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AND JANARDAN PRASAD SINGH

Wall of Silence
The Treatment Trap
The Battle Over Health Care

Medicare Meltdown

How Wall Street and Washington Are Ruining Medicare and How to Fix It

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Licenses are rarely revoked for incompetence. The watchdog group Public Citizen reported that the number of doctors disciplined by state medical boards has declined 20 percent between 2004 and 2010. The rare exceptions when doctors are disciplined usually involve cases of drug and sex abuse. Even in these cases, the wheels of public protection move slowly.

When a medical board suspends a doctor's license to practice medicine or otherwise disciplines a doctor, the reaction can prompt retaliation indicative of an entitlement mindset. In Arkansas in 2009, a doctor who had his license revoked by the state medical board placed a grenade near the car owned by the executive director of the board, Dr. Trent Pierce. When Dr. Pierce turned on the ignition, the device exploded. He suffered serious injuries to his face and body, and he lost sight in his left eye and hearing in his left ear. After a massive investigation by authorities, the perpetrator was identified, charged, and sentenced to prison. Dr. Pierce resumed his duties with the medical board after months of treatment and recovery.

A less harrowing form of retaliation occurred when the executive director of a state medical board in the Northeast received verbal threats and animal carcasses in the mail from doctors the board sanctioned. The director requested and received security protection from the state police. An executive director of a state medical board in the Midwest was verbally assaulted and received threats to her career from the colleague of a physician who had been disciplined by the board for failure to comply with state license requirements.

Public Citizen called on the federal government to investigate state medical boards for their failure to protect seniors on Medicare from doctors who are an immediate risk to their health and safety. It reported that 220 physicians were considered by the hospitals or managed care plans where they worked to be an immediate threat to the public. Seventy-five percent of them were stripped of their clinical privileges on an emergency basis, meaning they were no longer permitted to work in those facilities. Yet state medical boards took no action, and the doctors continue to have a medical license and can practice somewhere else.

The Office of the Inspector General in the U.S. Department of Health and Human Services can exclude a doctor from participating in the Medicare program if a threat to seniors' health exists and when a state medical board fails to act. The public can access names of doctors who

have been excluded from providing care to seniors on Medicare in an online searchable database. Here is an example cited by Public Citizen where the federal government was compelled to act when a state medical board did not:

> The OIG excluded a California oncologist for 10 years . . . because the OIG determined that he had rendered over 3,900 excessive, substandard, unnecessary, and potentially risky services to seven Medicare beneficiaries over a six year period of time. . . . Once the exclusion was in place, the licensing board did revoke the doctor's license. Then it stayed the revocation and put the license on probation. The stay has been lifted but if the OIG had not devoted its investigative power . . . to excluding this physician, the Medicare . . . patient population would have continued to be at grave risk during the four years that the licensing board took to get to an exclusionable point in its process.

Republican senators Charles Grassley from Iowa and Orrin Hatch from Utah and Democrat Max Baucus from Montana shined a spotlight on instances where physicians were sanctioned by their employer for wrongdoing, including sexual misconduct and fraud, but kept their medical license. They asked the Office of the Inspector General in the Department of Health and Human Services to evaluate state medical boards' performance. So far the OIG has not done so. The likely impediment is pressure from the medical lobby to protect its members from unwelcome scrutiny.

BREEDS CORRUPTION

Arthur Brooks, president of the conservative Washington think tank, the American Enterprise Institute, described the "malignant cronyism" that plagues America in an opinion editorial in the *Wall Street Journal*. He wrote, "The Occupy Wall Street movement was at least right to protest the malignant cronyism in our economy."

The same malignant cronyism is alive and well in health care. One of the most costly examples is the two-hundred-billion-dollar market where hospital supplies and equipment are bought and sold. Hospitals and other health care providers typically use middlemen known as group

purchasing organizations (GPOs) to buy supplies such as Band-Aids and medical devices such as defibrillators and hip implants. A handful of GPOs divide up about 90 percent of the market.

Manufacturers and vendors that want to sell their products to hospitals through these purchasing organizations pay them fees up to 3 percent of sales volume. In return, they gain access to customers that buy billions of dollars of supplies and equipment. They also gain control over the products that hospitals purchase.

GPOs used to be like Costco, which receives dues from members and buys products wholesale from manufacturers at the lowest price and passes the savings on to members. That changed in 1986 when Congress granted GPOs an exemption from Medicare's antikickback laws, which unleashed a polished form of legal white-collar corruption.

GPOs' main source of revenue changed from hospitals to manufacturers of supplies, equipment, and drugs. If GPOs negotiate with a manufacturer for a lower price for antibacterial soap, for instance, their revenue will decline. So GPOs have an incentive to favor companies that sell the highest-price products and pay the largest fees.

In a classic monopoly, a GPO might sign a single-source contract with a manufacturer or vendor and receive a bonus for doing so. As with any monopoly, single-source contacts drive up prices and lock out companies that offer better products at lower prices.

Companies locked out of the market have sued and won. A jury awarded more than five hundred million dollars in damages against a manufacturer of hospital beds that used GPO contracts to exclude a competitor from the market.

The Department of Justice has investigated GPOs for allegations of anticompetitive behavior and kickbacks, but federal authorities have taken no action against a GPO in nearly a decade. Lawmakers in Congress and executive branch officials have protected the GPOs even though price transparency and competition at the wholesale level would save Medicare billions of dollars. Government-proffered privilege breeds corruption and undermines the integrity of a vital supply chain in the health care industry.

A trenchant analysis of GPOs alleges that they wield so much power that they, not clinicians, decide the drugs, devices, and supplies used in the hospitals.

If hospitals don't buy enough volume, they pay stiff financial penalties. These arrangements may explain why the Midwest surgeon who

reviewed the inventory in his operating room discovered excess supplies. To avoid big penalties, a hospital will purchase more than it needs.

Fraud in Medicare takes many other forms. As a former Medicare official explained to us, there are two kinds of Medicare fraud. The first type is perpetrated by criminal gangs. The government's fraud reduction is targeted largely at criminal gangs because the political cost is much lower. Low-level gangs don't have lobbyists.

The second type is white-collar fraud carried out by drug companies, device manufacturers, hospitals, doctors, hospices, dialysis facilities, and other providers. White-collar fraud is pursued much more delicately because the fraudsters may be well connected in the White House or Congress. Run-of-the-mill fraud turns into corruption when protected by government officials. A handful of white-collar cases might be prosecuted each year to give the public the impression that the federal government is tough on fraud. Corporate cases rarely name top executives and companies never admit wrongdoing. Fines are a small blip on the balance sheet. Federal investigators avoid treading on politically protected territory because a phone call can stop an investigation in its tracks. Both kinds of fraud consume 10 percent of Medicare spending, or nearly sixty billion dollars a year.

Financial finagling also occurs under the category of "improper payments." These are mistakes made because of errors in calculating payment. They are not considered fraud because of the absence of intent to deceive for inappropriate gain, or at least the absence of evidence to prove intent to defraud. Medicare made forty-eight billion dollars in improper payments in 2010. These payments also include those made without adequate documentation of the medical necessity for surgery or other treatments, which presents abundant opportunity for mischief.

A more mundane but rampant type of abuse occurred as we were writing this book. An organization that called itself American Seniors Assistance called one of us and asked if any seniors on Medicare lived in the house, and if so, did they have diabetes and arthritis. Sensing a scam and desiring to learn firsthand how Medicare is being abused, the reply was yes, a fictional older woman lived in the house and she had arthritis.

The caller asked if the senior had lower back pain and knee pain and offered to have a back brace and knee braces delivered to the house by mail that "will help the arthritis in her back and knees," and "all doctors are recommending it" at "no cost" to the senior. Then the caller inquired whether the fictional senior has trouble getting up from a sofa,

whether a private insurance company will deny payment for a treatment or test. Unwieldy competition has not produced this outcome. It breeds confusion and worry.

Test-driving an insurance plan isn't an option, nor is a trial run for surgery. Everyone pays for health insurance and treatment in advance. There is no money-back guarantee. If a treatment is effective, you pay. If it doesn't work, you pay. If a drug has terrible side effects, you can't return it. If a surgeon flubs a surgery, you'll probably still pay the copay. Reliable information about the quality of care and cost is sparse.

This is why the Nobel Prize–winning economist Kenneth Arrow wrote fifty years ago that a "laissez-faire solution for medicine is intolerable." Health care has unique features of uncertainty and risk, and he was right.

Competition and consumer choice in health care are not new ideas. During the Reagan administration, economists at the American Enterprise Institute and the Heritage Foundation promoted health care competition and choice. When applied to health insurance and health care services, the market doesn't work very well.

True devotees of free-market competition would be eager to instill competition in markets within the health care sector, where it would yield lower costs and improve the quality of products and services. Competition in the upstream wholesale market for hospital supplies and equipment, now the domain of group purchasing organizations, is an ideal example. Hospitals and other purchasers would save billions of dollars if they could buy products from a true Costco-like purchasing model. Curiously, competition in the wholesale market isn't promoted by advocates of competition. We wanted to understand why, so we ferreted out a true advocate of competition and learned the stark reality.

WHY REPUBLICANS DON'T LIKE *THIS* KIND OF COMPETITION

Governor Rick Perry, Republican governor of Texas and candidate for the Republican ticket in the 2012 presidential campaign, wrote in his book *Fed Up!*, "No issue is more critical to the defense of freedom and the American way of life than the preservation of our free-market health care system." Newt Gingrich penned the foreword.

In the Medicare prescription drug legislation that Gingrich championed, a free-market approach would have allowed the importation of prescription drugs from countries such as Canada, but the industry scuttled it. A drug such as Lipitor, which is used to treat cholesterol, is made in Ireland, imported to the United States, and shipped to Canada, but it cannot be imported back to America for sale at a lower price charged in Canada. During the legislative debate, Republican congressman Dan Burton, who wanted to legalize drug importation from Canada with safeguards, said, "That is unconscionable. . . . Here we are, going to spend billions and billions and billions and probably trillions of dollars on pharmaceutical products. . . . That's just not right."

That's what Michael Albano, mayor of Springfield, Massachusetts, thought too. To save his city and municipal workers money, he set up a prescription drug buying program in Canada for city employees, retirees, and their families. Health care spending was out of control, more than doubling in eight years, triggering layoffs of city teachers, firefighters, and policemen.

The city started the program with one-third of eligible employees, retirees, and dependents. Total costs for drugs dropped three million dollars.

Springfield is not a wealthy community, Albano said. Most children live at or below poverty and seniors cut their medicines in half so they last longer. Or they go without them.

"This was a good program that saved the city money," Albano said. "The average family saved a thousand dollars a year, and the average retiree saved four or five hundred dollars a year. We didn't even have a copay."

The city planned to include all ten thousand eligible people, but Albano began to feel the heat. He said he received a call from the U.S. Justice Department. "They threatened to indict me even though what I was doing was perfectly legal," he said to us. "The next day I held a press conference and invited everyone. I said, 'If you are going to indict me for getting lower prescription drug costs for my retirees, go ahead, make my day.'" That was the end of that, or so he thought.

Albano soon realized how deeply the system is stacked against good people who want to do the right thing. U.S. customs intercepted insulin for his son that had been mailed from a Canadian pharmacy. Albano had followed the law. He had a valid prescription. The drug purchase was for

will save $148 billion from 2012 to 2021, or about $15 billion a year, according to the Congressional Budget Office.

There are far better ways to save $15 billion a year. If the public could vote on options to save money, they would vote for these:

1. CREATE A COSTCO FOR HOSPITAL SUPPLIES AND EQUIPMENT: SAVE $5 BILLION A YEAR

The two-hundred-billion-dollar market for hospital supplies and equipment is riddled with waste. It accounts for nearly 8 percent of total health care spending in the United States. The market should operate like Costco and provide the most favorable deal to customers, in this case hospitals, ambulatory surgery centers, and other health care facilities that purchase everything from alcohol dispensers to oxygen tanks, infusion pumps, and CT scanners.

Congress needs to repeal the exemption from the federal anti-kickback law that benefits the few group-purchasing organizations that dominate the market. These organizations have the incentive to sell the most expensive products, at the highest possible volume, to health care facilities. This is why many hospitals around the country have expired and unused supplies in their inventory, as we revealed in chapter 11.

Proponents of competition and choice would be wise to direct their attention to fixing this market with price transparency and competition. Hospitals would save money, and they could better absorb reduced Medicare payments.

Savings of just 10 percent in this market would total twenty billion dollars a year. Medicare's share of the savings could be as much as five billion dollars annually because it accounts for about one-quarter of total health care spending. Even more savings can be gained from improving efficiency in this market.

Opposition from product manufacturers will be swift and fierce. But the option should be on the table so policymakers, the media, and the public know that there are ways to put Medicare on a sustainable financial footing without asking seniors and taxpayers to pay more.

2. CUT IMPROPER PAYMENTS TO HOSPITALS AND DOCTORS: SAVE $4.8 BILLION A YEAR

Medicare officials estimate that the program pays forty-eight billion dollars a year in improper payments. While some of these payments occur because of billing mistakes, the improper payments that everyone should be worried about are those made to hospitals and doctors for unnecessary heart surgeries, angioplasties, stents, and cardiac defibrillators, to name a few overused procedures.

Seniors receive no benefit, and worse, they are exposed to unnecessary risk and possible harm. The prevailing culture—"They harm you and they bill you for it"—needs to stop.

Medicare officials are trying hard to pare back improper payments. They receive a tsunami-like push back from hospitals and doctors who frame the issue as cutting patient access to care. If the public only knew the extent of improper payments and the harm they can cause, its voice could help fight an industry that believes it is entitled to the public's money when it bills for medically inappropriate services.

If just 10 percent of Medicare's improper payments can be stopped, Medicare would save nearly five billion dollars a year.

3. CUT MEDICARE PAYMENTS TO HOSPITALS FOR ROUTINE DOCTOR VISITS: SAVE $1 BILLION A YEAR

In 2011 Medicare paid about 80 percent more for a fifteen-minute office visit in a hospital outpatient department than if the same visit took place in a doctor's private office. Seniors pay higher copayments too.

As physicians sell their practices to hospitals in record numbers, more routine visits are occurring in hospital outpatient departments. Medicare Part B costs will increase dramatically and seniors will bear more of a burden without receiving any benefit.

The Medicare Payment Advisory Commission recommends that Congress authorize Medicare to pay the same amount no matter where the service is provided. This recommendation should be implemented. Medicare would save one billion dollars a year.

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