beyond the problems specific to Medicare's experience with HMOs and Medigap is a fundamental problem with proposals that try to maximize seniors' choice of private plan and fail to offer standardized, reliable benefits, or make use of Medicare's buying power to deliver cost savings.

Beneficiary Health Problems Make Proposals Relying on Choice Unworkable

In order for a private insurance model to succeed at delivering the highest level of benefits for the lowest premium there must be vigorous competition between multiple private plans. Moreover, consumers must have access to information about the alternatives available to them and the ability to process that information.

At this time it is unclear if a sufficient number of private plans would offer drug coverage to create a vigorous market. However, what we do know is that even if such a market were to develop, a significant portion of Medicare beneficiaries will not be able to make effective use of the opportunity to choose between private plans.

Nearly a quarter (23 percent) of Medicare beneficiaries have physical health and/or other problems that make it difficult for them to evaluate the important differences between plans or make good choices.²⁵ A survey conducted by Mathematica Policy Research Inc. in 2000 found that 12 percent of Medicare beneficiaries are blind (1 percent) or say their vision is poor even with corrective lenses (11 percent). Nine percent are either deaf or have poor hearing even with hearing aids.²⁶ And a 1992 National Adult Literacy Survey found that 44 percent of adults over the age of 60 are functionally illiterate.²⁷

Beneficiaries also lack basic knowledge about Medicare, which makes decisions between competing coverage options particularly difficult. Mathematica found that despite ongoing controversy over legislation to add a drug benefit to Medicare, in 2000 32 percent of beneficiaries were unaware that Medicare does not pay for all health care costs. The people whom beneficiaries turned to for assistance in understanding Medicare and their coverage options were slightly better informed but still 24 percent did not know that Medicare does not cover all health care costs.

Beneficiaries Prefer Reliable Benefits to Confusing Choices

Proponents of a market-based approach are ignoring the preferences of the people the program serves who seek stable, reliable, and easy-to-understand benefits over the ability to choose among a confusing set of insurance policies.²⁸

- **Choice of plan is relatively unimportant to beneficiaries.** A survey of beneficiaries in 2000 found that only 14 percent who had the option of enrolling in an HMO in that year changed or even seriously considered changing how they receive basic Medicare services or supplemental coverage for costs and services not covered by Medicare.²⁹ Forty-four percent said they had *never* seriously considered their choices and 14 percent last thought about it when they first became eligible for Medicare. Even those who must make a change because they are new to the program or because their plan withdrew from the program do not seriously consider their choices. Only 30 percent of new beneficiaries and 52 percent of those dropped by their HMO thought very or somewhat seriously about their choices.
- **Beneficiaries dominant concerns are whether they will have access to care that is reliable and affordable and their choice of physician.** Sixty-three percent of beneficiaries felt that the ability to get care if sick would be extremely important if they were choosing a plan in 2000; 49 percent said choice of doctor would be extremely important and 47 percent said keeping premiums down would be extremely important.

Privatized Drug Coverage Leads to Less Effective Cost Containment

We have already seen that Medicare is more effective at combating increases in the costs of the benefits it currently covers – doctors and hospital care – than the HMOs that contract with Medicare to offer these services. This suggests that Medicare also would be more effective at containing the increases in the costs of prescription drugs, compared to private plans. In fact, the reason the drug industry objects to legislation providing drug coverage through Medicare is precisely because it fears Medicare would act aggressively to negotiate deeper drug price reductions.

By subsidizing many HMOs and other private insurers to offer prescription drug coverage, instead of providing coverage under Medicare, the buying power of Medicare's 40 million beneficiaries would be fragmented among many different entities, reducing its bargaining clout.

The effect of fragmenting Medicare's buying power on its ability to demand lower prices can be seen in the dramatic difference between the drug price discounts the federal government is able to negotiate in other programs, as opposed to the usual discounts that private insurers and HMOs

are able to achieve.³⁰ The Federal Supply Schedule Price, which the Department of Veterans Affairs negotiates with the drug companies on behalf of the federal government, is generally 52 percent less than the price paid by cash customers at the pharmacy (not including a reasonable pharmacy dispensing fee).³¹ This contrasts with the 12 to 40 percent discount from the manufacturer's list price that Pharmacy Benefit Managers (PBMs), insurers and HMOs are able to achieve.

If the drug industry is successful, and a program becomes law in which coverage is made available through multiple private plans, this would be a win-win for the drug industry. It would receive additional revenues as a result of taxpayer subsidies to the program, and it would not have to worry about Medicare using its market power to negotiate lower prices.

The likely effect of failing to take maximum advantage of Medicare's buying power to negotiate lower prices can be seen in the ever-rising additional premiums* of HMOs offering drug coverage and the ever-escalating costs paid by Medicare supplemental insurers for prescription drugs. In 14 states that had Medicare HMOs with drug coverage in both 1999 and 2002, the average additional premium for such plans increased more than 100 percent. In 8 states, the average premium for private plans with drug coverage increased by more than 300 percent. (See Figure 7). (Increasing premiums is not solely due to rising prescription drug costs; however, since such costs are growing faster than any other portion of health care costs it is logical to assume it is an important factor.) During that same time HMOs scaled back the generosity of the drug benefits they offered. In 2000, 70 percent of plans had annual caps of \$1,000 or less on the drug benefits they offered, up from 35 percent in 1998.³²

The experience is similar with private indemnity plans. From 1996 to 1998 Medicare insurers offering Medigap coverage for prescription drugs experienced a 15 percent annual increase in drug costs.³³

In its evaluation of the effectiveness of proposals that rely on competing private insurers to control costs, the Congressional Budget Office has found that they would achieve savings by creating tight formularies that would deny beneficiaries coverage for prescription drugs that they would like to have covered.³⁴ In contrast, if the federal government were to use its buying power to negotiate lower prices with drug companies large cost savings would be possible without limiting beneficiaries access to certain prescription drugs.

** Except for certain low-income beneficiaries, all Medicare recipients in 2001 had to pay a \$50 monthly premium to participate in the Medicare program. An HMO that provides coverage through the Medicare program may elect to charge beneficiaries an additional premium on top of the \$50 a month that all beneficiaries must pay.*

Figure 7
Change in Average Additional Premium for HMOs
Offering Rx Drug Coverage 1999 & 2002

State	Avg. Premium 1999	Avg. Premium 2002	Difference	Percent Change
Alabama	\$0	\$0	\$0	0%
Alaska	No plans	No plans	N/A	N/A
Arizona	\$21	\$11	(\$10)	-48%
Arkansas	\$89	No plans	N/A	N/A
California	\$26	\$43	\$17	65%
Colorado	\$26	\$72	\$46	177%
Connecticut	\$33	\$50	\$17	52%
Delaware	No plans	No plans	N/A	N/A
District of Columbia	No plans	\$79	N/A	N/A
Florida	\$9	\$32	\$23	256%
Georgia	\$5	\$32	\$27	540%
Hawaii	\$68	\$74	\$6	9%
Idaho	\$78	\$304	\$226	290%
Illinois	\$25	\$87	\$62	248%
Indiana	\$45	\$59	\$14	31%
Iowa	No plans	\$125	N/A	N/A
Kansas	\$25	\$29	\$4	16%
Kentucky	\$40	No plans	N/A	N/A
Louisiana	\$0	\$0	\$0	0%
Maine	\$58	No plans	N/A	N/A
Maryland	\$15	\$89	\$74	493%
Massachusetts	\$15	\$101	\$86	573%
Michigan	\$21	\$87	\$66	314%
Minnesota	\$230	\$94	(\$136)	-59%
Mississippi	\$0	\$0	\$0	0%
Missouri	\$30	\$38	\$8	27%
Montana	\$40	No plans	N/A	N/A
Nebraska	\$0	No plans	N/A	N/A
Nevada	\$26	\$15	(\$11)	-42%
New Hampshire	No plans	\$85	N/A	N/A
New Jersey	\$26	\$130	\$104	400%
New Mexico	\$17	\$20	\$3	18%
New York	\$23	\$59	\$36	157%
North Carolina	\$32	\$0	(\$32)	-100%
North Dakota	\$46	No plans	N/A	N/A
Ohio	\$18	\$43	\$25	139%
Oklahoma	\$20	\$15	(\$5)	-25%
Oregon	\$114	\$131	\$17	15%
Pennsylvania	\$38	\$67	\$29	76%
Rhode Island	\$13	\$63	\$50	385%
South Carolina	No plans	No plans	N/A	N/A
South Dakota	No plans	\$99	N/A	N/A

Tennessee	\$33	\$39	\$6	18%
Texas	\$11	\$44	\$33	300%
Utah	No plans	No plans	N/A	N/A
Vermont	No plans	No plans	N/A	N/A
Virginia	\$20	\$91	\$71	355%
Washington	\$0	\$138	\$138	N/A
West Virginia	\$65	No plans	N/A	N/A
Wisconsin	\$15	No plans	N/A	N/A
Wyoming	No plans	No plans	N/A	N/A

Source: Data for premiums in 1999 provided to Public Citizen by the Centers for Medicare and Medicaid Services. Data for premiums in 2002 available from the Centers for Medicare and Medicaid Services at www.medicare.gov under "Medicare Compare."

V. Lower Drug Prices Need not Stop New Drug R&D

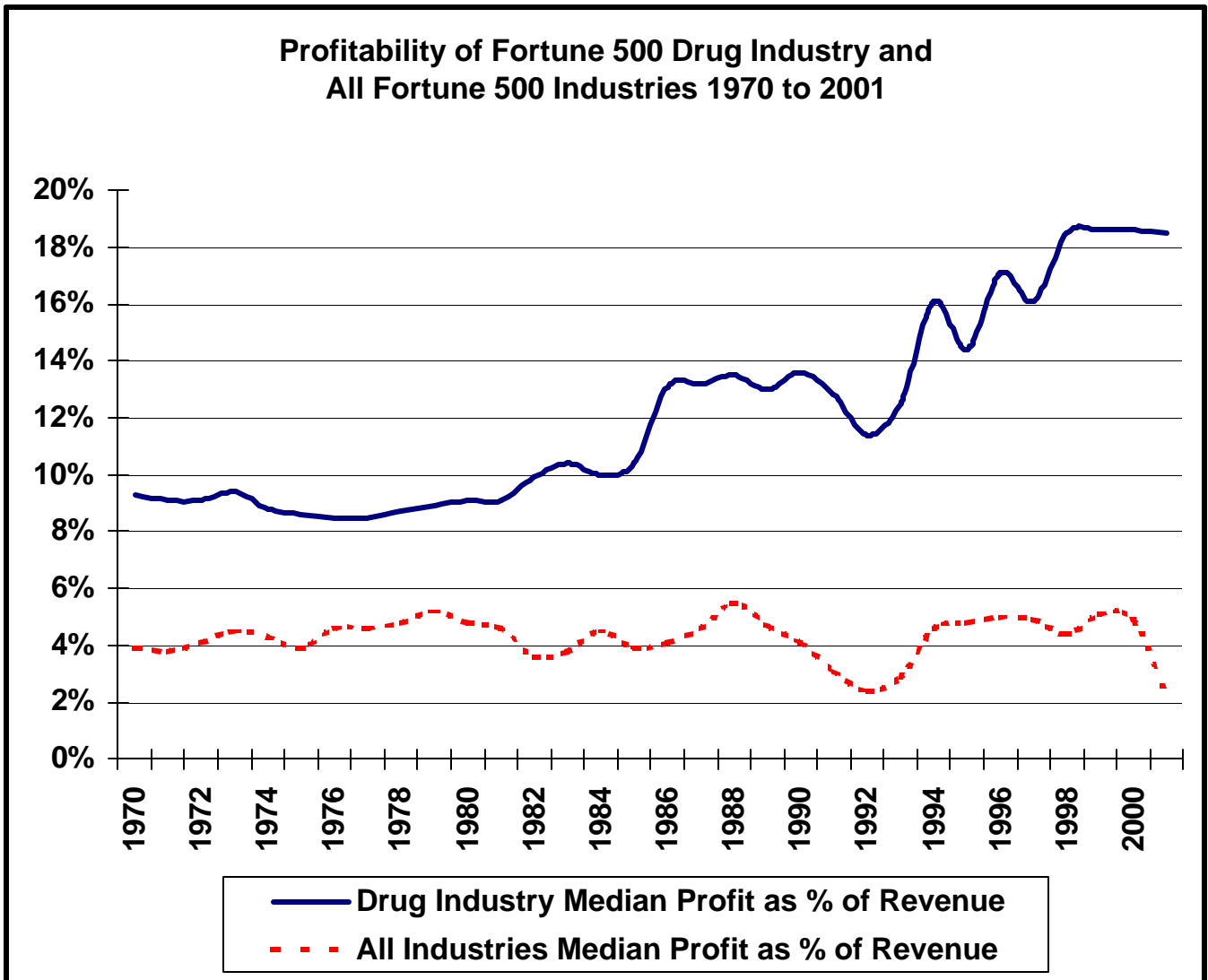
The supporters of giving private insurers a subsidy to offer drug coverage, instead of allowing Medicare to offer the benefit, claim that it will prevent Medicare's control of prices, thereby giving industry the necessary resources to develop new medicines. There are several reasons this fear is misplaced:

- **Significant price reductions are likely to have only a limited effect on drug companies' revenues.** A 1999 study by Merrill Lynch found that a Medicare drug benefit that included a 40 percent price cut for the industry would only reduce revenues by 3.3 percent, because the negative effect of price cuts would be offset by an increase in the volume of drugs purchased due to lowered prices.³⁵ The impact of a drug benefit and reduced drug prices for the estimated one-third of seniors who do not have coverage now and cannot afford prescription drugs would be the most dramatic. The report found that they would increase drug purchases by 45 percent. Those who do have coverage would also increase the volume of drugs they purchased almost completely offsetting the revenues lost by the industry due to lower prices.
- **If industry revenues were to be reduced it would not necessarily lead to a reduction in the invention of new cures for dread diseases.** Profit margins among drug companies are so high that in the event of a loss in revenue the industry has sufficient resources to assure that research and development is adequately funded. In every year since 1982, the drug industry has been the most profitable in the United States, according to *Fortune* magazine. During the 1980s the drug industry's profit as a percent of revenues was over two times the size of the average for all industries represented in the Fortune 500. In the 1990s it was over three times as profitable. (See Figure 8). Last year the top 10 U.S. drug companies in the Fortune 500 had the greatest return on revenues, collectively reporting a profit of 18.5 percent. (See Figure 9). This was *eight times* higher than the median for all Fortune 500 industries (2.2 percent). In contrast to the 18.5 percent of revenue that they channeled into profits last year, the Fortune 500 drug companies spent just 12.5 percent of revenues on R&D.³⁶ Moreover, 8 of the 10 most profitable Fortune 500 drug companies devoted more of their revenue to profits than to R&D.³⁷

- **A significant portion of the research to develop new drugs is done by the government at taxpayer expense.** According to an internal National Institutes of Health (NIH) document uncovered by Public Citizen, taxpayer-funded scientists conducted 55 percent of the research projects that led to the discovery and development of the top five selling drugs in 1995.³⁸ A study by a Massachusetts Institute of Technology (MIT) scholar of the 21 most important drugs introduced between 1965 and 1992 found that publicly funded research played a part in discovering and developing 14 of the 21 drugs (67 percent).³⁹ *The Boston Globe* found that 45 of the 50 top-selling drugs from 1992-1997 received government funding for some phase of development.⁴⁰ In all, taxpayers spent at least \$175 million helping to develop these 50 drugs.

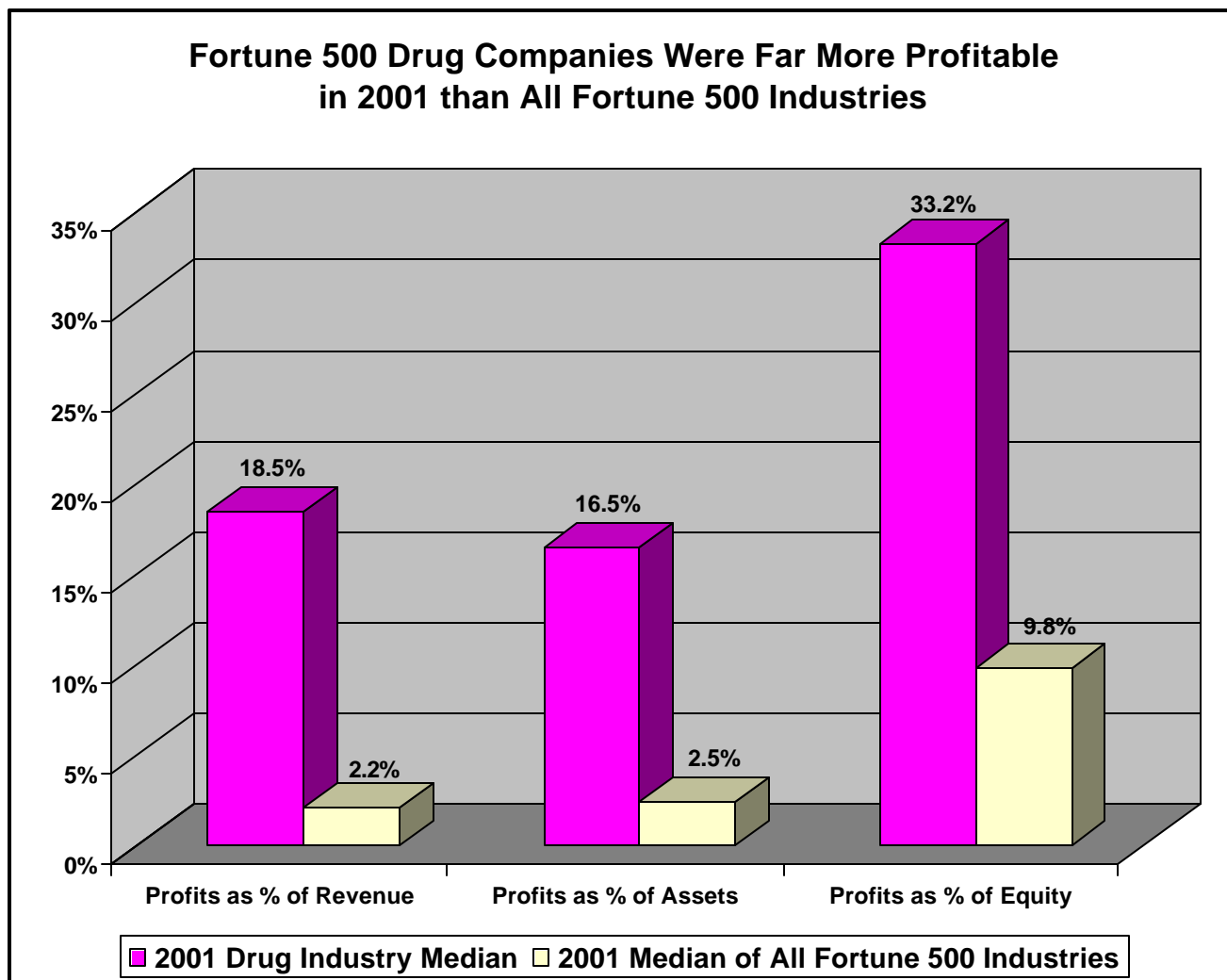
- **Much of the industry’s research and development efforts do not go into inventing new cures.** In fact, the FDA classified only 22 percent of new drugs brought to market in the last two decades as innovative drugs that represented important therapeutic gains over existing drugs. Most were “me-too” drugs, which often replicate existing successful drugs.⁴¹

Figure 8



Source: Public Citizen update of Stephen W. Schondelmeyer calculation, *Competition and Pricing Issues in the Pharmaceutical Market*, PRIME Institute, University of Minnesota based on data found in *Fortune* magazine, 1958 to 1999; Public Citizen's analysis of *Fortune* magazine data, 2000-2002.

Figure 9



Source: *Fortune* magazine, April 2002, Fortune 500 (www.fortune.com).

VI. Conclusion

The Medicare program's experience with private insurers and HMOs providing coverage to beneficiaries should be carefully considered as Congress debates how to structure a program offering prescription drug coverage. As this report shows, despite the fact that they are overpaid, HMOs are withdrawing from the program in large numbers. And yet they are still getting a respectful hearing in Congress as they request additional money – making them even more overpaid – as their price for staying in the program.

The lesson that Congress should learn from its experience with the Medicare+Choice program is simple. The private sector is less efficient and effective at offering health insurance to seniors and people with disabilities than the government. However, once a program is created allowing the private sector to begin offering coverage in exchange for taxpayer subsidies it becomes a greater and greater boondoggle as members of Congress become unable to back away from the program because of the constituents who would be affected if it fails. This creates a situation where members of Congress become bound to the notion that they must do whatever it takes to prop up the program.

Today, we are at a crossroads for the Medicare program. We can blindly entrust coverage to the private sector, or we can learn from the failures of HMOs to deliver doctor and hospital care efficiently and reliably, and avoid the same fate with prescription drug coverage.

Currently, Republican members of Congress and a handful of Democrats appear determined not to learn from experience. They want to begin the same bidding war to lure private insurance companies to offer drug coverage, as is already taking place with efforts to keep HMOs offering doctor and hospital services in the Medicare+Choice program.

In 2000 private insurers said they would not participate in a program devised by House Republican leaders that would have forced them to operate on a market-based model, in which they would have been exposed to substantial risks of losing money. So this year the Republican leadership changed course. The proposal leaders put forward would have private plans compete to offer drug coverage and accept the potential losses that come with any business venture – unless of course private insurers did not want to risk any losses, in which case they could apply to the federal government for almost complete protection against financial loss. This effectively asks taxpayers to guarantee their profits.

Clearly this is not the way to proceed. We should take the path that leads to reliable and efficient drug coverage for seniors and people with disabilities. That path is through a drug benefit provided by the Medicare program directly to beneficiaries.

Congress has a clear choice to make. Let it choose well.

Endnotes

¹ The White House has recently announced an initiative to attract Preferred Provider Organizations (PPO) into the Medicare+Choice program. If this initiative is successful and a proposal making drug coverage available through private plans were to pass, PPOs would be eligible to offer drug benefits under the program. However, the goal of this report is to reflect on the experience with private plans in Medicare and the lessons that can be drawn from that experience. Since Medicare's experience with PPOs to date is very limited this report will not speculate about how effective PPOs might be in offering drug coverage.

² Transcript Markup of H.R. 4954, U.S. House of Representatives, Ways and Means Committee, June 18-19, 2002.

³ Up until now, HMOs have been virtually the only type of plan to offer coverage through the Medicare+Choice program. This may change as a result of the recently announced initiative by the Bush administration to encourage PPOs to participate in Medicare.

⁴ Kenneth E. Thorpe and Adam Atherly, "Medicare+Choice: Current Role and Near-Term Prospects," Health Affairs, July 17, 2002.

⁵ M+C Changes in Access, Benefits, and Premiums 2001 to 2002, Centers for Medicare and Medicaid Services, available on CMS website.

⁶ Public Citizen analysis of data provided by Centers for Medicare and Medicaid Services.

⁷ Families USA, "Failing America's Seniors: Private Health Plans Provide Inadequate Rx Drug Coverage," May 2002.

⁸ Timothy Lake and Randall Brown, "Medicare+Choice Withdrawals: Understanding Key Factors," Kaiser Family Foundation, June 2002.

⁹ U.S. General Accounting Office, "Medicare+Choice Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000.

¹⁰ U.S. General Accounting Office, "Medicare+Choice Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000.

¹¹ U.S. General Accounting Office, "Federal Employees Health Program: Reasons Why HMOs Withdrew in 1999 and 2000," May 2000.

¹² U.S. General Accounting Office, "Federal Employees Health Program: Reasons Why HMOs Withdrew in 1999 and 2000," May 2000, p. 8.

¹³ Inspector General, Department of Health and Human Services, "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997," September 2000.

¹⁴ 2002 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds.

¹⁵ U.S. General Accounting Office, "Medicare+Choice Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings," September 2000. The Medicare Payment Advisory Commission report, March 2002, estimated that spending for beneficiaries in the M+C program was 4 percent higher than spending for demographically similar beneficiaries in the traditional Medicare program in 2001. However, this estimate did **not** adjust for the relative health of beneficiaries in the M+C program. If it had it likely would have shown that M+C plans were even more overpaid.

¹⁶ Ed Maibach and Tricia Neuman, "Marketing HMOs to Medicare Beneficiaries," Health Affairs, July/August 1998.

¹⁷ Marilyn Moon and Matthew Storeygard, "One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," The Commonwealth Fund, September 2001.

¹⁸ Moon and Storeygard, September 2001.

-
- ¹⁹ Inspector General, Department of Health and Human Services, “Adequacy of Medicare’s Managed Care Payments After the Balanced Budget Act of 1997,” September 2000.
- ²⁰ Kenneth E. Thorpe and Adam Atherly, “Medicare+Choice: Current Role and Near-Term Prospects,” *Health Affairs*, July 17, 2002.
- ²¹ Cristina Boccuti and Marilyn Moon, unpublished analysis of National Health Expenditure data.
- ²² William Scanlon, U.S. General Accounting Office, Testimony Before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 14, 2002.
- ²³ 2002 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds.
- ²⁴ Don Young, President, Health Insurance Association of America letter to Honorable Bill Thomas, Chairman, Committee on Ways & Means, U.S. House of Representatives, June 18, 2002.
- ²⁵ Patricia Neuman and Kathryn Langwell, “Medicare’s Choice Explosion? Implications for Beneficiaries,” *Health Affairs*, January/February 1999, p. 156.
- ²⁶ Marsha Gold et al., “Medicare Beneficiaries and Health Plan Choice, 2000,” Mathematica Policy Research, Inc. January 2001.
- ²⁷ Cited in Gold et al., January 2001.
- ²⁸ Marilyn Moon, “Can Competition Improve Medicare?,” The Urban Institute, September 1999.
- ²⁹ Gold et al., January 2001.
- ³⁰ Department of Health and Human Services, “Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices,” April 2000.
- ³¹ Department of Health & Human Services, “Report to the President: Illustrative Example of Pricing for Brand Name Prescription Drugs,” Table 3-1, April 2000.
- ³² HHS, Report to the President, 2000.
- ³³ National Association of Insurance Commissioners, “Medicare Supplement Insurance Issue Paper,” November 30, 2000, p. 13.
- ³⁴ Dan Crippen, Director, Congressional Budget Office, letter to Honorable Bill Thomas, Chairman, Committee on Ways & Means, U.S. House of Representatives, July 26, 2002.
- ³⁵ Merrill Lynch, “A Medicare Drug Benefit May Not Be So Bad,” June 23, 1999.
- ³⁶ *Fortune* magazine, “Fortune 500,” April 2002.
- ³⁷ Public Citizen’s Congress Watch, “Pharmaceuticals Rank as Most Profitable Industry, Again,” April 16, 2002.
- ³⁸ National Institutes of Health, Office of Science Policy, “NIH Contributions to Pharmaceutical Development: Case Study Analysis of the Top-Selling Drugs,” an administrative document dated February 2000; Public Citizen, “Rx R&D Myths: The Case Against the Drug Industry’s R&D ‘Scare Card’,” July 2001.
- ³⁹ Iain Cockburn (University of British Columbia) and Rebecca Henderson (MIT), “Public-Private Interaction and the Productivity of Pharmaceutical Research,” National Bureau of Economic Research, April 1997.
- ⁴⁰ Alice Dembner, “Public Handouts Enrich Drug Makers, Scientists,” *The Boston Globe*, April 5, 1998.
- ⁴¹ FDA/Center for Drug Evaluation and Research, “NDAs Approved in Calendar Years 1990-1999,” December 31, 1999. Donald Drake and Marian Uhlman, *Making Medicine, Making Money* (1993), p. 72.