Mitigating Losses from Health Care Fraud and Abuse

By David Cammack

“One hundred fifty billion dollars” is a staggering figure. Combine it with the phrase “in losses,” and the number becomes a nightmare. That nightmare – $150 billion in losses – is one estimate of the cost of health insurance fraud in America. According to new figures from the Centers for Medicare and Medicaid Services, U.S. health care spending reached nearly $1.7 trillion¹ in 2003. Some quick algebra shows health insurance fraud wastes nearly a tenth of America’s health care resources.

Fraud, by definition, is not self-revealing. You can only count what you detect. Losses from fraud or abusive billing practices are impossible to measure; they can only be estimated. The latest estimates from U.S. Department of Health and Human Services (HHS), the National Health Care Anti-Fraud Association¹, the National Insurance Crime Bureau, the Coalition Against Insurance Fraud¹ and the Centers for Medicare and Medicaid Services vary widely. But whatever the estimate, the figures are monumental – ranging from $45 billion to $150 billion lost each year. 

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Everyone is a victim. The immediate targets of fraudulent billing practices are private health payers and government funded health plans. But payers, employers and patients pay the price in higher premiums, lower benefits, higher taxes and higher co-payments. Survey reports from Mercer Human Resource Consulting found the average employee in 2003 costs U.S. employers $6,215 in annual health benefits, up 10 percent from $5,646 in 2002.

Between 1998 and 2003, the cost of health benefits rose by an astonishing 48 percent. A 1999 Health Insurance Association of America (HIAA) report, “Health Insurers’ Anti-Fraud Programs,” cited fraud as a contributing factor to that meteoric rise.

The impact goes beyond cost; quality of care can also be compromised with false or inflated claims. The health and well-being of patients can be compromised when they are exposed to unnecessary and dangerous tests and procedures. Some patients have become “paper pawns” through fabricated histories that threaten their future insurability and employability.

The U.S. health care system has inherent vulnerabilities that tempt and attract individuals or groups who may want to abuse the system. Our historical assumption of trust in our health care providers and their honesty leaves us exposed to their ethical choices. Another vulnerability is the sheer volume of payers and health care providers as well as the volume and diversity of claims that were not a consideration in years past. Electronic data exchange and other technological advances can present another kind of exposure for payers and patients to creative new schemes to defraud the system.

Perpetrators see health care fraud and abuse as a low-risk crime. The insurance industry offers an abundance of easy targets. Claims operations are geared toward processing massive amounts of claims efficiently and rapidly – with a focus on coding, not fraud. But health insurers have a powerful role to play. By establishing an aggressive, end-to-end fraud and abuse program, health plans can potentially save millions while continually providing accessible, affordable, high-quality care to their members.

**What is Fraud and Abuse?**

Fraud in the health insurance industry is intentional deception and misrepresentation resulting in the payment of unauthorized benefits or in the assumption of an inaccurate underwriting liability. Abuse in the industry is the practice of directly or indirectly causing financial loss to payers of benefits. According to a 1999 HIAA report, 34 percent of fraud and abuse comes from billing for services not rendered; 22 percent comes from upcoding, or the act of documenting a more serious patient condition than the one that actually exists; 18 percent comes from false diagnoses; 10 percent comes from pharmacy provider fraud, and most others come from creative schemes that include, but are not limited to, various forms of kickbacks.
Who Commits Fraud and Abuse?

Organized crime rings. Many criminals are migrating from drug trafficking into the safer and more lucrative trade of health care fraud. These rings are based anywhere from Central America to Russia, and they are assaulting the U.S. health care system. A typical method used by these groups is fabricating claims from non-existent clinics using purchased or stolen patient information.

Brokers and insurance agents. Phantom employer groups, premium skimming, misrepresenting employees health status or adding non-eligible members to employer groups are some of the favored practices of fraudulent brokers and agents.

Health plan employees. Some perpetrators of fraud are health plan employees who set up invalid health care provider records and divert payments to themselves or someone else. Other health plan employees have been caught selling ID numbers, processing false “pay to subscriber” claims or skimming premiums.

Plan members. Fraudulent practices among plan members include sharing or selling ID cards, submitting false claims or adding ineligible dependents.

Health care providers. Whereas most health care providers are honorable, some have admitted they feel “justified” in extracting payments that are not warranted. In a study published in 2000 by the Journal of the American Medical Association, “Fidelity and Deceit at the Bedside,” 54 percent of physicians reported “using deception of third-party payers to obtain needed benefits.” Thirty-nine percent reported exaggeration of a patient’s condition, changing a diagnosis or reporting signs or symptoms that did not exist.

Physicians and other health care providers can commit fraud by performing excessive and unnecessary diagnostic services or “diagnosing” non-existent chronic conditions to hook patients into long-term services. They may also abuse the health care reimbursement system by inflating charges, upcoding, unbundling (billing separately for a group of related services in order to obtain higher reimbursement) and underutilizing resources in capped arrangements.

Ignoring fraud creates risk, allows the problem to grow unchecked and increases avoidable payouts. On the other hand, a comprehensive program allows health insurers opportunities to prevent and recapture loss.

Key Components of a Comprehensive Fraud and Abuse Program

The most effective anti-fraud and abuse programs are end-to-end and aggressive, and include elements of process assessment, detection technology, education, prospective investigations, recovery investigations and resolutions.

Process Assessment. Process assessment includes reviewing a health plan’s operational areas with a focus on fraud and abuse vulnerabilities. An effective assessment should ask, “How strong are the plan’s provider database, claims operations, contracting and medical management?” A completed assessment will identify mechanisms such as internal policies and procedures that could help prevent future inappropriate payments.

Detection Technology. A process assessment will likely find holes in an insurer’s fraud detection capabilities, holes that are best managed with technology. An insurer may suspect abusive providers, but since fraud schemes are commonly statistical in nature, they are not generally revealed through single transactions. Effective detection technology will optimize identification of potentially fraudulent situations. Detection technology can deliver examples of behavior and allow insurers to document abusive patterns; it can retrospectively identify questionable providers from claims data; and it can analyze data to identify patterns of suspicious activity, targeting specific geographic areas and provider groups. Such technology will uncover irregular claims and treatment practices, as well as deliver advanced visualization, objective scoring and flexible reporting.

Anti-Fraud Education. Each year, various laws and regulations are passed requiring general fraud and abuse awareness education and specialized training for underwriters.
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claims examiners, investigators and other pertinent personnel. A successful anti-fraud program has, at its core, employees who are well informed and on the lookout for potential company exposures to fraud and abuse.

Prospective Investigations. Effective detection technology can facilitate prospective investigations, or investigations which uncover fraud and abuse before a claim is paid. Prospective investigations can realize significant savings. Recovering benefits already paid is much more difficult and much less profitable than preventing inappropriate payouts in the first place.

Recovery Investigations. If an investigation finds that a claim is inappropriately paid due to fraud or abuse, a comprehensive anti-fraud and recovery program are faced with a critical question: Should we build the program in-house or should we outsource? To answer this question, they need to determine if they can find and keep the right people, if they have all the tools they need for prevention and recovery, if they can continually train their investigators and if they have the resources to keep up with a problem that will become increasingly sophisticated and widespread.

Resolution. Resolution includes mitigation through prospective and recovery investigations, as well as long-term strategies that may include civil litigation, criminal prosecution, license revocation and sanction. Resolution strategies should result in timely, cost-effective resolution of payments.

The Critical Question

Health insurance executives who endeavor to implement a comprehensive anti-fraud and recovery program are faced with a critical question: Should we build the program in-house or should we outsource? To answer this question, they need to determine if they can find and keep the right people, if they have all the tools they need for prevention and recovery, if they can continually train their investigators and if they have the resources to keep up with a problem that will become increasingly sophisticated and widespread.

Conclusion

Any amount of money lost due to fraud is money wasted on the criminal or unscrupulous, money that could have been used to keep premium rates in check or to improve patient care. As health plans aim for increased success and profitability, a full-scale anti-fraud and abuse program can be as successful a profit-building strategy as raising premiums or adding new members. With health care costs rising at staggering rates, health insurers cannot afford to allow fraud to drain up to 10 percent of their resources.

REFERENCES

2. 1999. Health Insurers’ Anti-Fraud Programs. Washington, D.C.: Health Insurance Association of America. The first reference we can find that estimates up to 10 percent of the nation’s health care spending is used to pay for fraud is mentioned in this report: “In a 1992 report to Congress, the General Accounting Office used an estimate of 10 percent or $70 billion of the nation’s health care spending in 1991, a figure often used since then to represent the extent of fraud and abuse activities.” Other sources include the FBI’s Health Care Fraud Unit, whose website (http://www.fbi.gov/hq/cid/fchf/about/chf_about.htm) states: “Losses attributable to fraud and abuse have been estimated, by some, to be as much as ten percent of the nation’s total annual health care expenditure,” and the U.S. Department of Justice, which states in a publication titled “Cost of Crime and Victimization”: “The U.S. General Accounting Office reports that health care fraud totals 10 percent of total healthcare expenditures each year, which puts annual health care fraud losses at $100 billion.”
6. ibid., and Blaine Bos. 2001. 15th Annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans. Mercer Human Resources Consulting. Percentage cited was derived from finding the difference between average 1998 costs ($3817) and average 2003 ($5646) costs and dividing it by 1998 costs.
7. See reference 2.
8. ibid.
Michael Osterholm graduated from Luther College, Decorah, Iowa in 1975 with a degree in political science and biology. He later earned an MS in environmental health (1976), an MPH in epidemiology (1978), and a PhD in Environmental Health (1980) at the University of Minnesota. From 1975 to 1999, Osterholm took up a variety of positions at the Minnesota Department of Health, including in the past 15 years state epidemiologist and chief of the Acute Disease Epidemiology Section. In that time his team grew to be leaders in infectious-disease epidemiology and were involved in many internationally notable outbreaks, including foodborne diseases, the association of tampons in toxic shock syndrome, the transmission of hepatitis B in health-care settings, and HIV in health-care workers. Recently, Osterholm has been a national leader detailing the growing concern regarding the use of biological agents in civilian populations. In that role he served as a personal advisor to the late King Hussein of Jordan.

Osterholm is the author of more than 240 papers and abstracts and 18 book chapters on infectious-disease epidemiology. He is past president of the Council of State and Territorial Epidemiologists and served on the National Center for Infectious Diseases, Centers for Diseases, Centers for Disease Control and Prevention (CDC) Board of Scientific Counselors from 1992 to 1997. He serves on the National Academy of Sciences, Institute of Medicine (IOM), Committee on Emerging Microbial Threats to Health in the 21st Century, and the IOM Forum on Emerging Infections. He has also served on the IOM committee on Food Safety, Production to Consumption, and as a reviewer for the IOM report on chemical and biological terrorism. As a member of the American Society for Microbiology, he serves on the Public and Scientific Affairs Board (where he chairs the Public Health Committee), the Task Force on Biological Weapons, and the Task Force on Antibiotic Resistance. He is a frequent consultant to WHO, the National Institutes of Health, the Food and Drug Administration, the Department of Defense, and the CDC.

Osterholm currently heads the University of Minnesota’s Infectious Disease Research and Policy Center and is also a professor at the School.
of Public Health. After the September 11 terrorist attacks, he was appointed to the Secretary’s Advisory Council of Public Health Preparedness, Department of Health and Human Services (HHS), and currently serves as a Special Advisor to the Office of Public Health Preparedness in HHS. On April 1, 2002, Osterholm was appointed by Secretary Tommy G. Thompson to be the secretary’s representative on the interim management team to lead the CDC.

**TLID:** If I could take you back to a time before the world got so complicated, what drew you into the infectious diseases arena?

**MO:** Even when I was a young boy, I was fascinated by infectious diseases and wanted to become a medical detective. One of the very first books that I ever read was a compendium of Sherlock Holmes stories. In that sense, I have always loved the detective side of the infectious diseases issue. In high school, I was employed by the Iowa State Hygienic Lab studying the natural history of LaCrosse encephalitis in the hardwood forest areas of northeast Iowa. In addition, I did studies on the presence of salmonella in sewage that was discharged into one of the premier recreational rivers in our area. As an undergraduate, I went to Luther College in Decorah, Iowa; I knew as a freshman that I wanted to pursue a PhD in the area of infectious-disease epidemiology. The rest is history. Of note, I ended up pursuing a double major in my undergraduate studies; biology and political science. I was never quite sure if I was a biological politician or a political biologist. In many ways the approach was the same with either profession. Today I fully understand the importance of the intersection between science and public safety. Needless to say, I feel right at home directing the Center for Infectious Disease Research and Policy here at the University of Minnesota.

**TLID:** As a state epidemiologist in the past 15 years at the Minnesota Department of Health, you and your team have been involved in the investigation of many notable outbreaks. What was the most interesting or unusual outbreaks you were involved in?

**MO:** Each of the hundreds of outbreaks that we investigated have their own flavour. In some ways it’s like saying “which one of your children do you love best”. I believe that the work that we did with toxic shock syndrome in 1979-1981 was the most significant investigation from the standpoint of my career. This work established our team as national players in the field. As you may recall, our results did not agree with the CDC’s results, but subsequently it was shown that our studies appropriately identified the role that tampons have in the risk of developing toxic shock syndrome. Initially, the CDC said that Rely brand tampons were the single risk factor for developing toxic shock syndrome. In fact, the fluid capacity of tampons was the key factor. This investigation was difficult because we were in the public arena challenging CDC, the world’s expert in infectious diseases on a very high-visibility outbreak. We were just a state health department.

Other outbreaks that spring to mind include one involving salmonella and mozzarella cheese. This was one of the first outbreaks that demonstrated to us the potential for very low levels of sporadic contamination of a mass-produced or processed food to cause an outbreak with thousands of human cases. Despite the fact that lab testing did not identify salmonella in the product until more than 5 weeks into the investigation, our epidemiological data pointed to the vehicle in the first weeks. We were convinced that we were correct in our conclusions. All along our epidemiological investigation results were right on target; they were giving us the right answer. When salmonella was not immediately isolated from the cheese there were many individuals in the community, and even some in the public-health system, who questioned our conclusions. We kept faith in our “science” and ultimately showed that our conclusions were correct.

Today, the human being is the ultimate bioassay for contaminated foods. We now have many examples of mass produced foods that are widely distributed throughout the world and are contaminated with extremely low
concentrations of foodborne pathogens. We have seen outbreaks occur with levels of contamination as low as one or two cells per gram of food. With outbreaks associated with the consumptions of these products, the attack rates are extremely low, often less than 1% of the people who eat the product. However, the number of cases in these outbreaks can be extremely large given that there are millions of people consuming this food.

Finally, there is one outbreak investigation that will be an indelible memory. In 1995, we experienced an outbreak of Neisseria meningitidis infection in Mankato, Minnesota. Nine individuals became ill over a 1-month period. One young boy who had onset of his illness in the first week of the outbreak died from meningococcaemia. The case was extremely distressing for the community; it turned out that the boy was the exact same age as my daughter. I found myself wanting so badly to go home that day and hold my daughter for even a moment. I did finally end up driving more than 90 miles back to the Twin Cities at 0100 h just so I could kiss her goodnight as she lay there sleeping in her bed. After being home for only minutes, I turned around and drove back to Mankato. We had a community-wide immunization clinic that was to begin at 0600 h and I needed to be back in time for our 0500 h briefing. While the “personal side” of an outbreak can be difficult, in the end one must always divorce oneself from that situation and do one’s job. We can’t ever forget that we are there to do a job and if we don’t do it, it won’t get done.

TLID: You have been warning the US government for some time about the threat of bioterrorism, and that it’s not so much if it will happen but when it will happen. Why do you think the government didn’t earlier pay as much attention to addressing this threat as they could have done?

MO: I think there were two basic reasons for not paying more attention to this issue sooner. First, we clearly had many other pressing issues that required both resources and the limited expertise that we have in the area of public health. As the old saying goes, “you often don’t think about draining the swamp until you’re up to your backside in alligators”. Second, I think there was a lack of clear understanding as to the actual risk of bioterrorism and the fact that there are many possible individuals, groups, or countries that are willing to use these weapons.

TLID: You served as a personal advisor to the late King Hussein of Jordan. Can you tell us how that came about?

MO: My time with King Hussein was without a doubt one of the greatest opportunities I’ve had in my entire career. It was truly a professional gift. I had the opportunity to advise him as a result of working with Dr. Walt Wilson at the Mayo Clinic. Walt is a very close friend and was King Hussein’s personal physician. The King was a brilliant man who had incredible knowledge about bioterrorism. He understood its significance and he reinforced for me why he thought it was such an important and devastating weapon within the arsenal of terrorist-related tools. I detailed some of my work with him in my book “Living terrors: what America needs to know to survive the coming bioterrorist catastrophe”. Ironically, the book was published on September 11, 2000, 1 year to the day before the World Trade Center and Pentagon disasters.
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TLID: After the events of September 11 your focus has shifted greatly towards bioterrorism preparedness. What concerns you about preparing for the future?

MO: My concern now is very much oriented towards taking the resources we’ve been given and making sure that we provide a meaningful return to our communities. This is a unique opportunity for use to accomplish two goals. First, prepare the country for a future bioterrorism-related attack – it will happen and it will likely be much worse next time. The second goal is to help this country, and likely the rest of the world, prepare for any public-health crisis, particularly around those involving infectious agents. We will be able to use our training and tools every day for the routine types of problems like emerging infectious diseases and be better prepared to respond on a given day when a bioterrorism event occurs.

TLID: After last year’s anthrax attacks, TLID (December 2001 p 287), asked whether the days of open and free exchange of ideas in infectious diseases might be in danger of being over. What are your views on this?

MO: I don’t think that open exchange is dead for most things I think it has to be modified for some things, and even then it is important that there be a free exchange among legitimate researchers. Having said that, there is no bright line which will direct us to a right or wrong answer. We will be wrestling with this issue for some time to come.

TLID: Your team was one of the first to call attention to the changing epidemiology of foodborne diseases. What issues concern you the most about this field right now?

MO: I think a major question that confronts us is how good is our data for defining the problem of foodborne diseases and what are we willing to do to improve upon those data? Let’s take the first part of the above question. I think that we have made significant advances in protecting the world’s food supply. Note, I keep referring to the world’s food supply because so much of it is just that – food produced in one country and consumed in another. However, we have had a number of unfortunate “backslides” that have occurred, where the safety of the food supply has actually been reduced for certain food commodities. The very changing nature of our diet, where we eat out food, how we eat that food, and the increasing number of people we are immunocompromised, all add to the serious vulnerabilities of our food system as we know it today. For example, very few people understand the importance of produce in the area of foodborne disease transmission. We obviously all think that consumption of produce is a very healthy kind of thing to do. In fact, from an infectious disease standpoint, there is a greater enhanced risk of foodborne disease from this produce consumption than from most processed foods. In the many developing world farm fields, where much of our produce if now grown, the use of contaminated water, exotic wildlife contact, and even infected workers in the fields, all contribute to the problem. Also, today with the rapid increase in large food-animal-production facilities, the ability to effectively transmit infectious agents to large populations of animals is a very real problem. These consolidated operations represent a type of “developing-world inner-city” environment that makes it difficult to control pathogen spread. So, when you add all of these factors together, it’s easy to see why the vulnerabilities in our food system are substantial.

On the other hand, we have access today to technology that can greatly contribute to improving food safety. The problem is we just don’t use it. For example, the use of irradiation for a number of food items will provide a virtual guarantee that we eliminate foodborne pathogens from that food. In fact, if we were to use irradiation on our food supply in the developed world, the impact would be similar to what happened when we instituted pasteurization of our milk supplies and the elimination of milk-borne diseases. Unfortunately, there are many myths that exist in the community about the “theoretical” problems with irradiation and the impact that it has on the quality and safety of the food. We need to do much more to educate
the medical community and the general public about the overwhelming benefits of irradiation.

TLID: At the Emerging Infectious Diseases meeting in Atlanta we heard much about emerging infections, reemerging ones, and drug-resistant ones. Which ones do you foresee as public-health challenges?

MO: I think it goes back to the issues that I addressed before. I believe human migration is clearly an issue that will result in the spread and enhancement of infectious diseases on a worldwide basis. Bioterrorism and the use of biological agents not only cause disease and death, but also terror; this is an obvious issue. The change in world demographics, the ageing population, and many other demographic factors will be important considerations. As the baby boomers age, we are going to see a dramatic increase in cancers and other chronic diseases that result in some degree of immunodeficiency. This is a critical consideration for infectious diseases because many of these people will not die from their chronic health condition, but rather from an infectious-disease agent. We have to start considering this change in our population demographics, yet I don’t see much movement towards that planning yet.

Today, the ability of agents to move quickly around the world in a way that we have only a limited understanding of is also a critical factor. When we think about the potential for pandemic influenza, we often ask ourselves if we could have a repeat of 1918? We, we know that the primary reservoir for influenza viruses in the world is in aquatic birds. We know that before these strains can actually infect human beings, they must pass through an intermediary where recombination occurs with both the haemagglutinins and neuraminidases. Hogs are by far the best place for that to occur. Well, today the country with the fastest increase in hog production in the world, where 40% of the hogs of the world are now produced, is also the country with the world’s largest human population – namely China. Finally, it is also the location in the world with the largest concentration of aquatic birds. I believe China represents the most incredible reassortment laboratory for influenza viruses that anyone could ever imagine. In short, we should never be surprised when pandemic influenza finally happens.

TLID: In 1999, you fused medicine with business and founded the Infection Control Advisory Network Inc. (ICAN). What was your vision at the time for such an initiative?

MO: Public health, by its very nature, is part science, part policy, and part marketing and sales. It is the collective effort to get people to do the right thing based on sound and available information. ICAN was really an effort to improve upon the information that was readily available to health professional and public-health practitioners so that the decisions that they made could be based on the “best information”. We were an internet-based information system that provided current, comprehensive, and authoritative information at the fingertips of health practitioners. Today, medical journals are better than textbooks in terms of the current nature of the information. I have written book chapters that have taken more than 2 years to get published. At the same time, journals have a limited ability to provide for a comprehensive and integrated information system for specific disease issues. In addition, we need a delivery system that allows the information at our fingertips. That pipe by itself will not improve the information to health practitioners unless that information has the highest level of editorial review and user friendly organization. As I said before, this information has to be current, comprehensive, and authoritative, as well as easy to use. ICAN was an attempt to get at that type of a system. Unfortunately, we couldn’t get others to dream about it like we were dreaming about it. Today at the University of Minnesota we have taken that same ICAN material and are now beginning to develop a second edition of that system that will be used by everyone from the primary-care physician to the public-policy expert to find “the information” on the prevention, treatment, and control of infectious diseases.
What Does the New Medicare Drug Benefit Mean for You?

Interim discount card
From spring 2004 through 2005, beneficiaries can buy a card (for about $30) estimated to shave 10 to 15 percent off drug prices at the pharmacy.

Interim low-income help
People with incomes below $12,390 ($16,720 for couples) in 2004 will each get $600 a year on the card.

Coverage choice
From January 2006 beneficiaries can choose to (a) stay in traditional Medicare, a current Medicare HMO or a retiree plan without signing up for the drug benefit; (b) stay in traditional Medicare and enroll in a stand-alone drug plan; (c) enroll in a private health plan that offers drug coverage and Medicare health services.

Drug benefit
Enrollees will have an annual deductible of $250, an estimated premium of $35 a month (may vary in private plans) and a 25 percent copayment of drug costs up to $2,250 in a year. After that, enrollees pay all drug costs until they have spent $3,600 out of pocket (equal to $5,100 in annual costs for those with no other drug insurance). At that point catastrophic coverage kicks in, and enrollees pay five percent of prescriptions or copays of $2 for generics and $5 for brand names (whichever is greater).

'Dual eligible' subsidies
People eligible for Medicaid and Medicare will pay no premium or deductible and have no gap in coverage. They will pay $2 for generics, $5 for brand names and nothing above the catastrophic limit.

Other low-income subsidies
People with incomes below about $13,000 ($17,600 for couples) in 2006 and assets of under $6,000 ($9,000 for couples) will pay no premium or deductible and have no gap in coverage. They will pay $2 for generics, $5 for brand names and nothing above the catastrophic limit.

People with incomes between $13,000 and $14,400 ($17,600 and $19,500 for couples) in 2006 and assets under $10,000 ($20,000 for couples) will pay premiums on a sliding scale, a $50 deductible and 15 percent of drug costs with no gap in coverage. After spending $3,600 out of pocket in a year, copays will be $2 for generics, $5 for brand names.

Medicare Part B changes
The annual deductible for Part B (for outpatient care) will increase from $100 to $110 in 2005, then rise annually. The Part B premium will be linked to income for the first time, starting in 2007. People with incomes over $80,000 ($160,000 for couples) will pay more on a sliding scale.

http://www.aarp.org/bulletin/prescription/Articles/a2003-11-26-foryou.html