Medicare's Business Model – Hundreds of Health issues swirling around

Medicare's cost consistently grows 60% faster than inflation.[1] Medicare's[2] net outlays are about one fifth of the Federal budget,[3] on its way to one fourth. As these are 55% of the total, Medicare's budget[4] of $751 billion plus the $200 billion for Medicaid [5]SCHIP, is twice the spending of the Department of Defense.[6] In similar terms, the recent appropriation of $790 Billion for the financial sector to steady the worse stock crisis in 79 years is a $100 billion less than Medicare's every year, making Medicare a comparable financial event every eleven months. Medicare processes one point two billion claims a year, or a hundred million claims a month, or two thousand three hundred fifteen claims a minute, 24 / 7 / 365. The 75 year unfunded liability is $34 trillion.[7] Medicare is the health payment program for people age 65 and older (about 39 million), or those on permanent disability under Social Security (about 11 million) plus End Stage Renal Disease (300,000). Medicaid's enrollment is about 50 million.[8] 80 million Americans are under this health care coverage.[9]The total participants' proposals to ameliorate this collision course between the airplane of promises with the mountain of revenue spending are many.[10] But in reviewing those proposals, there is additional information which is not mentioned, or may have been considered, but isn't on the published lists.

There are 750,000 physicians in the U.S. as compared to 2 million attorneys. A fourth of the physicians are trained outside the country, and half of those are from Pakistan and India. There are 6 times the number of law schools now, as when the Association of American Law Schools was organized circa 1900. There are about the same number of medical schools (if not fewer) now as a century ago. There have not been enough medical schools to reach equilibrium to replace physicians dieing, retiring or disabled, much less sustain the growth of population needing health care for most of the twentieth century.

The Medicare business model of 1966, had many checks and balances which were only partially or never implemented. The following table discusses the Business model as designed, and the actual events, as reported. Medicare was never tried or implemented in accordance with the 1965 statute. We don't know if Medicare would work, as it has never been tried.

Abstract

This article tabulates the cost of healthcare, specifically the problem of administrative system unable to control waste or fraud due to overutilization by patients, and overprescription by physicians or hospitals or device manufacturers. When Medicare was adopted, the government had two decades of experience with health insurance coming out of the employer sponsored plans created during World War Two. The experience showed that the co-pay and deductible were reasonable requirements. The 20% co-pay meant if the patient thought the care was important, the patient would contribute one dollar for every four from the Government, and the patient would watch their own bills to make sure the charges were accurate, reasonable and necessary. If an overbilling occurred, the patient insured would complain, and not pay the co-pay. Likewise, the patient would not seek unnecessary services even if their portion was relatively reduced. Very few patients would want to waste their own money. Co-pay was adopted in Medicare, but almost immediately work arounds, circumvention, ignoring, waiving, or exempting co-pays became an industry wide practice inviting fraud, waste, and abuse. The article is a tabulation of hundreds of news reports dealing with Medicare co-pay and other cost issues.

Business Model, or **what Congress may have assumed when implementing Medicare**[11]	**Reality Check** as to what has happened to the business model and been reported since .	**Proposals** – many and varied

These are not in order of priority, or expense to the budget. The order is alphabetical for the first column

Aged and poor had a business model for help. Now some become poor to qualify for help. Medicaid covers the co-pay.	**Study Shows Increase Twice national average In Minnesotans On Medicaid.** **The Minneapolis Star Tribune (6/14/2012, Wolfe) reports on a study issued this week by the National Governors Association and the National Association of State Budget Officers, which found that "the number of Minnesotans on Medicaid shot up at nearly twice the national rate over the past two years, while state costs soared by 40 percent to surpass $4 billion for the first time." The piece notes, "While the weakened economy explains most of the rising Medicaid rolls in other states, much of Minnesota's increase came when Gov. Mark Dayton expanded the program by 80,000 people last year under an option in the federal Affordable Care Act**	Put a catastrophic cap on annual health costs, and people will not attempt to qualify for poverty to get Medicaid.
Aviation industry safety regulation model is not to have tens or hundreds of thousands of government inspectors monitoring safety, but to rely on the millions of eyes of non government pilots, airmen, customers, passengers, and shippers. This was a safety issue, and fraudulent repairs or fraudulent training have deadly consequences. The business model of medicare was to rely on co-pays and co-insurance, for the millions of eyes. That co-pays were ignored, meant it didn't happen.	**Ten Percent Of Medicare Budget Lost To Fraud.** ABC World News (3/1/2012, story 6, 2:50, Sawyer) reported, "This week, the FBI has been cracking down on Medicare fraud. It is estimated that 10% of the Medicare budget, billions and billions of taxpayer dollars, are lost to cheats and scammers." As these programs are 20 percent of the federal budget of 4 trillion dollars, that would mean 2% of the 4 trillion is lost to fraud every year, or 20% in 10 years, or $800 Billion.	**Stop medigap insurance, and require collection of co-insurance.** However, co-pays have disappeared into medigap insurance, Medicaid, or just never collected. The Result is fraud, in unknown quantities. Estimates are one dollar in ten, but the government just doesn't and can't know for sure.
Bribery and fraud. Blue Cross and Shield during WWII to act as governor against unnecessary	**GlaxoSmithKline To Pay $3 Billion To Settle Bribery, Fraud Allegations With US.** The announcement by the Justice Department of a settlement with drugmaker GlaxoSmithKline of bribery allegations generated heavy media coverage last	Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over

expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago. Off label use for drugs was legal if a Physician prescribed it. This eliminated any incentive for the drug company to get the drug approved for new uses.	night and this morning, including more than seven minutes of coverage on network newscasts. The CBS Evening News (7/2/2012) story 6, 2:50, Pelley) reported, "The US government is calling it the biggest case of healthcare fraud in American history. The British drug maker GlaxoSmithKline is accused of withholding important safety information about the diabetes drug Avandia [rosiglitazone] and illegally promoting two other drugs for unapproved uses. GSK agreed to pay $3 billion in fines." NBC Nightly News (7/2/2012) story 4, 2:00, Williams) reported, "At the launch of asthma drug Advair prosecutors say global drug giant GlaxoSmithKline pushed the sales force to push hard even for uses not Federally approved. Today the company admitted its sales force bribed doctors to prescribe its drugs by offering such incentives as Hawaiian vacations and tickets to Madonna concerts." ABC World News (7/2/2012) story 4, 2:15, Muir) reported, "The goal to rev up sales as part of what prosecutors say was a culture of greed where patient safety took a back seat to profit. The government claims GSK engaged in an illegal marketing campaign where drugs were promoted for disorders where there was no medical evidence they would help. Allegations of promoting the drug Paxil for treating depression in patients under age 18 even though the FDA's has never approved it for kids." The AP (7/3/2012) Holland) reports, "GlaxoSmithKline LLC will pay $3 billion and plead guilty to promoting two popular drugs for unapproved uses and to failing to disclose important safety information on a third in the largest health care fraud settlement in US history, the Justice Department said Monday. Accompanying the criminal case was a civil settlement in which the government said the company's improper marketing included providing doctors with expensive resort vacations, European hunting trips, high-paid speaking tours and even tickets to a Madonna concert." The Los Angeles Times (7/3/2012) Hsu) reports, "The agreement is the largest healthcare fraud settlement in history, spanning nearly every state, according to the Justice Department. It's also the largest payment ever by a drug company. The settlement is 'unprecedented in both size and scope,'" Deputy Attorney General James Cole said in a statement. The Philadelphia Inquirer (7/3) reports, "The $3 billion figure is the new record for pharmaceutical company financial settlements with the government over illegal marketing of drugs. The previous mark was the $2.3 billion paid by Pfizer in 2009."	use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago. Even auditing is unsuccessful, as this case was apparently brought under the whistleblower act, to wit, an employee or insider who ratted out the drug company.

USA Today (7/2) reports, "Under the terms of the plea agreement, GSK will pay a total of $1 billion, including a criminal fine of $956,814,400. The company also will pay $2 billion to resolve civil claims under the federal government's False Claims Act. Glaxo is pleading guilty to these violations of FDA regulations, which are misdemeanors. It has set aside $3.5 billion to cover the cost of the fines and other penalties related to the government's seven-year probe of the company's marketing practices for Paxil [paroxetin], Wellbutrin [bupropion] and Avandia, three of its blockbuster drugs."

Bloomberg News (7/3/2012) Feeley, Stern, Fisk) quotes Deputy HHS Secretary Bill Corr saying, "Today's historic settlement is a major milestone in our efforts to stamp out health care fraud. For a long time, our health care system had been a target for cheaters." Bloomberg adds, "Federal prosecutors began an investigation in Colorado in 2004, later taken over by the US attorney in Massachusetts, into whether Glaxo promoted drugs for unapproved uses and into ways Glaxo potentially influenced doctors."

In a front-page story, the New York Times (7/3/2012) A1, Thomas, Schmidt, Subscription Publication) reports, "The fine against GlaxoSmithKline over Paxil, Wellbutrin and Avandia makes this year a record for money recovered by the federal government under its so-called whistle-blower law. In May, Abbott Laboratories settled for $1.6 billion over its marketing of the antipsychotic drug Depakote. And an agreement with Johnson & Johnson that could result in a fine of as much as $2 billion is said to be imminent over its off-label promotion of another antipsychotic drug Risperdal."

The Washington Times (7/3/2012) Cunningham) reports, "The FDA, the FBI and the Department of Health and Human Services also helped to investigate GSK's illegal activities." The Times adds, "GSK agreed to plead guilty to a three-count criminal information, including two counts of introducing misbranded drugs, Paxil and Wellbutrin, into interstate commerce and one count of failing to report safety data about the drug Avandia to the Food and Drug Administration (FDA). GSK's guilty plea and sentence is not final until accepted by the US District Court."

The Wall Street Journal (7/3/2012) B1, Whalen, Barrett, Loftus, Subscription Publication) reports that GSK CEO Andrew Witty said in a statement, "Today brings to resolution difficult, long-standing matters for GSK. Whilst these originate in a different era for the company, they cannot and will not be ignored. On behalf of GSK, I want to express our regret and reiterate that we have learned from the mistakes that were made."

The Legal Times (7/3) reports, "GlaxoSmithKline agreed to a five-year

corporate integrity agreement, to be monitored by the Department of Health and Human Service's inspector general's office. GlaxoSmithKline must, among other things, change its executive compensation program to allow the company to recoup bonuses and long-term incentives if certain executives, or subordinates, engage in significant misconduct."

Forbes (7/3/2012) Herper) reports, "Glaxo's shares are up on a down day for the Dow and for rivals such as Merck, Pfizer, and Novartis. The stock's rise reinforces the idea that criminal fines for giant drug companies, no matter how big, are less a deterrent than a cost of doing business. If Glaxo feels the need to avoid doing the wrong thing again, it will be as much because of the harms that the various scandals here have already done to its business as because of this settlement, which essentially clears the deck for the company on a great many infractions, large and small, over the course of a decade. Settling these matters didn't change Glaxo, but the process of fighting them may have."

States Announce Shares Of Settlement. The Boston Herald (7/3/2012) Szaniszlo) reports that GlaxoSmithKline "will pay more than $35 million to the Massachusetts Medicaid Program as part of the nation's largest-ever health-care fraud settlement, Massachusetts Attorney General Martha Coakley said today. The AG's office led the state negotiations as part of a $3 billion settlement with federal and state authorities to resolve allegations that the company engaged in various illegal schemes related to the marketing and pricing of a wide range of drugs that it manufactures."

The Boston Globe (7/3) reports that Massachusetts Attorney General Martha Coakley said "Widespread marketing, with misrepresentations about the safety and efficacy of these drugs, can give doctors a false sense of security. And this ultimately has an impact on consumer safety."

The Bangor (ME) Daily News (7/3) reports, "Maine Attorney General William Schneider said in a statement that GlaxoSmithKline 'put the health of patients at risk and imposed enormous costs on Medicaid and taxpayers.' In Maine, the $4.4 million in settlement money will flow to the state's MaineCare program, which administers Medicaid services."

The AP (7/3) reports, "Michigan Attorney General Bill Schuette says the state is in line to get $23.8 million as part of a $3 billion settlement of an improper drug marketing case against GlaxoSmithKline LLC."

The New York Post (7/3) reports, "New York stands to receive $146 million" from the settlement. "New York Attorney General Eric Schneiderman says the record recovery will go to the state's Medicaid program."

The Denver Post (7/3/2012) Keller) reports that Colorado will receive more

than $4.5 million from the settlement.

The Denver Business Journal (7/3/2012) Subscription Publication) reports that Colorado Attorney General John Suthers' Medicaid Fraud Control Unit "was part of what Suthers described as 'a small team' that represented all of the states in the settlement, which was the result of government investigations and a string of whistle-blower lawsuits. 'These funds are a significant recovery for Colorado's Medicaid program,' Suthers said."

The Business Courier of Cincinnati (7/3/2012) Subscription Publication) reports, "Ohio Medicaid will receive $40 million in recoveries from GSK, with about $17 million of that going to the state and the rest going to the federal government."

The Milwaukee Business Journal (7/3/2012) Subscription Publication) reports, "The Wisconsin Medicaid program will receive a total of $9.6 million under the settlement, Wisconsin Attorney General J.B. Van Hollen said."

The Arkansas Business (7/3) reports, "Arkansas Attorney General Dustin McDaniel said Monday that Arkansas will get a $2 million share" of the settlement.

WPRI-TV Providence, RI (7/3) reports, "Of the $3 billion, Rhode Island's share is more than $4 million. Most will go to Medicaid in the state -- which is the very program GSK is accused of defrauding."

The South Florida Business Journal (7/3/2012) Subscription Publication) reports, "Florida will receive more than $56 million as part of" the settlement, "Attorney General Pam Bondi said on Monday."

The Wilkes Barre (PA) Times-Leader (7/3) reports that Pennsylvania Attorney General Linda Kelly "announced that Pennsylvania will receive more than $13 million" from the settlement.

The Financial Times (7/3/2012) Jack, Subscription Publication), Reuters (7/3), the Guardian (UK) (7/3), the Atlanta Business Chronicle (7/3/2012) Subscription Publication, Couret) , the Boston Business Journal (7/3/2012) Donnelly, Subscription Publication), the Arkansas Times (7/3), and the Dayton Business Journal (7/3/2012) Subscription Publication) also report on the settlement.

Dr. Drew Alleged To Take Payments From GSK To Promote Off-Label Claims.

The Wall Street Journal (7/5/2012, Whalen, Subscription Publication) reports in continuing coverage of a $3 billion settlement made by GlaxoSmithKline PLC with the US government for among other charges, promoting medications for uses not approved by the Food and Drug Administration. One of those

	promotions involved payments totaling $275,000 to Dr. Drew Pinsky, who hosted a radio show called "Loveline" as "Dr. Drew." He promoted the use of Wellbutrin for not suppressing "sexual arousal" as other antidepressants do, though the medication's label does not include such a claim. Other physicians are also alleged to have taken large payments from the firm or others associated with it and promoted its medications by making claims not supported by the label. The New York Daily News (7/4, Goldwert) reports that Pinsky "touted Wellbutrin SR for its ability to 'increase libido' in depressed patients. GSK did not have FDA approval to promote its drug as having fewer sexual side-effects." And "GSK also encouraged doctors and medical health-experts to prescribe Wellbutrin for non-FDA approved treatment for weight loss, ADHD and drug addiction." NPR (7/4, Hensley) reports in its "Shots" blog, "As part of a landmark $3 billion settlement of health fraud charges by GlaxoSmithKline, the government released a slew of documents that serve as a one-stop guide to alleged sales practices that ran rampant for years." And "Glaxo CEO Sir Andrew Witty said in a statement that the practices 'originate in a different era for the company' and that it has turned over a new leaf." The blog cites "Glaxo's alleged hiring of celebrity doctor Drew Pinsky through a PR firm to talk up the unproven use of the antidepressant Wellbutrin SR as a remedy for sexual dysfunction." ***Former GSK Executives Cited In Report Now Lead Other Firms.*** Bloomberg News (7/4, Kitamura) reports, "Two senior executives at GlaxoSmithKline Plc (GSK) singled out by the US Justice Department for pushing the Advair asthma drug for unapproved uses have moved on to some of Europe's top pharmaceutical companies. Jean-Pierre Garnier, chief executive officer from 2000 to 2008, is chairman of Swiss drugmaker Actelion Ltd. (ATLN), while Chris Viehbacher, Glaxo's former president of US pharmaceuticals, is CEO of Sanofi."	
Co-insurance does respond to usage. Providers know this, so they need or look for alternatives so patients get care entirely free of cost to the patient. As long as the patient has no skin in the game, many, most or all	**Texas Health Officials To Exempt Some Providers From New Medicaid Policy.** The Fort Worth Star-Telegram (2/24/2012, Branch) reports that Texas "health officials say they will exempt some providers from a new Medicaid policy that critics warned would disrupt cancer and mental-health treatments for the poorest and sickest Texans." At the beginning of this year, the state's Medicaid program stopped paying the entire co-payment for so-called "dual eligibles." However, "certain providers, including oncologists, psychologists and psychiatrists,	Ban 100% Medigap coverage insurance. The co-pays for Medicaid are better health programs than the non Medicaid can obtain, the so called high end or deluxe health plans (some unions or

patients, will not monitor treatment, or actively participate in therapy.	complained that the change could force them to limit the number of dual-eligible patients they treat because the cost of service wouldn't be adequately covered." Now, "under adjustments to the policy, providers of mental-health services and portable X-rays will be exempted from the new rules by May 1, said Stephanie Goodman, a spokeswoman for the Texas Health and Human Services Commission."	small businesses obtain).
Co-insurance was to monitor usage so that beneficiaries would have an interest in their health care. However Medicaid completely eliminated this feature, so that all care was government paid. A relatively small patient model consume the lion's share of benefits. Conn's population 2011 was 3.58 million. But 1.6 percent use. At $4 Billion annually, these 57 thousand patients consume $1.6 billion a year or $27,800 per patient per year.	**Connecticut Tries To Design A Better System For High-Need, High-Cost Clients.** The Connecticut Mirror (4/13/2012, Becker) reports "a group of just over 57,500 people represents nearly 40 percent of the cost of Medicaid, the largest single item in" Connecticut's budget, and "despite the price tag and dual insurance coverage, state officials and advocates say, the health care they receive is often inadequate." Connecticut "officials are hoping to design a better system and are applying to run a federal demonstration project that could net the state additional funding if it saves Medicare money." The proposed "model, outlined in a draft application slated to be submitted to the federal government next month, calls for improving care coordination, in part through creating 'health neighborhoods' -- teams of health care providers who would take a more holistic approach to a person's care."	Don't cover 100%. If needed for the poorest, cover 99%, but leave some incentive to self monitor their care.
Co-insurance would monitor use and fraud. It is an out of pocket reminder to users. Thus patients would not allow products or supplies to be sent to homes with bills, if the supplies were useless.	Medicaid pays the co-pay and deductible, so there is no incentive to conserve among the dual eligible, or disincentive to waste. The Government pays both sides, i.e. the charge and the co-pay.[12]	Put Medicaid on co-pay and deductible.
Co-insurance would monitor use. Why spend your own money, even if it was only a portion of the bill, if you were not ill or in need?	3d Party Medigap plan insurance picks this up, so there is no out of pocket. Ads on TV for scooters announce "no out of pocket", "no cost to you" "free"	Ban 100% Medigap plan coverage insurance.
Co-pay and co-insurance	**Sen. Conrad Optimistic That Viable Options For Curbing Medicare**	Why patients would

were to act as a caution for useless health care. Even if the state was paying 80%, the out of pocket was a thought provoker. But the breakdown of these, lead to quantity needs for providers and suppliers.	**Spending Exist.** CQ (3/1/2012, Ethridge) reports that "the Senate Budget chairman entered Wednesday's hearing about curbing Medicare spending as a skeptic, but he left optimistic that viable options exist after hearing witnesses agree on approaches to overhauling the program's payment structure." All "three expert witnesses at Wednesday's hearing called for a structural overhaul of the payment system, saying it encourages patients and providers to prioritize quantity over quality of services."	prioritize quantity of quality is unexplained. I don't think patients do want quantity over quality. But providers do. Solution: implement co-pays and co-insurance.
Co-pay and co-insurance were to act as a caution for useless health care. Even if the state was paying 80%, the out of pocket was a thought provoker. But the breakdown of these, lead to fraud. Besides the Provider number for a Medicare claim, the beneficiary's number is also required	**Stolen Provider Number used by Philadelphian Pleads Guilty To Healthcare Fraud.** The Philadelphia Daily News (6/28/2012, Hinkelman) reports that Tahib Smith Ali, owner of the Oasis Holistic Healing Village, "pleaded guilty to 50 counts of health-care fraud, 50 counts of making false statements and one count of aggravated identity theft. US District Judge Mitchell Goldberg did not set a date for sentencing." Federal prosecutors said that "Ali had no license or medical certification" although he did hire "a licensed chiropractor." He "could face as many as five years in a federal lockup, including a mandatory minimum two years for stealing the identity of Paul Bodhise, the licensed chiropractor from whom Ali bought the business." That's because he "submitted more than $1.4 million in fraudulent claims for chiropractic services to Independence Blue Cross under Bodhise's name and medical provider number."	Chiropractic care is billed under Part B with a 20% copay. At $35 per treatment, this owner billed for about 40 thousand treatments. If the beneficiaries were paying co-pays of $350 thousand dollars as expected and required, they would have complained and reported that Bodhise had not treated them. The fraud would have been uncovered long before a million dollars was stolen.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never	**Texas Doctor Charged With Record Level Of Medicare Fraud.** The arrest of a Texas doctor for an unprecedented degree of healthcare fraud is being covered by nearly all major US daily newspapers in addition to a Tuesday mention on the CBS Evening News (2/28/2012, story 8, 0:30, Pelley), which reported on the "breathtaking indictment in Texas," where "federal authorities are accusing a single doctor and six other people of stealing $375 million from Medicaid and Medicare. They allege they did it in only five and a half years. Prosecutors accuse Jacques Roy and the others of submitting claims for 11,000 patients who didn't need treatment." The AP (2/29/2012) says Roy sought "to bill Medicare for home health	Enforce co-pay, which will stop phantom patient fraud.

collected, except with medigap insurance coverage.	services that were not properly billed, not medically necessary or not done." The wrongdoing allegedly took place up until November of last year and represents the "largest dollar amount" ever uncovered in such a scheme by a task force of the Health and Human Services Department, which was created to combat Medicare fraud. According to the New York Times (2/29/2012, A18, Thomas, Subscription Publication), prosecutors said the scheme was "brazen" in that it "involved registering homeless people for home health care services they never received." A federal indictment referred to the operation as "staggering in its breadth and scope." Roy "ran an association of health care providers that certified patients for home health care and performed home visits. Even though he had only four doctors and about 15 nurses on his staff," the 11,000 patients he claimed to service would make his practice the largest in the US, which clearly wasn't accurate. The Wall Street Journal (2/29/2012, Zimmerman, Radnofsky, Subscription Publication) says a joint investigation by the HHS, FBI, and the Medicaid Fraud Control Unit of the Texas Attorney General had been underway for a year. In addition to the fake Medicare claims, there was also $24 million of fraudulent Medicaid claims. If convicted, Roy faces up to 100 years in prison and forfeiture of $18.5 million. The Los Angeles Times (2/29/2012, Serrano) says Roy's arrest "comes at a time when healthcare fraud is sharply increasing, with fewer people able to afford doctor visits and Medicare and other government programs paying less in reimbursements." In coincidental timing, Attorney General Eric Holder testified at a House Appropriations subcommittee hearing on Tuesday that efforts to thwart healthcare fraud were being ramped up. Holder noted the recovery of $4.1 billion in "stolen" funds last year was "the highest amount ever recovered in a single year." The Washington Post (2/29/2012, Horwitz) quotes HHS Inspector General Daniel R. Levinson, who said, "Using sophisticated data analysis, we can now target suspicious billing spikes." He noted that "the analysis found that in 2010, Roy 'certified' more than 5,000 patients for home health care; 99 percent of physicians certified no more than 104 people for such care." Also reporting this story are USA Today (2/29), the Washington Times (2/29, Cunningham), Bloomberg News (2/29, Stern), CQ (2/29, Norman, Subscription Publication), the Houston Chronicle (2/29, Langford), the Dallas Morning News (2/29, Trahan), the Fort Worth Star-Telegram (2/29), and The Hill (2/29, Pecquet) "Healthwatch" blog.	

Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	. **Colon Cancer Survivors, Advocates To Lobby Against Medicare Co-Pay For Polyp Removal.** The Hill (7/17/2014, Viebeck) reports on a planned Capitol Hill meeting in which "more than 30 advocates and survivors" of rectal and colon cancer will argue that "Medicare beneficiaries should not have to render a co-pay for a routine colonoscopy if a polyp is removed during the procedure." The Hill notes that these lumps of tissue, known as polyps, does not generally trigger cost-sharing in private health insurance," and the cost may serve as a deterrent for people who would otherwise get the screening.	1. Co-pay isn't collected any way. 2. The argument that co-pay deters people who don't want to pay the cost. Bingo, that is the whole idea of copay. 3. The waiver is pushed by providers who want more business.		4. **Color Medic** 5. The Hill advocate should n procedu generall for peop 6.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage, which is still of no concern to the patient.	**Two Physicians Accused Hospital Company Of Kickbacks.** The Charlotte (NC) Observer (1/2/2014, Garloch) reports on allegations of kickbacks against Health Management Associates, which is "the fourth-largest for-profit hospital chain with 71 hospitals in 15 states." Doctors Thomas Mason and Steven Folstad filed a lawsuit against the company and two hospitals it owns in 2010 for allegedly offering "illegal kickbacks to order unnecessary tests and admit more patients to increase corporate revenues." The suit was recently unsealed "after the U.S. Department of Justice decided to join the suit in connection with some of the doctors' claims against HMA."	If the 20% co-pay were charged and collected, the beneficiaries who had unnecessary treatment would have complained.		
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have	**New York City Health Department Accused Of Medicaid Fraud Scheme.** The New York Times (10/28/2014, A1, Weiser, Subscription Publication) reports in a front-page story that New York City's Department of Health and Mental Hygiene has been accused by Federal authorities of running "a five-year scheme to defraud Medicaid," working with contractor Computer Sciences Corporation to exploit loopholes in the program's computerized billing system and "collect reimbursements that amount to tens of millions of dollars."	If the 20% co-pay were charged and collected, the beneficiaries who had unnecessary treatment would have complained earlier than the 5th year.		

encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage	Manhattan US Attorney Preet Bharara said the city and the contractor "created computer programs that systematically, and fraudulently, altered billing data in order to get paid by Medicaid as quickly as possible and as much as possible." The lawsuit stems from a whistle-blower's complaint and was filed under the False Claims Act. The suit did not specify how much it is seeking but does demand "triple damages and penalties." Bloomberg News (10/28/2014, Gullo) reports that in response to the lawsuit, CSC spokesman Richard Adamonis denied the allegations, saying "the company didn't submit any claims to Medicaid for which the city wasn't entitled to be paid and Medicaid would have paid out the same amounts of funds for early intervention care 'irrespective of any claims processing issues.'" The AP (10/28/2014) reports that the city's law office contends "the case involves 'technical billing issues, not fraud.'" Also reporting are Reuters (10/28/2014, Stempel, Raymond) and the New York Post (10/28, Tacopino).	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**Four Arrested In Texas For Medicare, Medicaid Fraud.** The AP (6/29) reports, "Federal prosecutors announced the arrests Thursday of 39-year-old Marcello Herrera, owner of RGV DME, a durable medical goods supplier, and his wife, Carla Cantu Herrera, both of Mission. Two former employees also were arrested. Prosecutors allege the now-defunct company submitted claims between 2004 and 2010 to Medicare and Texas Medicaid totaling $11 million and received $7.1 million in reimbursement." Reuters (6/29, Taylor) reports that US Attorney Kenneth Magidson, of the Southern District of Texas, announced the arrests and said that up to 90 percent of the claims were fraudulent.	If the 20% co-pay were charged and collected, the beneficiaries who had unnecessary treatment would have complained earlier than the 7th year.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay	**How to Provide Universal Health Care Using One Easy Trick** https://townhall.com/columnists/anncoulter Ann Coulter TownHall.com **Posted: Mar 02, 2017 8:20** The only complicated part of fixing health care is figuring out how to take care of the other 10 percent of Americans -- the poor, the irresponsible and the unlucky. And the only reason that is complicated is because of fraud. The first sentence of Congress' Obamacare repeal should read: "There shall be a free market in health insurance."	If the 20% co-pay were collected, beneficiaries who had unnecessary treatment would balk, and not pay it raising the red flag, there is a problem here.

so it is seldom or never collected, except with medigap insurance coverage	Right there, I've solved the health insurance crisis for 90 percent of Americans. Unfortunately, no one can imagine what a free market in health care looks like because we haven't had one for nearly a century.[13]	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**Medicaid enrollment is expected to surge by nearly 12 percent next year in states expanding the program under the health law, but even states that will not expand eligibility** project a 5 percent jump in the number of people enrolled in the state-federal health insurance program for the poor, according to a new report issued Monday. **Total federal and state spending on Medicaid in 2014 is** expected to increase 13 percent in states that expand eligibility, and nearly 7 percent in those not expanding, said the survey of state Medicaid officials by the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. State spending growth was slightly lower for the 25 states that are moving forward with the Medicaid expansion (4.4 percent) compared to the remaining states (6.1 percent). The lower growth rates for the states that are expanding may be in part because many project they will save money as new federal dollars replace state spending on the poor, the report said. Twenty five states (including the District of Columbia) are expanding Medicaid to cover everyone under 138 percent of the federal poverty level, or $15,856 for an individual in 2013. The expansion was made optional by the Supreme Court last year. Although the federal government is paying full cost of the expansion through 2016 and no less than 90 percent thereafter, many Republican-controlled states said they could not afford the expansion. States who opted against the expansion will still see enrollment and spending increase under existing eligibility guidelines because of intensive outreach efforts related to the health law and because the makes it easier to sign up for coverage through the new online health insurance exchanges, the report said. Kaiser Health News by Phil Galewitz October 8 2013	The movement has been away from co-pay.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never	The CMS booklet Medicare & You up to the year 2010, had Copayment listed in the index in about 8 sections and on 25 pages. But starting in the Medicare & You 2011 and again in 2012 editions, copayment has been dropped from the index**.** By 2016, it was dropped from the book. Co-pay? What's that?	Return to co-pay and watch the fraud and over utilization wind down and eventually stop.

collected, except with medigap insurance coverage.		
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**New York State Recovers $335 Million In Medicaid Fraud.** The Greater Binghamton (NY) Press & Sun-Bulletin (1/23/2013, Bakeman) reports that, according to the New York state attorney general's office, New York "recouped $335 million in Medicaid funds in 2012 that had been obtained or spent fraudulently, the highest recovery in seven years." This total included a "$146 million settlement from pharmaceutical company GlaxoSmithKline, which had illegally marketed and priced its drugs;" the payment was part of a $3 billion, multi-state settlement. Attorney General Eric Schneiderman was quoted, "Part of my first major initiative when I took office was to bolster the Medicaid Fraud Control Unit with additional prosecutors, investigators, and auditors, in order to even more aggressively root out fraud and return money illegally stolen from New York taxpayers and their government." The AP (1/24/2013) reports, "One of the unit's most notable victories last year was the shutdown of a scheme to distribute black market prescription HIV drugs through a Long Island-based pharmacy that billed Medicaid more than $155 million." According to the National Association of Medicaid Fraud Control Units, "Typical frauds include *medical providers billing for services they never gave, double billing Medicaid and private insurers, phantom patient visits and falsifying symptoms or diagnoses to bill for unnecessary services and tests*." The Syracuse (NY) Post-Standard (1/24, Mulder) also covers the story.	Co-pay solves each of these frauds: 1) Phantom services, when the bill for the co-pay arrives, the patient asks 'Huh? What? I never ordered this." 2) double billing, when the 2nd bill arrives, the patient asks "huh? What? I already paid this." 3) Phantom visits, when the bill for co-pay arrives, the patient asks "huh? What? I never went." The problem of false symptoms or diagnoses is a not prevented by co-pay, as the patient won't know what the basis for these tests would be. But if the symptoms are too excessive of experience or history, they can be caught and monitored by the computer entry. Thus medi-gap insurance or waiver of co-pay is a pernicious undermining of the Medicare business model, as it has removed 40 million pairs of eyes from the bills.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims,	**Oklahoma Filed Medicaid Fraud Charges Against Pure Hope.** The AP (6/20/2012) reports, "The Oklahoma attorney general's office has filed Medicaid fraud charges against several employees of" the Pure Hope	Co pay is the protection against no service fraud.

including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	Corporation for "alleged involvement in a scheme to bill for sessions without providing services," including Pure Hope executive director and owner Bobby Harlan Long.	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage. To audit all accounts every day would require 1 million auditors to watch 50 million accounts and audit 1200 claims every man year of 175 days.	**GAO Report: Medicaid Fraud Program Cost US Millions.** Bloomberg News (6/14/2012, Wayne) reports that the Government Accountability Office has determined that "a program to fight fraud in the Medicaid health system for the poor has cost the US at least $102 million in auditing fees since 2008 while identifying less than $20 million in overpayments." Peter Budetti, the director of program integrity at the Centers for Medicare and Medicaid Services, said that "three companies won't have their contracts renewed, and two others will be reassigned." He remarked, "The results were extremely disappointing, way below what the expectations had been	Relying on auditing is counter productive. Use the business model wherein people won't spend money if it doesn't help them.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never	**Business Owner Accused Of Healthcare Fraud To Pay Millions In Restitution.** The AP (6/14/2012) reports that Lance Faulkner, "a prosthetics business owner who pleaded guilty to health care fraud has been ordered to pay more than $4.6 million in restitution." The piece notes that "prosecutors allege he billed Medicare and Medicaid for beneficiaries who didn't have prescriptions for the prosthetics from a license physician or other qualified health care provider." The Oklahoman (6/14/2012, Kelley) reports, "Along with the restitution, Faulkner will spend 51 months in prison and have to complete 104 hours of community service. He will be on probation for two years, according to court	Would beneficiaries take prosthetics they didn't need if they had to fork over their co-pays? I don't think so.

collected, except with medigap insurance coverage. Same with suppliers.	documents." The piece notes that "the case was investigated by the FBI and Office of Inspector General for the U.S. Department of Health and Human Services, and prosecuted by Assistant U.S. Attorney Amanda Maxfield Green."	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**Social Worker Pleads Guilty To Medicaid Fraud.** The St. Louis Post-Dispatch (6/14/2012) reports that Abdullah Jamaal M. Ali, "a licensed clinical social worker has pleaded guilty and was sentenced to five years in prison for submitting false claims to Medicaid for counseling services he did not perform." The piece notes that Attorney General Chris Koster's "Medicaid Fraud Control Unit investigated and prosecuted the case, and found that Ali claimed he provided family therapy to children when the children's family members were unavailable for the session, such as times they were at work; therapy services to two different children at two different locations at the exact same time; and in-home therapy to children after 9:00 p.m., when the families reported that Ali was never at their home during that time."	The 1st time a beneficiary got a bill for co-pay which they didn't get counseling, they would squeal like a stuck pig. Use co pays to avoid a social worker's fraud.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. It applied to Part B physicians but not Part A Hospitals. But a statute bans fraud waste and abuse. So the no-pay was started for Part A.	**Hospitals Paying More Attention To Safety Protocols.** American Medical News (5/14, O'Reilly) reports, "The 2008 'no-pay' rule adopted by the Centers for Medicare & Medicaid Services to encourage hospitals to stop medical complications has led to consistently funded infection control departments, more collaboration with physicians and other front-line staff, and higher compliance with evidence-based guidelines," according to a study published in the May issue of the American Journal of Infection Control. "More than 80% of infection-control professionals believe the CMS policy has led to greater focus on the health care-associated infections targeted under the rule," the survey of "317 infection preventionists at a nationally and industrially representative sample of hospitals" found.	The laws already exist to stop waste.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. CO-pay applied to Part B physicians but not Part A Hospitals.	**Enhancing Physicians' Use of Clinical Guidelines From JAMA by Peter J. Pronovost** 18xii2013 A dozen years ago, investigators identified adherence barriers to help guideline developers and other stakeholders design strategies to increase guideline use. Today, adherence to guidelines often remains low, causing omission of therapies recommended in the guidelines and contributing to preventable harm, suboptimal patient outcomes or experiences, or waste of resources. In part because of inadequate adherence to guidelines, preventable harm is the third leading cause of patient death, and one-third of health care spending—estimated at nearly $1 trillion, or $9000 per household—is for therapies that do not improve patients' health. One estimate suggests that each	Physicians practice medicine, insurance policies do not.

	year, 200 000 patients die from sepsis, 120 000 from teamwork failures, 100 000 from health care–acquired infections, 100 000 from venous thromboembolism and pulmonary embolus, 80 000 from diagnostic errors, and 68 000 from decubitus ulcers. Not all of these deaths are preventable, but many could be avoided if clinicians reliably used evidence-based therapies, many of which are included in guidelines. Increasing evidence suggests that harms once deemed inevitable, such as central line–associated bloodstream infections, are largely preventable. The Centers for Disease Control and Prevention (CDC) estimated that 100 000 to 200 000 fewer of these infections occurred in intensive care units (ICUs) between 1990 and 2010. One in five patients who develop these infections will die, and each infection costs approximately $40 000.	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the co-pays are universally waived and go uncollected.	**HHS Rule Would Give States Freedom To Charge Medicaid Patients More.** The New York Times (1/23/2013, A12, Pear, Subscription Publication) reports on a proposed Federal policy which "would give states more freedom to impose co-payments and other charges on Medicaid patients," meaning that "millions of low-income people could be required to pay more." The article explains that, "hoping to persuade states to expand Medicaid [under the Affordable Care Act], the Obama administration said state Medicaid officials could charge higher co-payments and premiums for doctors' services, prescription drugs and certain types of hospital care, including the 'nonemergency use' of emergency rooms." Under the rule, "a family of three with annual income of $30,000 could be required to pay $1,500 in premiums and co-payments."	Sure, have co-pays that aren't collected at $1,500, why not uncollected co-pays at $5,000, which sounds or looks even better. But it won't make any difference, as 100% of nothing is still nothing. The only time co-pay is attempted collection is to send a message the provider doesn't want your business.
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the co-pays are universally waived and go uncollected in Medicaid.	**Study Finds Medicaid Expansion May Not Reduce ED Use.** Research suggesting that Medicaid expansion may not lead to a reduction in emergency department use was covered on one of last night's national news broadcasts, in print in several newspapers, including in two front-page stories, and on several websites. Nearly all sources point out that the findings appear to refute the contention, often espoused by supporters of the Affordable Care Act, that expanding Medicaid would reduce ED use. The CBS Evening News (1/2, story 5, 2:00, Dubois) reported, "A new report out today calls into question one of the main goals of the" ACA: "to get people to stop using the emergency room	Sure, have co-pays that aren't collected at $1,500, why not uncollected co-pays at $5,000, which sounds or looks even better. But it won't make any difference, as 100% of nothing is still nothing. The only time co-pay is

	as their primary care doctor by making more of them eligible for Medicaid." The New York Times (1/3/2014, A1, Tavernise, Subscription Publication) reports on its front page that the research, "published in the journal Science, compared thousands of low-income people in the Portland," Oregon "area who were randomly selected in a 2008 lottery to get Medicaid coverage with people who entered the lottery but remained uninsured." Individuals "who gained coverage made 40 percent more visits to the emergency room than their uninsured counterparts." The researchers found that "the pattern was so strong that it held true across most demographic groups, times of day, and types of visits, including for conditions that were treatable in primary care settings." The Washington Post (1/3/2014, Kliff), in its "Wonkblog," and in print, points out that "when Congress was debating the Affordable Care Act in 2009, Health and Human Services Secretary Kathleen Sebelius cited the high number of uninsured Americans being seen at the emergency department as a reason to pass the law." In a statement at the time, she said, "Our health care system has forced too many uninsured Americans to depend on the emergency room for the care they need." She added, "We cannot wait for reform that gives all Americans the high-quality, affordable care they need and helps prevent illnesses from turning into emergencies." In a front-page story, the Wall Street Journal (1/3/2014, A1, Beck, Subscription Publication) reports that ACA critics said that the results verified their contention that expanding Medicaid would lead to higher, not lower, costs. The Los Angeles Times (1/3/2014, Morin) "Science Now" blog reports, "When surveyed by researchers, Medicaid recipients said coverage had helped improve their general health, reduce depression and relieve financial pressure, although medical data failed to show a significant change in measurable health indicators such as blood pressure and cholesterol levels." The researchers also found that the increased ED "use...was solely the result of outpatient visits; it was not accompanied by an increase in actual hospital admissions." The AP (1/3/2014, Cooper) reports that the researchers found that while "men were more likely than women to have additional ER visits...there was no racial, age or other groups that saw a statistically significant decrease in ER usage among the people selected for Medicaid." The researchers warn "against concluding that ER use rose because there wasn't enough access to primary care," as their previous indicated "that Medicaid patients reported more visits to doctors' offices and use of preventive care." The Boston Globe (1/3/2014, Conaboy) reports, however, that the researchers "noted that their study did not draw any conclusions about whether	attempted collection is to send a message the provider doesn't want your business. Result, the emergency rooms will still have a steady business.

	an increase in emergency department use is good or bad, for patients or the health care system." Additionally, "they...say the study population was not representative of people being added to Medicaid rolls nationally; the participants were largely white and urban." Bloomberg News (1/3/2014, Wayne, Smialek) reports that in an email, CMS spokeswoman Emma Sandoe said, "Before Jan. 1, it used to be the case that many people could not afford coverage or were denied coverage altogether due to pre-existing conditions." She added, "Today, those with coverage will have the peace of mind that they will be able to get the care they need or to afford a life-saving visit to the emergency room." **The Washington Times (1/3/2014, Howell) points out that while "it is unclear what" impact these findings may "have on state officials who are mulling the Medicaid-expansion question...White House deputy senior adviser David Simas said Thursday it 'is the right thing to do.'"**	
Co-pay by beneficiaries is the minute by minute check on fraudulent claims, including unnecessary services, overbilling, and poor service. But the government has not enforced co-pay and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**Federal Court Convicts Michigan Gynecologist Of $6.7 Million Medicare Fraud.** The Detroit Free Press (5/12, Baldas) reported that Sterling Heights gynecologist Jonathan Agbebiyi was convicted Friday by a federal jury in Detroit of conspiracy and healthcare fraud in a $6.7 million Medicare billing scheme. Agbebiyi recruited patients with everything from drugs to fast food in order to perform neurological tests that were not ordered by a referring doctor and resulted in no follow-up treatment. Nine other people have been convicted in the case, which involved three clinics in Livonia. US Attorney Barbara McQuade said Agbebiyi "exposed patients to neurological testing solely to generate money for himself." [14]	Physician claims have a 20% co-pay under Part B. Patients would not pay the 20% if they were lured by fast food. The co-pay would have prevented the fraud.
Co-pay by beneficiaries is the minute by minute check on unnecessary services, overbilling, and poor service. But the government has not enforced co-pay for hospitals and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage.	**Medicare Launches Two "Pay-For-Performance" Initiatives.** In continuing coverage, The Hill (10/2/2012, Viebeck) "Healthwatch blog" reports on two initiatives Medicare launched Monday, which "reward hospitals for good clinical practices and penalize them for high readmission rates." The first program, the Value Based Purchasing Program, entails Medicare retaining "1 percent of its hospital reimbursements and redistribute the money based on how well hospitals adhere to clinical guidelines and score on patient-satisfaction surveys." In the second program, "Medicare will begin penalizing hospitals with high readmission rates among heart attack, heart failure and pneumonia patients." The CBS Evening News (10/1/2012, story 7, 2:40, Pelley) ran a piece on	Let the patients decide if they are treated satisfactorily. This computer driven program will not solve the perceived problem of poor service or over utilization. I also assume these hospitals never collected their co-pays for Part A (nor made an

The 1st day of Part A hospitalization is supposed to be $1,000. If it were collected, Medicare would not have the problem described next, attempting to be solved as "pay for performance."	the new Medicare initiatives Monday night, referring to them as "a little-known piece of the healthcare reform law." CBS (Werner) reported, "Federal officials are concerned that many Medicare patients fail to get the necessary follow-up care and end up being readmitted to the hospital, often in the same month. So the government is now penalizing hospitals for excessive re-admissions in three areas: Patients recovering from heart failure, heart attacks, or pneumonia. In a problem hospital, if a released patient comes back within 30 days, there's a 1% penalty. Twenty-two hundred hospitals--roughly two-thirds of those receiving Medicare--will forfeit money. Up to 1% of a hospital's Medicare reimbursement. For example, if a hospital submits a $100,000 bill to Medicare, the penalty would reduce the reimbursement to $99,000. In all, the penalized hospitals will forfeit about $290 million in Medicare funds over the next year." The NPR (10/2, Rau) "Shots" blog also covers the story.	attempt either).
Co-pay by beneficiaries is the minute by minute check on unnecessary services, overbilling, and poor service. But the government has not enforced co-pay for hospitals and providers have encouraged waiving co-pay so it is seldom or never collected, except with medigap insurance coverage. The 1st day of Part A hospitalization is supposed to be $1,000. If it were collected, Medicare would not have the problem described next, attempting to be solved as "pay for performance." Patients would object to readmissions if they were stuck with co-pays.	**Fearing Medicare Penalties, Hospitals Seek To Reduce Readmission Rates.** The Wall Street Journal (1/22/2013, Landro, Subscription Publication) reports that since October, Medicare has been reducing base payments to hospitals with higher-than-expected readmission rates for heart failure, heart attack and pneumonia. With the penalties expected to expand to include other conditions, hospitals, fearing the penalties, are attempting to reduce the number of patients who need to be readmitted soon after discharge. The Journal notes that new research indicates that the problem is widespread. Bloomberg News (1/23/2013, Armour) reports, "Large US teaching hospitals such as those affiliated with major universities are more likely to be penalized under a US program linking Medicare pay cuts to higher rates of patient readmission, research suggests. ... While the current penalties 'may be modest for some hospitals, they may represent substantial financial shortfalls for hospitals operating on low profit margins,' wrote Karen Joynt, a cardiologist at Boston-based Brigham and Women's Hospital and lead author of the letter." Reuters (1/23/2013,) also covers the story.	Readmission problems would go away with co-pay.
Co-pay is an incentive to	**HHS OIG: Medicare Overspent $510M On ESRD Treatments.**	Implement the co-pay

patients to spot unknown charges. Beneficiaries would pay co-pays for medicine or treatment. If they didn't use it, they would report being billed for useless care	Modern Healthcare (5/11/2013, Lee, Subscription Publication) reported that the Centers for Medicare and Medicaid Services and "Medicare beneficiaries could have saved an estimated $510 million on drugs used to treat end-stage renal disease [ESRD] in 2011 if the reimbursement rate more accurately reflected current usage of these drugs," according to a report (pdf) from HHS' Office of Inspector General. The "report estimates about $510 million was overspent" on Amgen's "Epogen [epoetin alfa] and Aranesp [darbepoetin alfa]," and notes that there "may have been additional $19 million in savings for two iron supplements, Venofer and Ferrlecit." Together the "four drugs, the most commonly prescribed anemia management drugs in 2011, make up about 25% of the base rate payment made to dialysis centers for each dialysis treatment provided to each Medicare beneficiary."	and if the drugs are not being used, reports will be filed by the patients.
Co-pay is an incentive to patients to spot unknown charges. Business model of everyone with a co-pay was passed over, ignored, for Medicaid, which assumed the poor could pay nothing at all, ever.	**DC Councilman Proposes "Fee For Service" Model For Medicaid.** The Washington Times (4/20/2012, Howell) says DC Council member David Catania proposed "game-changing proposals Thursday intended to save money in the District's public health care framework - one to scrap the city's managed care system and another that requires many low-income patients to start paying monthly premiums for services 'so that everyone is pulling the wagon.' The District has contracts with two managed care organizations, United Healthcare and D.C. Chartered Health Plan, which are paid specified rates and direct patients to health care services within their provider networks." His proposal, "which at this point is merely a suggestion from the dais, would install a traditional 'fee for service' model in which providers would be paid by the District for each Medicaid-eligible service they perform."	Beneficiary financial participation solves many issues of health care, minimizes fraud, improves treatment, limits waste, avoids duplication of treatment (which is different from second opinion).
Co-pay is an incentive to patients to spot unknown charges. Business model of everyone with a co-pay was passed over, ignored, for Medicaid, which assumed the poor could pay nothing at all, ever	**Insurers Target Market For Individual Health Plans.** The Philadelphia Business Journal (5/11/2012, George, Subscription Publication) "John George" blog reports, "Like other insurers, United Healthcare has a variety of plan options and wide range of prices. Laden said a nonsmoker in his or her late 20s living in Philadelphia would likely pay between $43 and $197 a month, depending on the options and deductibles selected, while a family of four (nonsmoking husband and wife in their mid-30s with two children) living in the city would likely pay from $125 to $841 in monthly premiums."	

Co-pay is an incentive to patients to spot unknown charges. Business model of everyone with a co-pay, to prevent over use or fraud, was passed over, ignored, for Medicaid, which assumed the poor could pay nothing at all, ever. Instead relying on computer algorithms to tract over use.	**Pharmaceutical Company To Pay $22.75 Million In Settlement.** The San Antonio Business Journal (10/15/2013, Aldridge, Subscription Publication) reports Texas Attorney General Greg Abbott's office reached a settlement with Fougera Pharmaceuticals Inc. over allegations that the company inflated drug price reports to the state Medicaid program. The company will pay Texas and the Federal government $22.75 million. Fougera officials state on record that the company denies the allegations and any wrongdoing.	The levels of over use for the computer programs is either set so high to allow a $23 million fraud, or there are too many to monitor.
Co-pay is an incentive to patients to spot unknown charges. Business model of everyone with a co-pay, to prevent over use or fraud, was passed over, ignored, for Medicaid, which assumed the poor could pay nothing at all, ever. Instead relying on computer algorithms to tract over use.	**Florida Woman Charged With Medicare Fraud.** The Florida Times-Union (2/15,/2013 Treen) reports that, according to the Florida Attorney General's Office, a "34-year-old Jacksonville woman has been charged with fraud after Medicaid was billed more than $400,000 for services to ineligible recipients from January 2008 through June 2011." The owner of Homecare Unlimited, LLC, Edna Lorraine Watkins, billed Florida's Aged and Disabled Adult Waiver Program for services that were not rendered, as well as using a false Social Security number and hiding her previous felony convictions. If convicted, she could face $30,000 in fines and 90 years in prison.	The levels of over use for the computer programs is either set so high to allow a $400,000 fraud, or there are too many to monitor.
Co-pay is an incentive to patients to spot unknown charges. Business model relying on the eyes of the patients, Medicare should have made it easy to spot unknown charges, especially if the patient had a co-pay. The explanation of benefits used abbreviations, fine print, and codes so that little on nothing was understood. The form makers did not	**Federal Officials Overhaul Medicare Billing Statements To More Easily Find Fraud.** The Washington Post (3/7/2012, Jaffe) reports, "In the latest effort to enlist seniors in the fight against Medicare fraud, federal officials have overhauled Medicare billing statements to make it easier to find bogus charges without a magnifying glass." The revamped "format, which goes online Saturday on Medicare's secure Web site, www.mymedicare.gov, includes larger type and explanations of medical services in plain English."	Bigger type helps, but so would doing away with codes and abbreviations. And Sending out the explanation at the time of service, rather than months later when billed.

want the EOBs understood.		
Co-pay is an incentive to patients to spot unknown charges. Business model relying on the eyes of the patients, Medicare should have made it easy to spot unknown charges, especially if the patient had a co-pay. The explanation of benefits (EOBs) used abbreviations, fine print, and codes so that little on nothing was understood. The form makers did not want the EOBs understood.	**Investigation Finds Medicare Bill "Upcoding" Cost $11 Billion Over 10 Years.** The Washington Post (9/16/2012, Schulte, Eaton, Donald) reported that an investigation conducted by the Center for Public Integrity found that the practice of "upcoding" Medicare bills cost taxpayers some $11 billion in 10 years, as "doctors increasingly moved to higher-paying codes for billing Medicare for office visits while cutting back on lower-paying ones." The same practice occurred in hospitals, which "sharply stepped up the use of the highest codes for emergency room visits." The move to electronic health records likely will make the problem worse, the Post said, noting that "one electronic medical records company predicts on its Web site that its product will result in an increase of one coding level for each patient visit, potentially adding $225,000 in new revenue in a year."	Upcoding is another name for over utilization. It is not new, and the eyes to prevent it are those of the patient whose co-pay is increased.
Co-pay is an incentive to patients to spot unknown charges. Medicare could make this easier. The explanation of benefits (EOBs) used abbreviations, fine print, and codes so that little on nothing was understood. The form makers did not want the EOBs understood.	**HHS Agency Substantiates Watchdog Claim Of Rampant "Upcoding" in Medicare Advantage.** Fred Shulte of the Center for Public Integrity (8/7/2014) reports on an investigation conducted by the Department of Health and Human Services Agency for Healthcare Research and Quality, which found that "Medicare made nearly $70 billion in 'improper' payments — mostly overcharges from inflated risk scores — to Medicare Advantage plans from 2008 through 2013 alone." The Center for Public Integrity conducted an earlier investigation that uncovered the same billing inconsistencies, but also found that "risk scores rose much faster in some health plans than others and that federal officials repeatedly yielded to industry pressure to minimize efforts to recoup overpayments." These overcharges are referred to as "upcoding." The New Orleans Times-Picayune (8/8/2014) reports that Rep. Steve Scalise (R) has recently "touted" Medicare Advantage and voiced his opposition for any cuts to the program. **How Medicare Advantage Plans Code For Cash** **from Center for Public Integrity by Fred Schulte** 8/8/2014	Upcoding is another name for over utilization. It is not new, and the eyes to prevent it, are those of the patient whose co-pay is increased.

	A new federal study shows that many Medicare Advantage health plans routinely overbill the government for treating elderly patients — and have gotten away with doing it for years. Analyzing government data never before made public, Department of Health and Human Services researchers found that many plans exaggerate how sick their patients are and how much they cost to treat. Medicare expects to pay the privately run plans — an alternative to traditional Medicare — some $160 billion this year. The HHS study does not directly accuse any insurers of wrongdoing or name specific plans that were scrutinized. But the researchers offer the most comprehensive evidence to date that suspect billing practices have been common across much of the Medicare Advantage industry and are likely to get worse unless officials crack down.	
Co-pay was the hour by hour, case by case, check on fraudulent claims. The model came from Blue cross and blue shield from experience in the 1940s to the 1960s. This was not tried. The fraud check became those farthest away and removed from the fraudulent act.	**Kucinich Predicts Rise In Medicaid Fraud If Healthcare Law Overturned.** The Hill (4/26, Viebeck) reports in its "Healthwatch" blog, "Rep. Dennis Kucinich (D-OH) warned that Medicaid fraud will rise should the Supreme Court strike down the 2010 healthcare law." During a committee hearing Wednesday, Kucinich "said the health reform overhaul provided remedies for preventing future fraud and waste," and "he blasted the House GOP for targeting the healthcare law in its budget and for supporting provisions that would leave the 'bulk of' Medicaid anti-fraud efforts to the states." CQ (4/26, Bristol, Subscription Publication) reports that at the hearing, lawmakers said that "both the federal government and the states need to do a better job of detecting and halting Medicaid fraud, particularly in light of the program expansion called for in the health overhaul." The piece notes, "The panels focused on different varieties of alleged fraud in Minnesota, Texas and New York, with lawmakers grilling both state and federal officials about the situations and possible solutions."	Return control to the lowest set of eyes and nearest to the service and claim. This would address fraud at the lowest level. Patients won't pay for anything which doesn't help.
Co-pay. When you hear the word, think shared responsibility.	**Cigna CEO Says Court Ruling Won't Stop Healthcare Shift.** Bloomberg News (3/15/2012, Nussbaum, Wayne) reports, "A Supreme Court (1000L) ruling on whether the US health-care law is constitutional won't stop market forces transforming how Americans get their medical care, said Cigna Corp. (CI)'s chief executive officer." In an interview at Bloomberg's New York headquarters, Cigna CEO David Cordani said, "Employers are increasingly pushing **workers into plans where they share more of the cost and**	Co pays are simple solutions to management.

	responsibility for managing their medical care." The shift, "aimed at taming soaring health costs, has come to businesses including JPMorgan Chase & Co," Cordani said and added, "Even if the 2010 law is overturned, 'the problem still exists, the problem of affordability, eroding health status, an aging population. The good news is, a lot of change is unfolding in the marketplace today."	
Co-pays are the means to control overutilization. But Medicaid does not use co-pay, everything is free.	**GAO: Four Percent Of Medicaid Recipients Account For Nearly One-Third Of Spending.** National Journal (2/20/2014, Ritger, Subscription Publication) notes that a new report finds that 4.3% of Medicaid recipients account for 31.6% of total program spending. On the other end of the spectrum, the lowest 81.2% of recipients account for 33.1% of expenditures. The report was issued by the Government Accountability Office.	Would the 4% spend 10 times what others spend if they had a minimal co-pay? These ratios do not apply to Medicare Parts where co-pay and deductibles are collected.
Co-pays were the first line of defense of fraud, because the consumer (beneficiary) would not want to waste their own money. When that was ignored soon after Medicare started, other means to combat fraud were tried, such as whistleblowers, computer programs, and investigations. These do not provide 45 million sets of eyes on the charges.	**Senators Ask Providers About Auditors' Anti-Fraud Efforts.** Modern Healthcare (5/2/2012, Carlson, Subscription Publication) reports, "Senate Finance Committee members plan to issue an open letter to US healthcare providers Wednesday to broadly solicit advice on the best ways to prevent waste, fraud and abuse in federal healthcare programs." Kimberly Brandt, chief healthcare investigative counsel for committee's Republican staff, told the Health Care Compliance Association's annual Compliance Institute in Las Vegas, that "the senators hope to receive feedback on the audit contractors in response to the open letter," which "stems from a recent Senate Finance Committee hearing that left questions in the minds of many observers about the effectiveness of the ongoing efforts to fight waste and fraud in federal healthcare programs like Medicare."	The government can start to combat fraud by implementing the existing Medicare business model which was never done. Use co-pays, deductibles, stop insurers from scaring patients to buy medigap (i.e. use out of pocket caps), give people incentives to watch their care.
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and	**Milwaukee Medical Transport Company Convicted Of Medicaid Fraud.** **In a regional news brief, the Milwaukee Journal Sentinel (5/1) reported that "a Milwaukee medical transportation company was convicted Tuesday of 18 counts of Medicaid fraud. Frederick Rutledge, 44, of Menomonee Falls, the owner of Precious Transit...was charged in June with** falsifying records of dozens of trips to defraud Medicaid out of more than $10,000. **... Milwaukee County Circuit Judge Jeffrey A. Wagner found the defendant guilty and ordered a fine of $10,000, plus costs, to be paid within 60 days or it will**	**Charge a co-pay for Medicaid, and using an ambulance for a taxi will stop.** Medicaid has no co-pay and no incentive for patients to report waste or fraud, such

suppliers stopped collecting long ago.	**convert to a civil judgment**	as using ambulances as taxies. Riders are supposed to pay 20% (on a $300 or $400 bill that is $60 to $80). If they did they would report any fraud (or non transfer.)
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago.	**CMS Implements Payment Moratorium Against New Providers, Suppliers In Three Cities.** On Friday, the Centers for Medicare and Medicaid Services announced that new home health agencies in Miami and Chicago and ground ambulance suppliers in Houston "will not get paid for the next six months," CQ (7/26/2013, Adams, Subscription Publication) reported. The "temporary payment moratorium," which is scheduled to begin July 30, "is the first time CMS has used the power to stop taking registrations" under the ACA. CMS Administrator Marilyn Tavenner stated: "CMS is using all available tools, including these moratoriums, to combat fraud, waste and abuse in these vital health care programs. While maintaining patients' access to care, we are putting would-be fraudsters on notice that we will find and stop them before they can attempt to bill Medicare, Medicaid and CHIP." The "strict moratoriums... give federal health officials unprecedented power to choose any region and industry with high fraud activity," the AP (7/27/2013, Kennedy) reports. Sens. Chuck Grassley (R-IA) and Orrin Hatch (R-UT) have criticized CMS "for not using the powerful moratoriums sooner as a tool to combat an estimated $60 billion a year in Medicare fraud." The AP notes that the Department of Health and Services inspector general "lobbied hard to ensure moratorium power was included under the Affordable Care Act." In an article on the moratoriums, the Miami Herald (7/26/2013, Chang) details "Miami's ignominious status as a national Medicare fraud 'hot spot.'" Reuters (7/26/2013) also reports on the story. ***Federal Moratorium Applied Against Houston, Texas Ambulance Service Providers.*** In partnership with Kaiser Health News, the Texas Tribune (7/26/2013, Aaronson) reported that on Friday, in an effort to stop waste, "the Federal government...announced a six-month moratorium under the Affordable Care Act to halt enrollment of Houston-area ambulance service providers in	**Charge a co-pay for Medicaid, and using an ambulance for a taxi will stop.** Medicaid has no co-pay and no incentive for patients to report waste or fraud, such as using ambulances as taxies. Riders are supposed to pay 20% (on a $300 or $400 bill that is $60 to $80). If they did they would report any fraud (or non transfer.)

	Medicare, Medicaid and the Children's Health Insurance Program." This action is "the first use of a new law created by the ACA that allows the Health and Human Services secretary to issue a moratorium to combat fraud, waste or abuse in Medicare or Medicaid." Care is not expected to be affected. According to a statement made by the Centers for Medicare & Medicaid Services, Texas "determined that Medicaid and CHIP beneficiaries will continue to have access" to necessary services. ***CMS Bans New Home Health Providers In Several Counties.*** Reuters (7/26/2013) reported that due to risk of fraud, there has been a temporary ban put on new home health providers and ambulance suppliers on enrolling in Medicare, Medicaid and the Children's Health Insurance Program in a few areas around the country by the Centers for Medicare & Medicaid Services.	
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago.	Medicaid has no co-pay and no incentive for patients to report waste or fraud, such as using ambulances as taxies. Riders are supposed to pay 20% (on a $300 or $400 bill that is $60 to $80). If they did they would report any fraud (or non transfer.) **Ambulance Driver Convicted Of Medicare Fraud.** The Philadelphia Business Journal (5/16, George, Subscription Publication) reports, "Ivan Tkach, 30, of Philadelphia was sentenced today to 46 months in prison for his role in a scheme to defraud Medicare and the US government." He had been "excluded by the US Department of Health and Human Services in 2004 from providing services under the Medicare program due to his prior criminal convictions, yet he continued to operate Advantage Ambulance Co. and drive patients in ambulances." He pleaded guilty to "giving false statements in his application for reinstatement to the Medicare program in 2009," and has been ordered "to pay restitution in the amount of $1.26 million to Medicare."	Where are the competitors reporting these violations? Adopt the Aviation safety reporting business model, where all airmen watch each other and report violations.
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use.	**Pilot Program Seeks To Address Healthcare Overservicing.** The Financial Times (1/23/2013, McGregor, Subscription Publication) reports that several accountable care organizations are operating across the US on a pilot basis as part of the Affordable Care Act. The experiment is aimed at addressing overservicing and the costs to taxpayers associated with it. Under the pilot effort, if the ACOs meet benchmarks on patient health and wellbeing, and minimize hospital stays, they keep a portion of the costs saved. The Times notes that moving to this new system will require a reduction in patient expectations of what services are available to them.	The new term is over servicing. The reason its still a problem is no one collects co-pays.

Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago.	**Medicaid has no co-pay and no incentive for patients to report waste or fraud, such as using ambulances as taxies.** **Texas Medicaid Spending Outpacing Revenues.** The AP (5/8, Tomlinson) reports, "Texas' share for providing health care to poor children, the impoverished elderly and the disabled is growing faster than tax revenues to pay for services, creating another state budget challenge next year, top agency officials told lawmakers Monday." The state's "Medicaid director, Billy Millwee, told lawmakers that his program will likely achieve only 88 percent of the cost savings forecast in the current budget" According to the AP, "experts had warned lawmakers last year that they were underfunding the Medicaid program by $4.8 billion, an amount lawmakers will have to make up when they meet again next year	Charge a co-pay for Medicaid, and growth will slow or reverse..
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago	**Florida Counties Face Budget Problems With New State Medicaid Law.** The Tampa Bay (FL) Times (5/8, Lindberg) reports, "Pinellas taxpayers could see property taxes climb next year because of a new state law that changes the way counties are billed for Medicaid costs. County Administrator Bob LaSala estimates the budget hit because of the Medicaid changes to total $68.9 million over the next 10 years." And "none of the options, LaSala said, are good: raise taxes, slash the health and human services budget by using that alone to pay the Medicaid bills, deplete an emergency account commissioners created to get them through the crunch, or ask the Legislature to reverse the law."	**Charge a co-pay for Medicaid, and growth will slow or reverse..** Medicaid has no co-pay and no incentive for patients to report waste or fraud, such as using ambulances as taxies.
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago	**Medicaid has no co-pay and no incentive for patients to report waste or fraud, such as using ambulances as taxies.** **Massachusetts Man Pleads Guilty To Medicaid Kickbacks.** The Boston Globe (6/20/2012) reports, "Alexander Shrayber pleaded guilty to two counts of Medicaid kickbacks and four counts of corrupt gifts, offers or promises to influence official acts" for "paying kickbacks to employees at a regional transit authority in order to divert Medicaid-funded business to one of his companies." According to the office of the Attorney General, "Shrayber had an ongoing arrangement with these employees that involved monthly payments in return for bypassing the authority's 'low-bid system' and diverting	Charge a co-pay for Medicaid, and growth will slow or reverse..

	transportation assignments for MassHealth recipients from other companies to one of Shrayber's five transportation businesses."	
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago.	**Consumer Group Sues 8 Pharma Companies Over Drug Coupons.** The AP (3/7) reported Community Catalyst "is suing eight drug makers, alleging their programs offering coupons to reduce copayments for brand-name medicines are illegal." The group "alleges that the couponing programs violate federal bribery laws because they're meant to conceal information about the payments from health insurance plans." The drug makers "sued include North Chicago, Ill.-based Abbott Laboratories, Amgen, AstraZeneca PLC, Bristol-Myers Squibb, GlaxoSmithKline PLC, Merck & Co., Novartis AG and Pfizer Inc." Bloomberg News (3/8/2012, Milford, McCarty) quotes the plaintiffs' lawyer, who said, "A recent study estimated that these kickbacks will increase health benefit providers' prescription drug costs by $32 billion over the next 10 years." Community Catalyst "said in a statement the health plans, struggling with rising costs, provide drug benefits for civilian and uniformed municipals workers, retirees and their dependents throughout the city of New York, plumbers from Florida to Ohio, and carpenters throughout New England." According to the piece, "some of the drugs named in the lawsuits are Pfizer's Celebrex [celecoxib] and Lipitor [atorvastatin], Novartis's Diovan [valsartan], Amgen's Enbrel [etanercept], Merck's Nasonex [mometasone] and Vytorin [ezetimibe/simvastatin], and AstraZeneca's Crestor [rosuvastatin] and Nexium [esomeprazole]."	Return to copays, do not permit any substitute, insurance, coupons, or failure to collect. If the provider has not collected the co pay for any previous service, the provider should not bill for the next service. This example shows how coupons were used to subvert the law and business model. Everyone in the industry knows that many patients if charged will look much harder at a service to see if they want to receive it, and many services will be refused on the basis that it is not worth even 20 cents on the dollar (Part B copay).
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago	**Illinois Businessman Charged With Bribing Doctors.** The Chicago Tribune (6/21/2012) reports, "Raghuveer Nayak, a former fundraiser for US Jesse Jackson Jr. and Rod Blagojevich and a key figure in the US Senate seat scandal, was arrested" for "bribing doctors to send patients to his surgery centers." He was "released on an agreed bond of $10 million secured by six properties" by US Magistrate Judge Maria Valdez. "Prosecutors are seeking $1.8 million in 'alleged fraud proceeds'" from Nayak.	Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago
Co-pays were used Blue	**Stark Seeks Investigation Of Accretive Health.**	The solution is for the

Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago. But if the providers do try to collect copays, the Congressmen push back hard.	Rep. Pete Stark is seeking an investigation into Accretive health for "potentially violating a federal law that requires hospitals to provide emergency care regardless of citizenship, legal status, or the ability to pay," the New York Times (4/27/2012, B3, Silver-Greenberg, Subscription Publication) reports. Stark "said that he was most alarmed about Accretive's tactics of demanding that patients seeking emergency care pay outstanding balances before receiving treatment." The Huffington Post (4/27/2012, Young) reports that the lawmaker "in a letter...to Marilyn Tavenner, the acting administrator of the Centers for Medicare and Medicaid Services, and to Daniel Levinson, the inspector general for the Department of Health and Human Services," wrote that a recent New York Times "article outlines abusive debt collection tactics undertaken by a hospital contractor; tactics that may be in violation of several federal laws." CQ (4/27/2012, Subscription Publication) reports that Stark said in the letter, "The debt collection tactics apparently being used by Accretive Health to get money from patients waiting to be seen by an ER doctor or recuperating in a hospital bed are abominable." The Hill (4/27/2012, Viebeck) "Healthwatch" blog reports, "'To the extent [Accretive's] activities violate federal law,' he wrote to CMS administrator Marilyn Tavenner, 'I request that you report back to me on federal enforcement measures that CMS can and will undertake.'" Also covering the story are Modern Healthcare (4/27, Evans, Subscription Publication) and Crain's Chicago Business (4/27/212).	patients who can't afford health care to go on Medicaid. But if they are ineligible for Medicaid, they are supposed to pay up and make some accommodation. Congress knows investigations are expensive for all. The push back will stop collections of co-pays and deductibles, and remove any incentive for the patient to monitor usage or fraud.
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago. Addicts might cheerfully pay co-pay to get excessive drugs for their dependence. The FDA and DEA are supposed to be on top of this..	**Cardinal Health Announces Agreement With DEA Over Florida Facility.** The AP (5/16) reports in a story appearing on over 170 news sites, "Pharmaceutical wholesaler Cardinal Health Inc. said Tuesday one of its Florida facilities will be barred from shipping controlled substances for two years under a settlement" with the Drug Enforcement Administration. The facility in Lakeland, Florida "will remain open and other operations will continue," and the company "also intends to improve procedures that are designed to prevent prescription drugs from being abused." The Wall Street Journal (5/16, B2, Barrett, Martin, Subscription Publication) quotes Cardinal CEO George Barrett, "This agreement allows us to put this matter behind us," and the DEA's Joseph Rannazzisi, "Cardinal Health is not above the law, and with this agreement it admits that it neglected its vital responsibility to prevent the diversion of controlled substance medications." USA Today (5/16, Leger) explains that "the Drug Enforcement Administration sought to revoke Cardinal's license in February, accusing the	This calculates to a million pills a year per pharmacy, or 4150 pills every business day of the year. At an average of 8 pills per prescription, that exceeds 500 prescriptions per day, everyday. Wonder why it took 3 years to figure this out? No co-pay was collected.

	company of selling excessive amounts - more than 12 million oxycodone pain pills - to four Florida pharmacies over three years." It also contains the quotes from Rannazzisi and Barrett. The agency said that it also "may pursue civil penalties, including fines, against the company." Bloomberg News (5/16, Schoenberg, Milford) reports that the DEA "had challenged Dublin, Ohio-based Cardinal's procedures, contending the Lakeland, Florida, distribution center posed a public safety threat by shipping large quantities of the prescription painkiller oxycodone to pharmacies." It also quotes the statements by Rannazzisi and Barrett. The Financial Times (5/16, Rappeport, Subscription Publication) also covered the news, but quoted no officials.	
Co-pays were used by Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago Attempts to have even minimal co-pays are vigorously resisted.	**Lawsuit Filed Regarding Arizona Copayments.** The Yuma (AZ) Sun (5/25, Fischer) reports that a public interest law firm filed a lawsuit in the US District Court alleging that the copayment requirements set by the Arizona Health Care Cost Containment System (AHCCCS) on childless adults are illegal. Co-pays through AHCCCS were $1 for a physician's visit and $5 for nonemergency use of the emergency department, but in 2010, they increased **to $5 and $30**, respectively.	Note the co-pays are the price of a Big MAC hamburger, and a half a ticket to Disneyland.
Co-pays were used by Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But provders and suppliers stopped collecting long ago. Co-pay, if collected, not just billed, would also solve the problem of clerical errors and honest	**Report Says 2,600 US Pharmacies Have Suspicious, Excessive Medicare Billing.** Bloomberg News (5/11/2012, Wayne) reports, "More than 2,600 US drug stores, or four percent of all retail pharmacies, may have suspicious or excessive billing to Medicare, government investigators said." Certain "pharmacies dispensed unusually high percentages of painkillers and other controlled substances or expensive brand- name drugs, according to a report today from the inspector general for the Health and Human Services Department that analyzed claims data from 2009." Bloomberg News adds, "Daniel Levinson, the inspector general for the Health and Human Services Department, recommended that Medicare tell the insurers who administer the program's drug plans to report potential fraud to the government." The AP (5/11/2012, Alonso-Zaldivar) reports, "In written comments,	Return to co-pay for drugs, and patients will report problems, better than insurers.

mistakes. People will watch their drugs, if they are paying part of it. Previous to 2006, only Part B drugs were partially covered. Then Part D began.	Medicare administrator Marilyn Tavenner said the agency mostly agrees with the inspector general's call to action." However, "she suggested that requiring private insurers to monitor and report suspicious activity could place a burden on the companies and may flood government officials with leads that turn out to be useless." Tavenner wrote, "We believe it is important to note that (the inspector general's) report identified what appeared to be questionable billing based on its own data analysis but did not determine any actual fraud committed by the pharmacies." The Hill (5/11/2012, Viebeck) "Healthwatch" blog reports, "The HHS report singled out several areas of the country where pharmacies irregularly billed Medicare with extremely high amounts per beneficiary." For instance, in "Miami...nearly one in five pharmacies had questionable billings in 2009." The report also indicated that "in Los Angeles...more than half of pharmacies with questionable billing charged for unusually high percentages of brand-name drugs." CQ (5/11/2012, Adams, Subscription Publication) reports, "Independent pharmacies were eight times more likely than chains to have questionable billing, the report found." While "independent pharmacies made up 34 percent of all retail pharmacies that billed Medicare for prescriptions in 2009, they accounted for 80 percent of the stores with odd patterns." Also covering the story are Reuters (5/11/2012, Krauskopf) and the Kansas City Business Journal (5/11/2012, Subscription Publication).	
Co-pays were used by Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But providers and suppliers stopped collecting long ago. Co-pay, if collected, not just billed, would also solve the problem of clerical errors and honest mistakes.	**MedPAC Wants New Fees For Medigap Plans.** Modern Healthcare (4/6, Daly, Subscription Publication) reports, "Congress should add a new charge for Medicare beneficiaries who buy supplemental insurance, according to a recommendation from its advisory panel." The amount "of the fee for Medigap plans was not specified but left up to the secretary of HHS, according to a unanimous recommendation by the panel (pdf). Medicare Payment Advisory Commission members and other health policy experts have frequently criticized such plans as cost drivers for Medicare because they often cover all out-of-pocket costs for beneficiaries, which critics contend leads to overutilization of healthcare services." ***MedPAC Approves Limit On Out-of-Pocket Costs.*** CQ (4/6, Adams, Subscription Publication) reports, "Medicare beneficiaries would be protected from never-ending out-of-pocket costs under a recommendation the Medicare Payment Advisory Commission approved on Thursday." CQ adds, "Funding for capping catastrophic expenses would come partly from an additional charge on	Better than have a surcharge is to eliminate the need for the Medigap plan, and remove the fear and threat used to market the plans.

	supplemental insurance plans, such as Medigap policies. The proposal is expected to be included in the panel's June report to Congress."	
Co-pays were used by Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes, but not for HOSPICE. Thus providers have no incentive (i.e. lose a patient) to shorten Hospice stay. Hospice is a Part A benefit with no co-pay.	**Analysis: Hospice Industry Targeted Healthier Patients To Increase Profits.** In a nearly 3,500 word article entitled "Hospice Firms Draining Billions From Medicare," the Washington Post (12/27/2013, Whoriskey, Keating) reports that, over the past ten years, more patients in hospice care have been surviving over a long term. The Post notes that "healthier patients are more profitable because they require fewer visits and stay enrolled longer." The article profiles the growing "hospice movement" across the country and offers specific examples of several companies. Of the $17 billion annual industry revenue, Medicare pays $15 billion. The Post conducted an analysis of "more than 1 million hospice patients' records over 11 years" and found, among other things, that "per-patient operating profit has risen from $353 in 2002 to $1,975 in 2012."	Hospice has become long term care.
Co-pays were used by Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. Co-pays were adopted by Medicare for similar purposes. But provders and suppliers stopped collecting long ago. Co-pay, if collected, not just billed, would also solve the problem of clerical errors and honest mistakes.	**Excuses for clerical error and honest mistake are reported at between 6 and 9 percent.** **Report Indicates Food Stamp, Medicaid Fraud May Be Widespread In New Hampshire.** The Concord Monitor (4/6/2012, Spolar) reports, "As he predicted last month, House Speaker Bill O'Brien yesterday called the results of a private analysis 'eye-opening' by shedding light on potential welfare fraud in New Hampshire." The analysis "found 9.15 percent of 24,355 people receiving food stamps in New Hampshire have a primary address that is out-of-state, along with 6.14 percent of 86,386 Medicaid recipients." Meanwhile, "fifty-six people on Medicaid are dead, including a woman who died in November 1983, and two are incarcerated, the report found." The Nashua (NH) Telegraph (4/6, Landrigan) reports that "O'Brien acknowledged that most of the cases flagged in the review are not welfare fraud and are more likely clerical errors or honest mistakes by applicants," but still "said the initial findings" show "the need for his House-passed bill to place further restrictions on welfare fraud within state law."	According to this report, clerical errors and honest mistakes run 6 to 9 percent. If beneficiaries are charged co-pays, they will have an incentive to keep their records accurate, without clerical errors or honest mistakes.
Co-pays. Use coupons to circumvent the co-pay requirement.. Co-pays were	**Survey: 6% Of Seniors Use Banned Drug Coupons.** The National Journal (4/17/2012, Subscription Publication) reports, "Six percent of seniors have used coupons to purchase brand name drugs even though	Return to copays, do not permit any substitute, insurance, coupons, on

used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use.	Medicare has banned that tactic, according to a survey from the National Coalition on Health Care." NCHC estimates that "if the 6 percent of survey respondents is true of all Medicare recipients," then "2 million Medicare beneficiaries are using coupons to buy drugs that end up costing the government more money." The group's CEO John Rother said in a statement that consumers using the banned coupons "might see lower costs for brand-name drugs, but their health plans still end up paying more to the brand-name manufacturer," which results in "higher costs for everyone."	failure to collect. If the provider has not collected the co pay for any previous service, the provider should not bill for the next service. This example shows how coupons were used to subvert the law and business model. Everyone in the industry knows that many patients if charged will look much harder at a service to see if they want to receive it, and many services will be refused on the basis that it is not worth even 20 cents on the dollar (Part B copay).
Competition between hospitals and physicians was assumed in 1966. But Medicare pays hospitals more than physicians, so services are heading to hospitals.	**Hospitals Buying Private Practices, Increasing Costs.** The AP (12/17/2012) reports, "North Carolina patients are likely to pay more for services ranging from heart tests to routine office visits if their doctors are employed by a hospital," according to an investigation by the Charlotte Observer and the News & Observer of Raleigh, which found that the "higher charges are part of a national shift that experts say is raising costs for many patients." The investigation showed that for "many routine services, insurers pay hospitals more than independent doctors." But under "Medicare rules, hospitals are allowed to collect more than doctors -- and that means the out-of-pocket share for Medicare patients is also larger." America's Health Insurance Plans spokesperson Robert Zirkelbach said hospitals purchase private practices, and the care costs increase for patients "often for no other reason than the sign on the door changed."	Return to doctors practices separate from hospitals.
Competition drives down prices, limiting it drives up prices.	**Study: Hospitals Use Sophisticated Strategies To Increase Ability To Demand High Prices.** The National Journal (5/8, Sanger-Katz, Subscription Publication) reports,	Do away with certificate of need, and let beds open up. Remove AMA

	"Hospitals are using sophisticated strategies to increase their ability to demand high prices from insurers, a new study in Health Affairs suggests." The report indicates that "hospitals are now focusing on purchasing hospitals and services considered "must have" or buying hospitals spread throughout a state or region to improve their negotiating clout." Additionally, "according to the study's authors, hospital executives saw the employment of doctors as a further strategy to lock in favorable contract terms." According to Politico (5/8, Dobias), "the article doesn't attempt to resolve the dispute in health policy circles over whether new models in the health law, like accountable care organizations, will pave the way for high quality and efficiency or lead to new hospital-dominated monopolies as the leading hospitals absorb physician practices and smaller health centers and increase their clout."	from limiting medical schools.
Data. Medicare in the 1960s never imagined using the data for tracking tens of millions of beneficiaries every diagnosis and expense.	The COMMON working file, is used by Part B suppliers to check on eligibility for medicare. Under consolidated billing, if a beneficiary enters Part A treatment (with generally no co-pay for 3 months of treatment) the Part B coverage is suspended under consolidated billing so Medicare doesn't pay twice for the same services. The common working file is privately maintained from Medicare records. It has great detail for each individual beneficiary, to wit, all medications charged to medicare use, each piece of durable medical equipment charged to the account, each hospitalization, each home health, all therapy. The list can go on for pages, and is a thorough snap shot of the patient's health record, with providers and suppliers.	So much for privacy of medical records. Anyone with a Medicare provider number, the beneficiaries HICN, and willing to pay the small fee, can get all of the information, even though only a single part is relevant to the billing.
Disability, When added as qualification for Medicare, the plan was to evaluate the disabled every two years for improvement. One in four medicare patients are not seniors.	**GAO Cites Children's Disability Program For Lack Of Reviews.** On its front page, the Boston Globe (5/24/2012, A1, Wen) reports that the Social Security Administration "failed to follow up on the progress of 400,000 beneficiaries with behavioral, learning, and mental disorders, allowing families to receive monthly cash benefits for years even if their children's condition has improved, according to a draft report from the Government Accountability Office obtained by the Globe." The Supplemental Security Income program could see savings of "$9 for every $1 spent on disability reviews by determining that some children no longer qualify." The GAO "also cited many instances of incomplete data or highly subjective factors being used to evaluate children with mental impairments, who now account for more than half of all cases."	The Judges grant the disability for a 2 year look back and 2 year prospective, i.e. 4 year period, assuming the states will monitor the patients lest they improve and are not reevaluated.
Everyone is insured, either	This two or three tier system is a violation of anti-trust laws, resulting in price	Have one tier of charges

by a 3rd party insurer, or by self-insurance. When Medicare was adopted, the medical costs for 3rd party insurers (through employer plans) and the self insured were about the same, with some discounts for bulk sales (i.e. insuring all the employees of a company.). Insurers, wanting to sell insurance to more employers and others, went to providers (hospitals) and suppliers (physicians) and negotiated a two tier system of billing, cheaper costs when paid for by the insurance company, and the provider accommodated the two tier by doubling or tripling or charging ten times the cost to the self insured. Medicare then set its fee schedule and Medicare approved amount, not ever expecting to pay what the provider might charge the uninsured.	fixing, called invidious discrimination in the 1920s. But health industry gets a pass as the government sets prices (fee schedule and approved amount), number of seats in medical schools, rationing physicians and health care professionals. **Indiana Supreme Court To Weigh In On Overbilling Lawsuit.** The Indianapolis Star (4/30, Swiatek) reports the Indiana Supreme Court will review an overbilling lawsuit against the state's largest hospital group, IU Health, by two of its uninsured patients. Although the claims in the case amount to only a few thousand dollars, "a finding favoring the IU Health patients could fling open the door to multimillion-dollar class-action legal claims from uninsured patients against IU Health and other hospitals as well." The case is drawing concern from the Indiana Hospital Association, which "has filed a friend-of-the-court brief with the Supreme Court in support of IU Health's legal position." According to the attorneys involved, "it's the first time the state Supreme Court will wrestle with the legalities of a hospital charging uninsured patients more than insured ones." In a story appearing on over 25 news websites, the AP (4/30) reports, "The court's consideration of the issue comes even after a new federal law requires hospitals to give discounts to uninsured patients similar to those given to insured ones." IU Health spokeswoman Lauren Cislak says that law "led IU Health to offer uninsured patients a 40 percent discount off its full-price 'chargemaster' rates in January of last year." Cislak noted that IU Health's discount "applies to uninsured patients regardless of income and is based on the best rates it charges its commercial insured customers or Medicare."	for all, those with 3rd party insurance, Medicare, or Medicaid, and those who are self-insured. This suit shows the hospital with the University of Indiana charged 40% more to self-insured than those with a 3rd party insurer. The fear of bankruptcy comes because the health providers gauge self-insured. This encourages companies to give health benefits. Solo businesses and small businesses, pay higher rates than large businesses, which have more leverage in pricing. Elsewhere we see that insurers object to laws requiring half of the premium for insurance be spent on health care (instead of administrative fees, profit, overhead, salaries of agents, etc).
FDA reviews products, and CMS uses the review to approve coverage.	FDA doesn't review devices. So get the 510(k) clearance, 35 years after grandfathered rules apply and go for CMS coverage.	**2011,** AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com] **Experts Concerned About Combined FDA-CMS Reviews.** CQ HealthBeat (1/13, Adams) reports, "As federal officials weigh whether to move ahead with a plan to offer a

		consolidated approval and reimbursement review for new medical products, most people who commented on the idea wanted guarantees that companies could either opt for a combined review or stick with the current separate procedures." Notably, the FDA and CMS "asked last fall for comments on a proposal to combine their currently separate reviews of drugs and medical devices." At present, "the FDA...reviews such products to determine if they are safe and effective enough to be sold in the United States," while "CMS officials examine the same products to determine whether the federal government will cover them and to set the reimbursement levels."
Flexner report[15] circa 1910 shut down medical schools and rationed medical school seats. All women's medical schools, and all but 2 minority or black medical schools were closed.	The MCAT[16] requires prior courses in microbiology, chemistry, and physics. Twice the number of students take it as have med school seats available.	Open 200 new medical schools, and double the number of seats.
Flexner report was so successful, that reports continue to pour in to limit choices, and reduce coverage under the guise of improvement.	**Healthcare Access Found To "Worsen Dramatically" Over Past Decade.** McClatchy (5/8, Galewitz) reports on a study by Urban Institute researchers, published in the journal Health Affairs, which found that "tens of millions of adults under age 65 – both those with insurance and those without – saw their access to health care worsen dramatically over the past decade," which is interpreted to mean that "more privately insured Americans are delaying treatment because of rising out-of-pocket costs, while safety-net programs for the poor and uninsured are failing to keep up with demand for care." The study noted that while the healthcare reform law "won't necessarily solve all those access problems," it "does offer several new strategies, such as new payment methods to control rising costs, which could help improve access, but there's no	All health care stakeholders want restrictions, less competition, more regulation, more expense.

	guarantee they will work." Reuters (5/8, Morgan) quotes the researchers, "If the key coverage provisions in the (law) are ruled unconstitutional or repealed, projections indicate that the numbers of uninsured people will grow. Given what we have observed over the past decade, we would be likely to see further deterioration in access to care for all adults -- insured and uninsured alike." The Huffington Post (5/8, Young) reports, "Between 2000 and 2010, more working-age adults reported they had no regular source of medical care, hadn't seen a doctor or a dentist within a year, had unmet medical and dental needs and went without health care because of cost." The Milwaukee Journal Sentinel (5/8) reports, "An estimated 13% of the adults under 65 in Wisconsin reported not seeking health care because of the cost in 2010, according to the study." The Washington Post (5/8, Kliff) "Wonkblog" reports, "A forthcoming paper in the Journal of Health Economics...finds that high rates of uninsurance mean worse outcomes even for those with coverage." In the paper "health-care economist N. Meltem Daysal compared outcomes for insured heart attack patients in California over a six-year period, 1999 to 2006, when the state saw a 19 percent reduction in mortality rates for such cases" and found there was much variation in how health outcomes were improving.	
Flexner report was so successful, that reports continue to pour in to limit choices, and reduce coverage under the guise of improvement.	**Analysis: Insurance Exchanges Should Be Used By States To Narrow Plan Choices.** The Hill (5/9, Baker) reports in its "Healthwatch" blog on an analysis published in Health Affairs, which said that "states should use their new insurance exchanges to narrow down the number of plans consumers can choose from," and urges states to "follow Massachusetts's example as they create their exchanges." Lead author Rosemarie Day, a former deputy director of Massachusetts's exchange, "said consumers in Massachusetts preferred choosing from a handful of carefully vetted, clearly described healthcare plans," and added that "there is less evidence for the model used in Utah, where any plan that meets certain minimum standards can participate in the exchange."	Interfering in market forces has brought us to this difficulty. All health care stakeholders want restrictions, less competition, more regulation, more expense. Only problem is the country gets less care at higher cost.
Flexner report was so successful, that reports continue to pour in to limit choices, and reduce coverage under the guise of	**Highmark, University of Pittsburgh Medical Center At Odds On Rate Increases.** The Pittsburgh Business Times (5/9, Mamula, Subscription Publication) reports, "How much rates will rise through Dec. 31, 2014, has become the latest point of disagreement between health insurer Highmark Inc. and the University of	Having insurers compete does not provide more physicians or hospital beds. The focus is wrong.

improvement.	Pittsburgh Medical Center." The Business Times notes that "if reimbursement rates approach parity as a result of the contract, it would be the first time in a decade that insurers will compete on such things as product and service, rather than price, according to Joseph Friedman, who leads the managed care litigation practice group at the Downtown law offices of Thorp Reed & Armstrong LLC."	
GAO was the business model for fraud prevention for military procurement, but which is a fraction of the Medicare claims Medicare would review and audit claims, based on co-pays as a monitor for tens of millions of beneficiaries and participants...	**House, Senate Lawmakers Ask GAO To Review Medicare Anti-Fraud Efforts.** CQ (6/27, Subscription Publication) reports that yesterday, "a bipartisan group of lawmakers in the House and Senate asked the Government Accountability Office...to review the Medicare program's anti-fraud efforts, with an emphasis on the effectiveness of the outside contractors hired to do much of the oversight." The letter (pdf) read, "Healthcare providers are responsible for interacting with, and responding to, each of these contractors." It added, "In order for this contractor oversight to at once be effective at detecting improper payments and not unnecessarily burdensome to providers, it must be undertaken subject to a coherent strategic plan, consistent standards and active coordination." The senators and representatives who signed the letter "are asking the GAO to ensure that there are 'valid, clear and consistent' criteria for Medicare audits and that providers don't have to provide the same information to multiple contractors."	GAO isn't big enough to audit Medicare.
Government expansion. Anything to increase resources (money) government?	**Medicaid Expansion Quirk Could Cover Immigrants In States That Opt Out.** The AP (1/24/2013, Alonso-Zaldivar) reports on an "unintended consequence of how last year's Supreme Court decision changed the Medicaid provisions of President Barack Obama's health care law," which could leave legal immigrants in states that do not expand the program with coverage while some U.S. citizens go without. This interpretation of the law was cited as one of the reasons Arizona Governor Jan Brewer made the surprising decision to opt-in to expansion last week. Documents explaining her choice read, "If Arizona does not expand, for poor Arizonans below (the federal poverty line), only legal immigrants, but not citizens, would be eligible for subsidies." According to the AP, "the Obama administration confirmed Arizona's interpretation." The article also notes that this "quirk" could be of political consequence to Florida and Texas, both Republican-led states with high immigrant populations.	Citizens vote, residents aren't supposed to vote.

Hospitals and physicians have stopped quoting costs, leaving these to private or hidden contracts with insurers. Patients have no idea what anything costs, nor do they care.	**Massachusetts AG Circulating Proposal To More Tightly Regulate Healthcare Costs.** The Boston Globe (4/6, Kowalczyk) reports, "Attorney General Martha Coakley's office is quietly circulating a proposal to more tightly regulate hospitals and doctors and the prices they are paid to care for patients." The attorney general's "staff has drafted legislation and has briefed providers, business leaders, key legislators, and the governor's office on the plan to contain health care spending." The Globe adds, "Providers and insurers would have to provide detailed price information to patients before they undergo a test or treatment, and the Division of Insurance and Department of Public Health would have new authority to limit the prices and market power of providers under Coakley's proposal."	Transparency of costs of health services, with co-pay will reduce over utilization, fraud, waste, clerical error, honest mistakes.
Hospitals and physicians have stopped quoting costs, leaving these to private or hidden contracts with insurers. Patients have no idea what anything costs, nor do they care. Co-pays were to monitor over utilization.	**Massachusetts Group Holds Conference On Medicaid, Medicare Fraud And Abuse.** The Boston Globe (5/18, Lazar) reports in its "White Coat Notes" blog, "As Massachusetts leaders seek to slow soaring health care costs, a growing network of community-based organizations is trying to squelch Medicaid and Medicare fraud and abuse -- which also drive up costs." The network, "known as the Massachusetts SMP (Senior Medicare Patrol) Program, will outline its efforts to eliminate fraud at a day-long conference in Marlborough," that "will feature presentations by an agent with the Boston office of the FBI, an agent from the state's office of Inspector General and the state's Undersecretary of Consumer Affairs and Business Regulation."	Typically, these all day conferences focus on big 9 figure catches, and ignore the minute by minute drain.
Hospitals and physicians would quote costs to patients who had to pay the bills. Patients would ask, presumably, how much does it cost me?.	No transparency. The fee schedules and Medicare approved amounts are kept from patients and Government Judges. No patient knows what things cost, as the claims are submitted to the carrier for payment.	All costs to be quoted with real numbers, not inflated. Open 200 more medical schools.
Hospitals and physicians would quote costs to patients who had to pay the bills. Patients would ask, presumably, how much does it cost me?.	**How to Charge $546 for Six Liters of Saltwater**[17]	All costs to be quoted with real numbers, not inflated. Open 200 more medical schools
Hospitals and physicians	**Medicare Working To Encourage Seniors To Leave Low-Rated Plans.**	There is little

would quote costs to patients who had to pay the bills. Patients would ask, presumably, how much does it cost me? Patients would judge value for success.	USA Today (11/6/2012, Jaffe) reports on the "novel approach" Medicare officials are using to encourage seniors to leave poor-performing health insurance plans. The first step in the approach was personalized letters "informing seniors they are enrolled in a plan that received low ratings," sent to 375,000 Medicaid Advantage members and 150,000 drug plan members. The next step: "Medicare is making it harder for people to sign up for one of the 26 plans. If they search for plans on Medicare's plan finder website, they can access and join other, better performing plans electronically but to join one of the 26, they must contact that insurance company directly." For many beneficiaries, plan ratings are not as important as price, restrictions on drugs and whether their doctors participate. An industry spokesman said "the ratings system is flawed. He says it's based on measures that don't sufficiently take into account, for example, plans serving a disproportionate number of beneficiaries with many chronic conditions or special needs, or who live in underserved areas."[18]	transparency among insurers or providers.
Hospitals were charities. Their sponsors were churches and foundations, Baptist, Catholic, Church of Jesus Christ of Latter Day Saints, Shriners, Presbyterian, Methodist, etc. Hospitals also had Medical school affiliations.	Hospitals went commercial, squeezing out the charities until they are now all business. Enough to hire lobbyists. A bed 's capitalized value is $800,000 and a working bed is worth $1.6 million.	Triple the number of hospital beds.
Hospitals were owned and operated by charities, presumably in the beneficiaries best interest. Certificates of need were later invented giving monopoly control on the basis of regulation and protecting the public.	**Michigan Hospital Forced To Shut Down Tuesday.** The AP (4/4/2012, Subscription Publication) reports, "Cheboygan (Mich.) Memorial Hospital said it has been forced to shut down Tuesday after a proposed sale of the facility to McLaren Health Care Corp. was blocked, throwing hopes of preserving health services at the area's largest employer into doubt." The Cheboygan (MI) Daily Tribune (4/4, Britton) reports, "According to a CMH press release, the key issue preventing the sale is with 'Federal recertification requirements and licensure of its emergency services and outpatient surgery area. The Center for Medicare Services (CMS) is unwilling to grant a waiver to allow McLaren Health Care to immediately operate those areas as planned without additional surveys being completed.'"	Let the market decide how many beds should be made. Use certificates only for safety not as a barrier to entry.

Hospitals were owned and operated by charities, presumably in the beneficiaries best interest. Consolidation removed competitive influences on the business of customer service.	**Judge Dismisses Suit Challenging Scripps Deal.** The U-T San Diego (3/13/2013, Sisson) reports, "A judge has dismissed a patient poaching lawsuit filed in 2009 by Tri-City Medical Center against Scripps Health. In a final ruling filed Feb. 22 and announced Tuesday, Superior Court Judge Earl H. Maas stated that Tri-City failed to show 'unfair competition' or to 'establish the existence of an actual controversy' between the two parties." The lawsuit "stems from Scripps' purchase of the Sharp Mission Park doctors group in 2008." According to Modern Healthcare (3/13, Kutscher, Subscription Publication), Tri-City Medical, a "**330-bed public hospital** in Oceanside, about 40 miles north of San Diego, filed suit against Scripps Health after the four-hospital system based in San Diego acquired the **former Sharp Mission Park medical group** and subsequently **hired 65 Tri-City physicians**. The decision to go to court came as Tri-City faced mounting challenges, including decreasing revenue, increasing debt, **declining patient volume** and allegations of mismanagement." Although Tri-City "did not respond to a request for comment," Scripps CEO Chris Van Gorder issued a statement, lauding the Judge Maas's decision but lamenting that the "time and money Tri-City has spent pursuing this case is a waste of public funds."	Let the market decide how many beds should be made. Hospitals acquire patient lists through physician groups.
Hospitals were owned and operated by charities, presumably in the beneficiaries best interest. Consolidation removed competitive influences on the business of customer service.	**Hospitals, Market Share and Consolidation** **from JAMA by David Cutler (et al)** A large reduction in use of inpatient care combined with the incentives in the Affordable Care Act is leading to significant consolidation in the hospital industry. What was once a set of independent hospitals having arms-length relationships with physicians and clinicians who provide ambulatory care is becoming a small number of locally integrated health systems, generally built around large, prestigious academic medical centers. The typical region in the United States has 3 to 5 consolidated health systems, spanning a wide range of care settings, and a smaller fringe of health care centers outside those systems. Consolidated health systems have advantages and drawbacks. The advantages include the ability to coordinate care across different practitioners and sites of care. Offsetting this is the potential for higher prices resulting from greater market power. Market power increases because it is difficult for insurers to bargain successfully with one of only a few health systems. Antitrust authorities are examining these consolidated systems as they form, but broad conclusions	Let the market (not Government) decide how many beds should be made. Note that consumers have NO bargaining power. The incentive to avoid OVER utilization was co-pay.

	are difficult to draw because typically the creation of a system will generate both benefit and harm and each set of facts will be different. Moreover, the remedies traditionally used (e.g., blocking the transaction or requiring that the parties divest assets) by antitrust authorities in cases of net harm are limited. For this reason, local governments may want to introduce new policies that help ensure consumers gain protection in the event of consolidation, such as insurance products that charge consumers more for high-priced clinicians and health care centers, bundling payments to clinicians and health care organizations to eliminate the incentives of big institutions to simply provide more care, and establishing area-specific price or spending targets.	
Hospitals will naturally seek economical purchases of devices, drugs and equipment.	**Hospital Chiefs Get Paid for Advice on Selling 17/07/2006** hospital executives interact with companies that sell products as varied as syringes and financial services. In the case of the Healthcare Research and Development Institute, executives benefit from payments made by companies their hospitals do business with. [19]	The health industry routinely invests in itself, doctors in drug companies, doctors in hospitals, hospital executives in the hospitals. Just be aware of these deals, when they complain about federal cutbacks.
If you build it, they will come, or insurance is the key to treatment. But even in 1966, Insurance never delivered a baby, set a broken arm, performed a surgery. Physicians and nurses do these.	AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com] **Sent:** Wednesday, November 17, 2010 7:36 AM **Study: Access To Healthcare Tight In Massachusetts Despite 97% Insured.** The Boston Herald /AP (11/17) reports that according to an annual report from the Massachusetts Health Council access "to health care in Massachusetts remains tight, with hospital emergency rooms increasingly picking up the slack, even as the state has experienced a surge in the number of insured residents." Notably, the "report found that while 97 percent of the state's residents were insured...finding a doctor wasn't always easy" because only "44 percent of primary care doctors are accepting new patients, and primary health services are increasingly being provided by hospital emergency departments." The report also makes "policy recommendations for lawmakers."	Open 200 medical schools or 1,657 new schools. See Years to Equilibrium for the cost for expanding medical physician training.
Insulating beneficiaries from costs, also removes no	**Man Charged With Medicare, Medicaid Fraud In Houston.** The AP (4/4) reports, "Another person has been accused in a health care scam	Fraud is reported faster if the beneficiary is paying

monitoring of fraud by beneficiaries.	that allegedly bilked Medicare and Medicaid out of more than $45 million. Federal prosecutors in Houston on Tuesday announced charges against 56-year-old Tony Nnonso Obi." He is "charged with conspiracy to commit health care fraud, health care fraud and money laundering." **Radiation Clinic Agrees To Pay $3.8M For False Medicare Claims.** The Atlanta Journal-Constitution (4/4, Rankin) reports Radiotherapy Clinics of Georgia in DeKalb County "have agreed to pay a $3.8 million settlement to resolve a false claims investigation, the US Attorney's Office said Tuesday." The clinics have "been accused of over-billing Medicare for treatments provided to prostate cancer patients and billing for unnecessary services." An attorney "who represents Tarlton, said the doctor was pleased with the agreement" and "also praised the Justice Department and the Office of Inspector General for the Department of Health and Human Services for aggressively investigating allegations of Medicare fraud."	part of the bill.
Insured? All are insured either by a 3rd party insurer, or by self-insurance. When Medicare was adopted, the medical costs for 3rd party insurers (through employer plans) and the self insured were the same. Insurers, wanting to sell insurance to more employers and others, went to providers (hospitals) and suppliers (physicians) and negotiated a two tier system of billing, cheaper for the insurance company, and the provider accommodated the two tier by doubling or tripling or charging ten times the cost to the self insured. Medicare then set its fee schedule and Medicare approved amount, not ever expecting to pay what the provider might charge.	**Federal Rules Offer Patients Protection From Abusive Collections Practices.** The Raleigh (NC) News & Observer (6/25/2012, Alexander, Garloch) reports, "Hospital patients who can't afford to pay their bills would get protection from abusive collections practices under new proposed rules issued by the US Treasury Department." These "rules, which seek to clarify hospitals' responsibilities under the federal Affordable Care Act, give patients at least four months to apply for financial help before hospitals can turn them over to collections agencies or file lawsuits." While the majority of North Carolina hospitals enjoy tax-exempt status, "a recent investigation by The News & Observer and The Charlotte Observer found that many uninsured patients are never offered charity care."	Four months isn't very much time. This is not apparently medicare co-pay, but balances for ER.

Insurers are able to sell insurance because patients are scared of the out of network, or uninsured rates. The insurers profit from the sales.	**Aetna Dispute With Phoenix OB/GYN Practice May Affect Some 5,000 Patients.** The Arizona Republic (5/8, Alltucker) reports that in Arizona, approximately "5,000 metro Phoenix women covered by Aetna could be forced to switch doctors or medical practitioners next week because of a dispute between the insurance company and a large East Valley obstetrics and gynecology practice." Yesterday, "Drs. Goodman and Partridge OB/GYN said...that it will no longer contract with Aetna effective May 15 over disagreements about the health insurer's administrative practices and reimbursement rates." Should that contract lapse, "the medical practice with six East Valley locations no longer will be an 'in-network' provider for Aetna-insured patients, who may be forced to switch physicians or pay cash to continue seeing Goodman and Partridge practitioners."	If the physicians would charge the same to all, eventually people would drop their insurance, and those fees could be split between providers and patients.
Insurers, wanting to sell insurance to more employers and others, went to providers (hospitals) and suppliers (physicians) and negotiated a two tier system of billing, cheaper for the insurance company, and the provider accommodated the two tier by doubling or tripling or charging ten times the cost to the self insured.	**Accretive Settles Minnesota Suit Over Hospital Debt Collections For $2.5 Million.** The AP (7/31/2012, Lohn) reports Minnesota Attorney General Lori Swanson "announced a legal settlement Monday that will bar a Chicago medical revenue company from doing business in Minnesota for six years after she accused Accretive Health Inc. of intrusive efforts to collect money from patients in several hospitals." On the front page of its Business Day section, the New York Times (7/31, B1, Silver-Greenberg, Subscription Publication) reports Accretive Health, "one of the nation's largest collectors of medical debt, has agreed to pay $2.5 million to the Minnesota state attorney general's office to settle accusations that it violated a federal law requiring hospitals to provide emergency care, even if patients cannot afford to pay." As part of the settlement, Accretive Health is also "barred from contracting with hospitals within the state for at least two years, effectively ending its business at three Minnesota hospitals." Moreover, during the subsequent four years, Accretive "will have to obtain permission from the attorney general before resuming business in the state." Modern Healthcare (7/31, Evans, Subscription Publication) adds that Accretive also "agreed to destroy or return health and financial information of its Minnesota clients within 60 days of closing down its Minnesota operations." The company will also "pay for an independent consultant to verify it did so." Meanwhile, CQ (7/31, Bunis, Subscription Publication) notes that in May, Accretive "put together a bipartisan group of former Health and Human Services officials and political leaders to 'develop a process for implementing national standards for how hospitals and other providers interact with patients regarding	Apparently, this is not collecting a medicare co-pay, but balances for ER from un insured patients, non-medicare patients. If they had insurance that may have covered. Note the team to advise on financial obligation. There is a 2 year post employment freeze on government political appointees

	their financial obligations.'" But it was not apparent Monday as to whether Accretive "plans to maintain that group, headed by Michael Leavitt, HHS secretary under President George W. Bush." **Reuters (7/31, Siddiqui) and the Wall Street Journal (7/31, Rubin, Subscription Publication) also cover the story.**	
Lessons from Medicare are applied to non-medicare attempts at health care regulation	**Massachusetts Legislators Reach Compromise On Healthcare Cost Containment Bill.** The Boston Herald (7/31/2012, Murphy) reports Massachusetts legislators "finalized a health care cost containment measure intended to trim more than $160 billion from health care costs over the next 15 years, and improve the quality of care for patients." Conference committee members expect a vote on the measure Tuesday. If it becomes law, "the bill would mark the most significant overhaul of the health care marketplace since former Gov. Mitt Romney signed a law in 2006 requiring most residents to purchase health insurance." The Boston Globe (7/31) reports the bill "would allow health care spending to grow no faster than the state economy overall through 2017" and would slow spending "to half a percentage point below the growth of the state's economy" for five years after that. However, "sticking to the cap could be a significant challenge for the state's robust health care industry." The bill includes a provision "to attack the market power of providers...that can demand high prices for their services because of brand-name or geographic dominance, one of the most-cited reasons for rising medical spending," as well as "provisions to reduce malpractice lawsuits, enhance public health and increase cost transparency for consumers." The conference committee dropped "some of the most stringent limits on providers" and a ban on hospitals in systems negotiating with insurers as a group.	Geographic dominance comes from the state restricting new hospitals, or requiring certificate of need.
Life expectancy advances faster than legislation.	**Bill Would Allow Seniors To Use Federal Employee Health Plans.** The New York Times (3/16, Weisman) "The Caucus" blog reports that "four Republican senators -- Rand Paul of Kentucky, Jim DeMint of South Carolina, Lindsey Graham of South Carolina, and Mike Lee of Utah --" initiated "a conversation Thursday on changes to Medicare, releasing a proposal that would end the federal fee-for-service insurance program in 2014 and enroll all recipients into the health insurance plan now offered to federal employees." Their plan would "give seniors and other recipients a menu of health insurance plans to choose from," including "all of the options available to members of	Return entry into Medicare to life expectancy.

	Congress and federal workers, but fee-for-service would end." Their plan also involves "a sliding scale for payments." In addition, "eligibility for the program would also slowly rise by three months a year for 20 years, going from age 65 to 70." The Hill (3/16, Pecquet) "Healthwatch" blog quotes Graham, who said, "Our goal is to save Medicare from bankruptcy and ensure seniors have affordable, high-quality health care - a crisis President Obama has only made worse during his time in office. Allowing seniors access to the Federal Employee Health Benefit (FEHB) program, which members of Congress and federal employees use, will give them more choices and lower their out-of-pocket costs."	
Life Expected time participants would use Medicare was 5 years, as beneficiaries hey didn't go into the program until they had reached life expectancy .	Disabled participants can stay for 80 years, as they are not restricted by age. Disabled make up one in four Medicare Participants.	Set up a separate program for the disabled and do not call it Medicare.
Life Expected time participants would use Medicare was 5 years, as they didn't go into the program until they had reached life expectancy .	Senior Participants stay for 20 years.	Set a years cap (such as 15 years) for usage, so people will delay going on so as not to run out of coverage.
Life Expected time participants would use Medicare was 5 years. So, audits were expected to be contemporaneous.	**Supreme Court Rejects Hospitals' 25-Year-Old Medicare Claims.** Reuters (1/23/2013, Baynes) reports that Tuesday, the US Supreme Court rejected a suit brought by 18 hospitals seeking to revisit certain Medicare reimbursement claims from up to 25 years ago. The group of hospitals claims that CMS miscalculated these payments between 1987 and 1994, basing their case on a previous lawsuit which found that the agency had relied on a flawed process to arrive at the number of low-income patients treated at other hospitals, leading to underpayments. The Court unanimously ruled that the hospitals claims were too old. Modern Healthcare (1/23/2013, Carlson, Subscription Publication) explains, "Providers had asked the high court to give them the same extra time to find underpayments in Medicare reimbursement that the government gave its outside contractors to find overpayments." The court, however, "rejected the	25 year old claims runs about as long as the beneficiaries.

	equity argument, noting the dozen or so private companies that manage Medicare claims have an extremely difficult job in looking for errors among claims from thousands of US hospitals, while hospitals, in contrast, have only their own claims to worry about."	
Line by line costs would be reviewed for co-pay. But as Medicare out ran its audit, the government went to bundling, so no one knows what one or ten items cost, just the total.	**Medicare Actuary: Controlling Cost Growth Is The Primary Challenge.** CQ (2/29/2011, Ethridge, Subscription Publication) reports that on Tuesday, Richard S. Foster, chief actuary for the Centers for Medicare and Medicaid Services, "Medicare's actuary warned...that controlling cost growth is the primary challenge to the entitlement program's financial stability, but that neither the premium support system sought by Republicans nor cost-cutting measures pushed by the administration provide all the answers." At a House Budget Committee hearing, Foster "cited programs promoted under the health care overhaul (PL 111-148, PL 111-152) -- such as bundled payments and better coordination of medical services under Medicare accountable care organizations and medical homes -- as efforts that can reduce cost levels but not the overall growth rate," but "said that the biggest contributors to the cost rate growth are the volume of services, a preference for new, more expensive health technologies, and economic inflation	Premium support , and cost-cutting have never been implemented, so we don't know how well they would work. What was implemented from the 1940s to 1960s was the business plan, which was never implemented. Here, the actuary suggest more bundling, moving even farther from line item costs. E.g. the $20 aspirin on the medical bill.
Medicare assumes medical schools would produce enough physicians to maintain full service. In 1970, there were 20 million eligible for Medicare at age 65+. The Ratio of care was about 150 patient to each provider. Beginning in the 1970s other groups were added to the Medicare systems, ESRD and disabled, increasing the base to about 45 million.	As of 2012, the ratio of medicare patients to medicare providers (physicians, therapists, druggists) is about 300 to 1 (45 million beneficiaries divided by 150 thousand providers) **Sebelius Touts ACA Equalization Of Medicaid, Medicare Primary Care Reimbursements.** The Hill (5/10/2012, Viebeck) reports in its "Healthwatch" blog, "Health and Human Services Secretary Kathleen Sebelius credited the 2010 healthcare law for a new proposed rule that would bring Medicaid primary care service fees in line with those paid under Medicare. The rule was announced Wednesday along with news that approximately 150,000 Medicare providers received nearly $560 million more in reimbursements last year because of the law." In a statement, Sebelius said, "[T]his proposed rule helps states and physicians provide every American, no matter where they live, access to the care they need to stay healthy. This new rule can help improve health and reduce costs by preventing illnesses before they happen." Furthermore, "Acting administrator for the Centers for Medicare and Medicaid Services Marilyn Tavenner noted that the	The article does not specify what categories the 150 thousand providers fill, all physicians or some therapists, some chiropractors, some nurses assistants or practitioners, some druggists, etc. Long term projections are to add more patients without increasing the providers, so the care ratio will continue to shrink. The beneficiaries in 2012 have half the number of

	payment increase will help prepare primary care networks for 'increased enrollment as the healthcare law is implemented.'" In a story carried by more than 125 news sources, the AP (5/10) reports that the rule would be "good only for the next two years, even if the Supreme Court upholds the law." In the short-term, White House officials say "it will bring Medicaid payment rates in each state up to what Medicare pays." If the Supreme Court rules in favor of Obama's health care legislation, "expect a lobbying campaign to make the two-year raise permanent." The Washington Post (5/10, Aizenman) reports, "The proposed regulation implements a two-year pay increase included in the 2010 health-care law. The increase, effective in 2013 and 2014, brings primary care fees for Medicaid, which covers indigent patients, in line with those for Medicare, which insures the elderly and some disabled patients." The National Journal (5/10, Fox, Subscription Publication) quotes Tavenner, who said, "Today's action will help encourage primary care physicians to continue and expand their efforts to provide checkups, preventive screenings, vaccines, and other care to Medicaid beneficiaries." The Washington Post (5/10, Kliff), in its "Wonkblog," notes that Roland Goertz, chair of the Academy of Family Physicians, argued that "primary care reimbursements are...an issue worth fighting for - especially after gaining a foothold within the Affordable Care Act." He remarked, "There's little question that low reimbursement discourages doctors from caring for Medicaid patients. Medicaid parity will enable doctors to care for more Medicaid patients." Also covering the story were CQ (5/10, Norman, Subscription Publication) and Modern Healthcare (5/10, Subscription Publication).	providers as in 1966. So providers are paid more to treat more. Or beneficiaries and taxpayers lose more to get less.
Medicaid expansion. 1960 U.S. census had about 180 million residents.[20] About 1.5 million population per medical school. When adopted Medicare was to cost the average wage earner a dollar a month to cover health care for the aged, over 65 (as reported in Taking Charge, Lyndon Johnson's public statement).	**Stick and Carrots - More States Consider Opting Out Of Medicaid Expansion.** The Washington Post (7/4, Aizenman, Somashekhar) reports on the growing number of Republican state leaders who are "revolting against the major Medicaid expansion called for under President Obama's health-care overhaul, threatening to undermine one of the law's most fundamental goals: insuring millions of poor Americans." The governors of Florida, Iowa, Louisiana and South Carolina have indicated that they will seek to opt out of expanding the program. Governors "of half a dozen other states - including Texas, home to one of the largest concentrations of uninsured people - are considering following suit. The governors argue that expanding their Medicaid programs, which are jointly funded with state and federal money, would crush state budgets."	Consider opening 1,000 medical schools instead. The cost is less and the long term benefits are sure. Medicare and Medicaid have never been funded, as the current expense has been due to deficit borrowing.

The Hill (7/5/2012, Viebeck) reports in its "Healthwatch" blog, "At least 15 governors have indicated they will not participate in the expansion of Medicaid under the healthcare law, striking a blow to President Obama's promise of broader insurance coverage." The piece notes that "the decision is...loaded with politics, particularly for Republican governors who are adamantly opposed to 'ObamaCare.'"

The AP (7/4, Alonso-Zaldivar) reports, "Officials at the Health and Human Services department say they are not particularly concerned. They may have lost the stick, but they still have carrots." Mike Hash, director of the HHS office responsible for the health overhaul, remarked, "We believe that states will in fact take advantage of the coverage for these individuals because of many factors. One is the available federal funding." He noted that "not every state took part when the Children's Health Insurance Program was launched in the 1990s," although "within two years they were all aboard." The Kansas City (MO) Star (7/4, Helling) and the Waterville (ME) Morning Sentinel (7/4, Mistler) reported on their states' plans.

Five States Have Already Extended Medicaid Over Past Two Years. The Washington Post (7/4, Kliff) reported in its "Wonkblog" that "over the past two years, five states have quietly executed the Affordable Care Act's largest coverage expansion to date, extending benefits to more than 500,000 Americans. ... Five states – California, Connecticut, Minnesota, New Jersey and Washington - as well as the District of Columbia took the Obama administration up on the offer."

Medicaid Expansion Likely To Play Role In This Year's Elections. The Christian Science Monitor (7/4, Feldmann) reports that by ruling states have the option of refusing to expand Medicaid, the Supreme Court "has served up a juicy campaign issue." The Monitor notes, "The issue is likely to play big in competitive gubernatorial elections. Ditto races for state legislatures, which will also play a role in deciding whether a state opts out of expanded Medicaid."

Louisiana Governor Says He Will Oppose Medicaid Expansion. Politico (7/5/2012, Lee) reports, "Louisiana Gov. Bob Jindal, who has vowed to reject the expansion of Medicaid under President Barack Obama's health care law, charged Tuesday that the president 'measures success by how many people are on food stamp rolls and government-run health care.'" Gov. Jindal said, "This is a bad law. Obamacare, it doesn't do what the president promised," adding, "Governors have the right, now with the Supreme Court ruling. They should stand up. We're not expanding Medicaid. We're not implementing the health exchange."

Medicaid was unknown to Medicare in 1966. Co-pay would control costs. When Medicaid assumed the co-pay, so patients had no skin in the game, costs rose.	**Medicaid Cutbacks Divide Democrats** House Condemns Provisions Crafted By Governors By Jonathan Weisman Washington Post Staff Writer Monday, November 28, 2005; A01 Controversial House legislation designed to gain control of Medicaid growth has split Democrats, with lawmakers in Washington united in their opposition while Democratic governors are quietly supporting the provisions and questioning the party's reflexive denunciations. The Medicaid provisions have become a flashpoint for the opposition of Democrats -- and some moderate Republicans -- to the $50 billion budget-cutting bill that narrowly passed the House last week. The provisions would reduce Medicaid spending by $12 billion through 2010 and $48 billion over the next decade, in part by making it difficult for more affluent seniors to transfer their assets to relatives, then plead poverty to get Medicaid to pay for them to stay in nursing homes.[21]	Return co-pay to Medicaid.
Medical device, What is it?	**House Republicans Ask FDA If Smartphones, Tablets Are Medical Devices Under ACA.** The Hill (3/5, Viebeck) "Healthwatch" blog reports that six Republican lawmakers on the House Energy and Commerce Committee, including Chairman Fred Upton (R-MI), wrote to the FDA, inquiring if "smartphones, tablets and apps will be regulated as medical devices under President Obama's healthcare law." The Republicans "said the Affordable Care Act's excise tax on medical devices, if applied to mobile apps and smartphones, could 'affect the growth and innovation in this market.'" The letter acknowledged that "the FDA's draft approach to regulating mobile medical devices would only apply to technologies that were explicitly marketed for medical uses," but lawmakers were still concerned "about the potential of 'actual use' becoming a factor in the future."	**Certainly an activity of daily living and standard of living issue.**
Medicare appeals would be made by patients and beneficiary tax payers. This encouraged a pro-pay attitude, which was adopted by Social Security Judges	By 1966, within a few months of passage, providers and suppliers became the overwhelming number of appellants, using the appeals system designed for patients.	Have separate rules for appeals by patients, and those from hospitals, physicians, suppliers and providers.

which paid the claims. To be "user friendly" the hearings were non adversarial, claims were expected to be routinely paid. Appeals were cheap to pursue up to law suits in federal court.		
Medicare as secondary payor was intended to cover health costs when caused by others, such as an auto accident.	Little monitoring is done if the amounts are small. This article lists one hundred million as the amount to get attention. **US Busts $279 Million No-Fault Auto Insurance Scam In NYC.** The AP (3/1/2012) reports from New York, "A cadre of corrupt doctors and scam artists sought to cheat auto insurance companies out of $279 million in bogus medical claims - the largest-ever fraud involving New York's no-fault law, authorities said Wednesday." The AP continues, "The investigation resulted in federal racketeering, health care fraud, mail fraud and money laundering charges against 36 people, mainly of Russian descent," including ten physicians and three attorneys. "At a news conference, US Attorney Preet Bharara said while the false claims totaled $279 million, the actual loss to private insurers was $113 million." The New York Daily News (3/1/2012) reports, "Two NYPD cops posing as car-accident victims helped bust a ring of Russian-American scammers who bilked $113 million from insurers with bogus clinics, the feds said Wednesday. Authorities called it the biggest no-fault insurance fraud case in history, more audacious in breadth and complexity than other similar schemes. 'They turned that law on its head,' Manhattan US Attorney Preet Bharara said." The New York Post (3/1/2012 Golding) reports, "The fraudsters allegedly took advantage of the 'patient-friendly provisions' of New York's mandatory 'no-fault' automobile insurance coverage, which guarantees up to $50,000 in medical benefits for anyone hurt in a car crash." Bloomberg News (3/1/2012, Van Voris) reports, "Lawyers connected to the scheme filed fraudulent personal injury claims and suits to make additional money, the government said in the indictment. Charges against participants in the alleged scheme include racketeering conspiracy, health-care fraud conspiracy, conspiracy to commit mail fraud and conspiracy to launder money." The Wall Street Journal (3/1, /2012 El-Ghobashy, Subscription Publication) reports that Bharara said the investigation was ongoing, and would not say if any patients would be charged in the probe. The New York Law Journal	If the accused do not have money for attorneys to defend the criminal charges, state paid attorneys will defend them. If they are convicted of non violent crimes, the correctional facilities will provide free health care, free dental care, air conditioning, heating, food clothing shelter and recreation, for the duration. An alternative solution is to get Medicare out of the secondary payor business model, as is done for non-Medicare injured who are treated all the time. The health industry knows how to wait for the settlement or litigation for torts (i.e. wrongs).

	(3/1/2012, Subscription Publication) and Reuters (3/1, Stempel, Berkowitz) also report this story. Brooklyn Neighborhood Is Focus Of Probe. The New York Times (3/1/2012, Rashbaum, Subscription Publication) reports that "when the details were announced on Wednesday, they cast an unflattering spotlight on how immigrants from the former Soviet Union have often dominated such schemes in the city. This one, like many others, had its nerve center in Brighton Beach, Brooklyn, the locus of the city's Russian-speaking immigrant population, many of whom grew up under a Communist system that bred disdain for the rules and a willingness to cheat to get around them."	
Medicare assumed some competition in health care, more physicians, etc. But health industry gets a pass as the government sets prices (fee schedule and approved amount), number of seats in medical schools, rationing physicians and health care professionals.	**New Rules Seek To Ease Regulatory Burden On Hospitals, Healthcare Providers.** USA Today (5/11/2012) reports, "The Obama administration announced...it has changed or eliminated five regulations, saving the economy an estimated $6 billion." The President "also signed a new executive order 'making it a continuing obligation of our government to scrutinize rules on the books to see if they really make sense,' said a White House statement." The "changed regulations affect street signs, railroads, hospital paperwork and gas stations." The Hill (5/11/2012, Viebeck) "Healthwatch" blog reports that the "first rule issued Thursday will make small revisions to the Medicare Conditions of Participation in order to give hospitals more flexibility in their operations." A "second rule would eliminate overlapping or outdated rules that govern healthcare providers." Bloomberg BusinessWeek (5/11/2012, Zajac) reports, "Hospitals will be allowed to replace some staff physicians with nurse-practitioners and physician assistants, saving the industry an estimated $330 million a year, the government said." Hospitals "will also be able to reorganize supervision of their outpatient departments, saving an estimated $305 million a year." Meanwhile, "dialysis clinics, which treat people suffering kidney failure, won't be required to build fire-protection structures that are necessary in hospitals, where patients are unconscious or immobilized." CQ (5/11/2012, Norman, Subscription Publication), in an article titled "HHS Issues New Regulatory Relief Rules, But Not Without Push-Back," reports, "More than 1,100...letters objecting to a provision in the hospital rule were the result of a writing campaign by anesthesiologists" who "objected to a provision that they said would go too far in expanding the types of medical professionals -- namely nurse practitioners -- able to administer drugs and	Open 200 medical schools or 1,657 new medical schools with 50,000 seats a year, instead of 15,000 seats.. See Years to Equilibrium for the cost for expanding medical physician training. If it saves money to replace physicians, why not use candy stripers or volunteers?

	biologics, including powerful painkillers vulnerable to abuse. CMS kept that proposal in the final rule."	
Medicare assumed some competition in health care, more physicians, etc. But health industry gets a pass as the government sets prices (fee schedule and approved amount), number of seats in medical schools, rationing physicians and health care professionals.	**Nurse Practitioners To Fill Doctor Gap** The Washington Post (5/13, Sarah Kliff) reports that nurse practitioners are preparing to fill an expected gap in the supply of doctors in the US. The American Academy of Nurse Practitioners plans "advertisements, public service announcements and events" and "will follow up on the public relations blitz with state-level lobbying efforts, looking to pass bills that will expand the range of medical procedures that their membership can perform." The Post points out that they likely will get "a fight" from doctors' groups such as the American Medical Association.	Fill doctor gap by opening 1,000 medical schools.
Medicare assumed some competition in health care, more physicians, etc. But health industry gets a pass as the government sets prices (fee schedule and approved amount), number of seats in medical schools, rationing physicians and health care professionals.	**Nurse Practitioners See Greater Role Meeting Healthcare Needs Under Affordable Care Act.** The Hill (5/15, Baker) reports in its "Healthwatch" blog, "The American Academy of Nurse Practitioners (AANP) says nurse practitioners should be an increasingly important resource as President Obama's healthcare law begins to take effect." The law is expected to worsen an existing "shortage of primary-care doctors," with "new demand for healthcare services." AANP President Kaye Jensen called it "a health care crisis of unmatched proportions." The Washington Post (5/15, Kliff) reports in its "Wonkblog" that "nurse practitioners are rolling out a campaign this week to explain what, exactly, nurse practitioners do - and why patients should trust them with their medical needs." Penny Kaye Jensen, president of the American Academy of Nurse Practitioners, remarked, "We know that the Affordable Care Act will extend health coverage to millions of Americans. It's important for consumers to understand what we do and that we're fully prepared to care for them." ***Nurse Practitioners Seek Updates To Texas Regulations.*** The Dallas Morning News (5/15, Garrett) reports that, "nearly 7,000 nurse practitioners and about 4,500 of their nursing colleagues with advanced training" are calling for "updating a 23-year-old law that imposes 'unnecessary restrictions' on their treating of patients." They object to not being allowed to "prescribe medications	

	in many situations," and have "released a study by Waco economist Ray Perryman that says nurse practitioners, certified nurse anesthetists, clinical nurse specialists and nurse midwives could fill many current gaps in the state's health care system -- and help it survive an expected wave of 6 million newly insured Texans," if the Affordable Care Act "survives judicial scrutiny and is carried out in 2014." Texas Medical Association president Bruce Malone said that it would be "a big issue" were there a proposal for independent practice for nurses, but physicians would be "receptive" to "an update of rules governing doctor supervision and nurses' prescriptive authority."	
Medicare assumed some competition in health care, more physicians, etc. But health industry gets a pass as the government sets prices (fee schedule and approved amount), number of seats in medical schools, rationing physicians and health care professionals	**Hospitals, Medical Groups Turning More Often To "Locum Tenens" Physicians.** Forbes (5/16, Japsen) reports, "The worsening doctor shortage means more work for physicians on temporary jobs, but could be trouble ahead for patients looking for a medical professional as more Americans get health benefits under the Affordable Care Act." One "side of the nation's worsening doctor shortage can be seen in a new report from Staff Care, an Irving, Texas-based physician staffing company and subsidiary of AMN Healthcare (AHS)." Staff Care "says hospitals and medical groups can't find enough permanent physicians they need and are turning more and more to what the industry calls 'locum tenens' physicians."	The term "**locum tenens**" comes from the Latin meaning "to hold the place of". It simply means someone, usually in health care, who substitutes for someone else. Why not open 1000 medical schools instead?
Medicare business model was that health care for seniors could be provided for $1 per month per worker in 1966 money.	**Insurers Stand To Gain $1 Trillion In New Revenue Over Eight Years Under ACA.** Bloomberg News (5/15, Wayne) reports, "Health insurers will gain $1 trillion in new revenue over the next eight years under the 2010 health- care law, assuming it's upheld by the Supreme Court, according to a Bloomberg Government study." Bloomberg adds that "the amount is equal to about one-half percent of the nation's estimated gross domestic product from 2013 to 2020, and insurers led by UnitedHealth Group Inc. (UNH) would keep about $174 billion -- $22 billion a year -- for profit and administrative costs."	This moves about $10,000 per worker in NEW revenue to insurers. UnitedHealth, with AARP's endorsement, has half of he Part D prescription plan drug market. UnitedHealth pays a referral fee to AARP for enrollees who choose UnitedHealth's plans.
Medicare business model	**Insurance Companies To Lose One Trillion In Revenue If ACA Found**	This saves about $10,000

was that health care for seniors could be provided for $1 per month per worker in 1966 money. With a trillion dollars at stake, the insurers are rallying the troops against retreat.	**Unconstitutional.** The Washington Post (5/16, Kliff) reports in its "Wonkblog" that Bloomberg Government "number crunchers have taken a look at what happens if the Supreme Court strikes down the Affordable Care Act and its expected expansion of health care coverage to 32 million Americans. They find that, should the Affordable Care Act be found unconstitutional, insurance companies will lose $1 trillion in revenue between 2013 and 2020." Bloomberg Government health care analyst Matt Barry remarked, "It's the sheer size of the number that was startling. I don't know if people fully appreciate the stakes involved here. It's not just politics - there's a lot of money, and a lot to lose." The Hill (5/16, Viebeck), in its "Healthwatch" blog, quotes Barry, who said, "It's a confirmation of, one, how much money we're spending as a nation on healthcare, and two, how much is riding on this court case and the Supreme Court's decision. You're talking [about] an amount of money here that can affect the economy, not just an industry."	per worker in NEW revenue to insurers. UnitedHealth, with AARP's endorsement, has half of he Part D prescription plan drug market. UnitedHealth pays a referral fee to AARP for enrollees who choose UnitedHealth's plans. Presumably the trillion would come from outside the health industry. The list of Amici supporting Obamacare is available, with the names of these insurers.
Medicare had no lifetime limits on coverage. Part A did have co pay of total costs after 150 days per benefit period. Lifetime caps are a private insurance model for working employees.	**Private insurance lifetime caps were eliminated. Report: ACA Has Cut Insurance Coverage Lifetime Limits For 105 Million Americans.** The National Journal (3/6/2012, Subscription Publication) reports on data released Monday by the Department of Health and Human Services, which showed that "the 2010 health reform law has eliminated lifetime limits on insurance coverage for more than 105 million Americans." HHS Secretary Kathleen Sebelius remarked, "For years, Americans with lifetime caps imposed on their health insurance benefits have had to live with the fear that if an illness or accident happened, they could max out their health coverage when they needed it the most. Now, because of the health care law, they no longer have to live in fear of that happening." The Hill (3/6, Pecquet) reports in its "Healthwatch" blog, "The state-by-state report is part of the White House's push to highlight popular provisions of the law ahead of its second anniversary later this month. ... The administration also released updated state-by-state data on other benefits of the health law, including the number of Medicare beneficiaries receiving new preventive benefits and the various grants awarded to states." The New Orleans Times-Picayune (3/6, Barrow) reports, "The federal health insurance law of 2010 has eliminated lifetime coverage limits for more than 1.4 million Louisiana residents in the private insurance market." CQ (3/6,	Although the caps are eliminated, there are no additional hospital beds, medical students, nursing students, or health providers to give the service. Give the patients 10 policies, but the policies diagnose, or cure or treat a disease. This is an empty gesture without a 10 fold increase in health providers.

	Subscription Publication) also reports this story.	
Medicare required equipment to be reasonable and necessary. After 1976, Medicare relied on FDA's finding that equipment is safe and effective to be paid.	98% of all medical equipment is cleared by the FDA as having been sold before 1976 without any review of safety and effectiveness.	Cover only equipment which has been FDA Approved, not just cleared.
Medicare required services to be reasonable and necessary.	Service is demonstrated by Certificate of Medical Necessity.	Return the Certificate to FDA standard of safe and effective.
Medicare requires drugs to be reasonable and necessary. Medicare relies on FDA's finding that drugs are safe and effective. FDA approval of drugs would mean only useful products would be paid by Medicare.	40% (?) of drug prescriptions are for Off label use. 2% of prescription drugs were never FDA approved for anything.[22]	Stop off label coverage. Either get it approved, or no coverage. Otherwise there is no incentive to do the clinical trials.
Medicare requires drugs to be reasonable and necessary. Medicare relies on FDA's finding that drugs are safe and effective. FDA approval of drugs would mean only useful products would be paid by Medicare.	**Utah's Inspector General Recovers Improperly Paid Medicaid Fund.** The Salt Lake (UT) Tribune (5/24/2012, Stewart) reports that Utah's Medicaid Inspector General, Lee Wyckoff, along with his auditing team, has "recouped $5.6 million in overpaid Medicaid claims and avoided $4 million in spending by cracking down on the off-label use of psychotropics and other questionable prescribing practices, according to information obtained from the governor's office" during the past year. Further, "negotiations are underway with hospitals to recoup another $20.5 million, a chunk of it in inflated hospital emergency charges dating back to 2008." Last year, Utah lawmakers created the inspector general position, which is meant "to recoup, reduce, avoid and minimize costs and to 'seek recovery of improperly paid Medicaid funds,'" in response to concern for Medicaid funding.	Stop off label coverage. Either get it approved, or no coverage. Otherwise there is no incentive to do the clinical trials.
Medicare requires drugs to be reasonable and necessary. Medicare relies on FDA's finding that drugs are safe and effective. FDA approval of drugs would mean only	**Abbott Settles Depakote Marketing Dispute With DOJ, States For $1.6 Billion.** Abbott Laboratories reached a settlement with the Justice Department and several states over illegal marketing practices for its anti-seizure drug Depakote, in which Abbott will pay $1.6 billion in criminal and civil fines. The announcement generated heavy media coverage, including a brief mention on	Use same definitions across the board in different statutes, i.e. Medicare and FDA and NIH and VA and all health related fields. Off

useful products would be paid by Medicare. The problem arises when congress did not use the same language in Medicare as it had previously in FDA. Medicare is reasonable and necessary. FDA is safe and effective. This means that once a drug is approved by the FDA for ANYTHING, if can be prescribed off label by a physician for anything else. The restriction is that drug companies are not supposed to MARKET for off label use, just wink and nod to physicians to figure that one out.	ABC World News. ABC World News (5/7/2012, story 8, 0:30, Sawyer) reported, "Tonight one of the largest drug companies, Abbott Laboratories has agreed to a staggering settlement. Today $1.6 billion in criminal and civil fines for improperly marketing the anti-seizure drug Depakote in nursing homes. The company convinced the nursing homes to use the drug to treat aggression in dementia patients, despite the lack of credible evidence that the drug was effective for that use." The New York Times (5/8, Schmidt, Thomas, Subscription Publication) reports, "The settlement comes as the Justice Department and the states have increased scrutiny of the sales and marketing practices of pharmaceutical companies, particularly in cases in which they market drugs for uses that are not approved by the Food and Drug Administration." The Wall Street Journal (5/8, Loftus, Kendall, Subscription Publication) reports that in addition to the fines, Abbott would plead guilty to a misdemeanor charge of violating a federal drug law. The Journal quotes Deputy Attorney General James Cole saying, "Today's settlement shows further evidence of our deep commitment to public health and our determination to hold accountable those who commit fraud, We are resolute in stopping this type of activity and today's settlement sends a strong message to other companies." The Washington Post (5/8, Aizenman) reports, "The settlement, which includes an agreement to plead guilty to a criminal misdemeanor, is the second-largest in a string of multimillion-dollar payouts in recent years resulting from stepped-up enforcement by the Justice Department and state investigators against drug makers that 'misbrand' their products." The AP (5/8) reports, "At a news conference at the Justice Department, US Attorney Timothy Heaphy said that the top levels of Abbott carried out a strategy of systematically marketing the drug for purposes other than what federal regulators had allowed. The illegal conduct was not the product of 'some rogue sales representatives,' said Heaphy, the US attorney for the western district of Virginia. He said the company engaged in the strategy from 1998 to at least 2006	label marketing is fine with the FDA, under the reasoning that the physician on the spot can best judge the needs of the patient. Abbott should have used its time to study the drug in clinical trials.
Medicare was passed with laws that hospitals and providers, taking federal funds, had to treat all comers. Insurance policies do not deliver babies,	**Uninsurance Said To Cause "American Tragedy."** The Hill (6/21/2012, Viebeck) reports in its "Healthwatch" blog that more than 26,000 Americans will die due to uninsurance, according to a new Families USA report. "Families USA Executive Director Ron Pollack called premature deaths among the uninsured 'an American tragedy and an American shame.'" He added, "The Affordable Care Act lets us wake up from this terrible healthcare	Then give them an insurance policy, give them 10 policies. But without more seats in medical schools, the line to get treatment grows

diagnose, proscribe, treat or cure.	nightmare of premature death. Wiping out health reform means the nightmare will continue for all Americans." Also covering the story are CQ (6/21, Norman, Subscription Publication), Reuters (6/21, Morgan), and Forbes (6/21, Herper).	ever longer, and rationing ever more dear.
Medicare was President Lyndon Johnson's Great Society health plan, patterned after the Blue Cross Blue Shield of industry with co-pay deductibles. It became Johnson's signature legislation (after ballooning the Vietnam War).	**Potential Budget Deals Involve Tweaks, Not Defunding, Of ACA.** As Congress seemed to move closer to a deal to resolve the government shutdown and avert a debt ceiling breach Tuesday, several provisions of the Affordable Care Act played a major role in the back-and-forth. As many national outlets, and heavy coverage in the beltway publications, suggest, tweaks to the Affordable Care Act may be necessary to end the budget crisis. Generating the most buzz so far are the Congressional health care subsidies, the medical device tax, and an obscure provision known as the reinsurance fee. In an overview piece, the Wall Street Journal (10/16, Radnofsky, Subscription Publication) reports on the collection of changes Republicans are seeking: some minor and obscure, some better-known. Still, the paper acknowledges that no matter how far-reaching their deals have been, they do not accomplish the main goal that set off the impasse in the first place: defunding the law in its entirety. As CNN (10/16, Smith) puts it, the "potential" deals circulating to end the budget impasse "barely touch the core of Obamacare, the health insurance program congressional Republicans set out to cripple." And to this point, Politico (10/16, Nather) reports that Tea party groups "are furious over the prospect that Congress is drifting toward" a deal that would "just take the usual one or two tepid dings out of President Barack **Obama's signature health care law**, just like Congress has in previous fights." A proposal known as the "Vitter amendment" is garnering the most attention. USA Today (10/16, A1, Korte) reports that "Congress' own health insurance" may be "one of the last obstacles to reaching a deal to reopen the government and avoid default." On Tuesday, House Republicans floated a bill to end the budget impasse, "but it also would have eliminated the employer contribution for health care for all members of Congress, their staffs, the president, the vice president, and all their political appointees." However, as Politico (10/16, Allen) reports, President Obama vowed on Tuesday that he "would veto debt-ceiling legislation if it includes a provision pushed by Sen. David Vitter (R-La.) and House GOP leaders" that would end	Congressional employees have subsidized at 70% their costs.

	health subsidies for congressional and senior executive branch officials. Similarly, according to Bloomberg News (10/16, Rubin, Hunter, Tiron), Senate Majority Leader Harry Reid is holding out for a deal from the House which doesn't include two specific changes to the ACA: those that "would delay for two years a medical-device tax and prevent the government from contributing to the health insurance of members of Congress, the president, the vice president and the Cabinet."	
Medicare will cost the average worker in 1966 $1 per month.	**Government benefit programs in trouble** By MARTIN CRUTSINGER, AP Economics Writer 25/03/2008 Trustees for the government's two biggest benefit programs warned that Social Security and Medicare are facing "enormous challenges" with the threat to Medicare's solvency far more severe.[23]	Debt financing postponed the problems.
Medicare would review and audit claims. The model was military procurement.	95% of claims are paid, without review. There is no audit.[24] On appeal to Judges (4th review) 70% are "covered" (i.e. paid), on further appeal to the Council (5th review) 70% of remainder are covered or kept alive. Denials (i.e. not paid) are 98% of all appeals.	Double (10%) , triple (15%), quadruple (20%) audits.
Medicare's business plan was based on the experience, success and precedent of the World War Two health incentives and Blue Cross and Blue Shield. Medicare immediately morphed into a different business model, nor cost to you health care.	**Healthcare Law Challenge To Feature Clash Of Legal Precedents.** The Washington Times (3/13, Cunningham) reports, "As President Obama's health care law heads for an epic Supreme Court showdown this month, the administration and its opponents are struggling to convince the court that it can rule in their favor without upsetting years of precedent or opening the door to all sorts of mischief." Federal attorneys have "the tough task of arguing that the justices can uphold the federal government's power to force all Americans to buy insurance without giving legal sanction to other mandates," but "the more than two dozen states suing to overturn the law face a tall hurdle of their own: convincing the court that it can strike down new Medicaid rules embedded in the law without giving the states carte blanche to ignore the strings that are attached routinely to federal spending on such items as education, transportation and the legal drinking age."	In many places the regulations, or cases, or laws state they are not precedent. If not, what is the problem?
Nothing would permit waste from being prevented. Sec. 1395kk-1. Contracts with medicare administrative contractors	**CONSTRUCTION Pub. L. 108-173, title IX, Sec. 901(a), Dec. 8, 2003, 117 Stat. 2374, provided that: "Nothing in this title [see Tables for classification] shall be construed - "(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly**	This statute is ignored, either by 1) limiting the definition of title to just to that section on contractors, 2) arguing as to what the meaning of

	known as the 'False Claims Act'); or "(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.	waste is, 3) denying the waste, fraud, abuse as too unfriendly, 4) creating other rights which have more priority. Why not enforce this across the board?
Original Medicare was for seniors, not poor and disabled Medicaid has changed this business model. States are scored on insurance rather than physician ratio. State Rank depends on what is measured? Reimbursement rates? Texas is 48th Easy eligibility? Quality of care? Scope of services?.Life expectancy - Texas is 30th (2010). Fertility Rate - Texas is 4th (2008) The AHRQ report is from hospital reports.	**AHRQ Ranks Texas As Worst In US In Healthcare Services, Delivery.** The AP (7/6) reports, "Texas ranks worst in the nation in health care services and delivery, according to an annual scorecard issued by the federal Agency for Health Care Research and Quality." According to the AP, "The Texas Medicaid law for the disabled and poor offers one of the most limited health care programs in the nation, and more than 25 percent of Texans do not have health insurance of any kind, which is the highest uninsured rate in the nation." The Houston Chronicle (7/6, Ackerman, Walczak) reports, "Texas scored 31.61 -- less than half of top-ranked Minnesota's 67.31 - out of a possible 100 points in the Agency for Healthcare Research and Quality annual rankings." The state, "rated 'weak' or 'very weak' in nine of 12 health delivery categories...dropped from 47th place in 2010 to 51st in 2011, behind all other states and Washington, D.C." The Austin (TX) American-Statesman (7/6, Roser) reports, "Texas rated below the average of all other states on treating women under 70 with breast cancer who received breast-conserving surgery and radiation within a year of diagnosis, as well as four factors involving management of home health care patients: those who got better at getting in and out of bed and those having shortness of breath, pain when moving around and urinary incontinence." The state "scored best on preventing weight loss among long-term nursing home residents; controlling pain among shorter-term nursing home residents; children who received the Haemophilus influenzae type B, or Hib, vaccine; small children who received all recommended vaccines; and the number of prostate cancer deaths."	AHRQ ranks on number of uninsured rather than medical school seats and patient to physician ratio, or life expectancy. Insurance policies never gave shots, diagnosed, treated, or cured a disease. Hospitals agenda is to claw back expenses from the uninsured.
Original Medicare was for seniors, not poor and disabled Medicaid has changed this business model.	**CDC: Medicaid Paid For 41 Percent Of Ohio Births.** The Zanesville (OH) Times Recorder (12/25/2013, Zimmer) reports on new data from the Centers for Disease Control and Prevention that found that 41.2% of all 2010 births in Ohio were paid for by Medicaid. The same report (PDF) found that private insurance paid for 50% of births, and 4.7% of delivering mothers	Medicaid has become the funding source in Ohio.

	were uninsured.	
Over charge for drugs would be solved with co-pays. The patient would compare the cost from other suppliers.	**California Accuses Drug Companies of Fraud** By JOHN M. BRODER LOS ANGELES, Aug. 25/ 2005 - The attorney general of California sued 39 drug companies on Thursday, accusing them of bilking the state of hundreds of millions of dollars by overcharging for medicines. Attorney General Bill Lockyer charged that the drug makers, including some of the world's leading pharmaceutical concerns, defrauded the state's Medi-Cal system for at least the past decade. Mr. Lockyer said the drug manufacturers charged Medi-Cal as much as 10 times the price for some drugs as they charged others, like private pharmacies and hospitals.[25]	Medi-cal is Medicaid in California. Co-pay was dropped from Medicaid. Co-pay is the best and first chance to stop over charging.
Participants would pay co-insurance and deductibles. The co-pay would be a reminder that money was being spent, while millions of decisions are made. The example was the health insurance experience from WW2 and Blue Cross and Blue Shield.	Providers do not collect co-insurance, or make feeble effort, so as not to discourage utilization.[26]	Require providers to show proof of co-insurance is being paid, and deny payment to the provider until the co-pay is met.
Participants would pay co-insurance and deductibles. The co-pay would be a reminder that money was being spent, while millions of decisions are made. The example was the health insurance experience from WW2 and Blue Cross and Blue Shield.	**Insurer "Redirects" Members To Cheaper Medical Imaging.** The Columbus (OH) Dispatch (7/2/2012, Sutherly) reports that an initiative from Anthem Blue Cross and Blue Shield in Ohio "to spread the word about low-cost alternatives for medical imaging is popular with price-conscious consumers, who have the final say in where they have their imaging done." Anthem, "since rolling out the program in September...has 'redirected' 3,561 of its Ohio members elsewhere for medical imaging services. With an average savings of about $800, that's nearly $3 million in cost savings so far."	This confirms what was learned in the 1940s to 1960s that consumers are good managers of their own care if given the chance or incentive. Good management includes price and location.
Participants would pay co-insurance and deductibles. The co-pay would be a reminder that money was	**Growing Numbers Of Employers Offer Incentives For Employees To Stay Healthy.** The Wall Street Journal (6/29, Ensign) "At Work" blog reported that about 20% of employers this year have offered a discount on their employees' health	Incentives in health care are workable. Patients will respond.

being spent, while millions of decisions are made. The example was the health insurance experience from WW2 and Blue Cross and Blue Shield.	insurance premiums if those employees refrain from using tobacco products. In addition, about 21 percent of employers this year are offering discounts on premiums if employees get an annual health risk assessment. According to the blog post, these companies are interested in using incentives to influence employees' behavior and thus help to keep health costs lower.	
Participants would pay co-insurance and deductibles. The co-pay would be a reminder that money was being spent, while millions of decisions are made. The example was the health insurance experience from WW2 and Blue Cross and Blue Shield.	**Bishops Threaten To Sue Over Birth Control Mandate.** The Hill (5/16, Viebeck) "Healthwatch" blog says the US Conference of Catholic Bishops wrote HHS a letter Tuesday threatening court action over the Obama Administration's mandate that health insurance plans provide birth control to women without a co-pay. The letter read, "[F]orcing individual and institutional stakeholders to sponsor and subsidize an otherwise widely available product over their religious and moral objections serves no legitimate, let alone compelling, government interest." The letter to HHS was accompanied by 20 pages of comments on a "forthcoming rule to accommodate certain religious organizations, such as Catholic hospitals, that were not exempted from the original mandate." Lawyers for the bishops argue that the arrangement was insufficient for individual, pro-life employers, who "can drop out of the health insurance marketplace altogether, or offer or provide the objectionable coverage." The AP (5/16) reports, "The bishops said in a statement Tuesday to Health and Human Services that the prospective new rules don't do enough to protect religious liberty." The National Journal (5/16, McCarthy, Subscription Publication) reports, "The birth control brouhaha has died down since Republicans took a political beating following a now-infamous House Oversight and Government Reform hearing that had no female witnesses. HHS still has to develop a final rule on the accommodation	Require providers to show proof of co-insurance is being paid, and deny payment to the provider until the co-pay is met.
Patients had an incentive to keep costs low because of their co-pay out of pocket. But auditing disappeared relying on patients' own incentive to keep their costs low. Recruiters stepped in to keep the beds filled.	**Former Hospital Official Pleads Guilty To Medicare Fraud.** The Houston Chronicle (2/23/2012, Langford) reports, "A former member of Riverside General Hospital's executive staff pleaded guilty Wednesday for his role in a $116 million Medicare scheme that paid kickbacks to patient recruiters and personal care home owners in exchange for directing residents to Riverside's mental health clinics. Mohammad Khan, 62, pleaded guilty before US District Judge Sim Lake to one count of conspiracy to commit health care fraud, one count of conspiracy to pay health care kickbacks and five other counts of paying and offering to pay kickbacks." But "Khan's attorney, Wayman Prince, said his client is assisting investigators with the FBI and the US	Won't keep the beds filled if the patient is paying some of the cost.

	Department of Health and Human Services Office of Inspector General probe into how Medicare patients receive care at Riverside's mental health clinics."	
Patients had an incentive to keep costs low because of their co-pay out of pocket. But auditing disappeared relying on patients' own incentive to keep their costs low.	**Walgreen Co. Required To Return $42,000 To Missouri Medicaid.** The AP (5/25) reports, "Missouri Attorney General Chris Koster says the state's Medicaid program will receive about $42,000 from a national legal settlement with Walgreen Co. The settlement resolves complaints that Walgreens Co. improperly tried to get people to switch their prescriptions to its pharmacies." Walgreen Co. "has agreed to pay civil damages totaling $7.9 million to states and the federal government." The St. Louis Business Journal (5/24/2012, Weiderman, Subscription Publication) reports, "According to Koster, the settlement resolves allegations that, between Jan. 1, 2005 and June 11, 2010, Walgreens unlawfully offered gift cards and gift checks to influence people who participated in government health care programs such as Medicaid and Medicare to transfer their prescriptions to Walgreens' pharmacies." The Journal added, "The $7.9 million national settlement is based on the total amount Walgreens offered in gift cards and gift checks."	Patients apparently responded to bribes to switch drug refill business. Since the patients were not paying for the drugs, the down the road cost was not a disincentive to find the lowest price. Indeed, the beneficiaries probably never know what the drug costs the government. So who cares? (other than the next generation of taxpayer whose national debt is covering the extra costs)
Patients in hospitals were in multi bed wards, or semi private rooms.	Hospitals place patients in semi-private or private rooms. Keep the beds filled.	Pay for open ward rate, and if patient wants privacy to pay the difference.
Patients were to watch their account.	**Indictment: Identity Thieves Hit Two Detroit Hospitals.** The Detroit Free Press (11/18, Baldas) reports that two identity thieves stole the personal information of hundreds of patients at two Detroit-area hospitals to defraud the government out of $489,000, according to an indictment. Markitta Washington and Martez Lear are accused of filing false tax returns in the names of at least 305 victims. The two were found to have "stacks of hospital patient records" at their shared home, the indictment says. The Detroit News (11/18, Williams) reports that Markitta Washington is a former employee of Henry Ford West Bloomfield Hospital and DMC Harper Hospital, who allegedly used her access to patient medical records to facilitate the crime.	**Where are the patients? Not watching their accounts.**

Physicians started and founded and owned hospitals, or founded medical schools. Such as Mayo Clinic, Johns Hopkins, Cleveland Clinic, etc. Physicians were independent of hospitals, and acted as a balancing competition..	The Omnibus Budget Reconciliation Act of 1989 law made it a crime for physicians from referring business to themselves.[27] Thus hospitals had less competition, and have become the bottle neck in health care.	Repeal 42 U.S.C.S. §1395nn, 42 C.F.R. §411.350 through §411.389]..
Physicians started and founded and owned hospitals, or founded medical schools. Such as Mayo Clinic, Johns Hopkins, Cleveland Clinic, etc. Physicians were independent of hospitals, and acted as a balancing competition..	**Prosecutors Urge Tuomey To Settle False Claims Act Case.** Modern Healthcare (5/29/2013, Carlson, Subscription Publication) reports, "Pressure is mounting for executives" at the Sumter, South Carolina-based Tuomey Healthcare System to "settle their epic legal conflict with the federal government to avoid rendering the community hospital insolvent." After a jury decided on May 8 that the "242-bed hospital violated the Stark law and False Claims Act by financially rewarding specialty doctors who referred patients to the hospital," the Federal prosecutors "warned Tuomey officials that they intend to seek at least $237 million in damages." That figure, which Acting Assistant US Attorney General Stuart Delery "said was the minimum potential penalty," is actually "greater than the combined revenue Tuomey received in 2011, according to its most recent public disclosures (pdf)."	The protection against fraud is co-pay.
Physicians are in competition with drug companies and insurers.	**Insurers Said To Approve FDA Safe Use Category.** The Washington Times (5/8/2012, Cunningham) reports, "Health insurers gave a tentative thumbs-up Monday to the Food and Drug Administration's proposal to make drugs treating chronic conditions available without a prescription by classifying them in an all-new category." The proposal "has pitted players across the health care industry against each other. While doctors complain it would cut them out of the loop and make patients pay out of pocket for more drugs, pharmacists say it would make drugs cheaper and more accessible." America's Health Insurance Plans spokesman Robert Zirkelbach warned about liability and coverage questions. But National Institute for Health Care Management president Nancy Chockley pointed to past experience with falling prices of medications approved for over the counter purchase and to the increased convenience	Ten times more physicians and more drug companies would alter the competitive relationship.

Physicians would write prescriptions of controlled substances, drugs. Business model was a free market for health care. The pricing would be available. However, wholesalers can buy drugs off of drug stores, and not disclose the price. However law enforcement limits production.	**Pharmacist Group Says DEA May Be To Blame For Some Medication Shortages.** The Hill (5/23, Viebeck) reports in its "Healthwatch" blog on a letter by the National Community Pharmacists Association to Sen. Tom Harkin (D-IA) in which it "praised provisions of the Senate's FDA bill...that would probe whether law enforcement practices contribute to drug shortages. The group's suspicion, also voiced by Sens. Chuck Grassley (R-Iowa) and Sheldon Whitehouse (D-R.I.), is that certain limits placed on drug manufacturers by the Drug Enforcement Agency (DEA) may lead to short supplies in medical environments and on shelves." The letter points out that "drugs to treat ADD and ADHD have seen the worst shortages," commenting, "We believe that these controlled substances are in short supply, in part, because of the inflexibility of the current DEA quota system."	Quota system? Who allowed that?
Plain language. Abbreviations are effective to obfuscate information.	**Consumer-Friendly Medicare Benefits Statement To Debut Next Year.** The New York Times (5/10/2012, Jaffe) reports in its "The New Old Age" blog, "There's good news for anyone who...has ever tried to decipher one of the inscrutable statements, called Medicare summary notices, mailed quarterly to roughly 36 million beneficiaries." Beginning "next year, officials will begin using a new consumer-friendly format; it's already available online at www.mymedicare.gov." Noting that "an easy-to-understand explanation of each service in larger type replaces the descriptions containing baffling abbreviations and medical terms," the blog says "the change comes with an incentive for reading more carefully: Medicare will offer rewards of up to $1,000 for tips that lead to uncovering fraud."	Abbreviations were normal when records were kept by hand writing, but are unnecessary when digitized information is available.
Precedent is ignored. Administrative decisions in medicare are not precedent and not binding on future decision makers. But they are so treated by the industry (when it is to their advantage).	“After a thorough consideration of the Medicare administrative appeals process, HHS has determined that it is neither feasible nor appropriate at this time to confer binding, precedential authority upon decisions of the [Medicare Appeals Council] *** it is often difficult for the agency to ensure that all relevant issues and authorities are presented to the Medicare Appeals Council] for consideration before it makes a final determination in a particular case. Moreover, the agency is not able to appeal adverse or erroneous rulings by the Medicare Appeals Council]. Affording precedential authority to decisions where a particular legal argument has not been raised or thoroughly considered may result in an inaccurate or incomplete interpretation of an agency regulation or ruling, and may ultimately result in greater problems and uncertainty in subsequent cases when the issue is raised more clearly or in different factual	If not precedent, then so remind the readers and stakeholders on a regular basis to avoid false expectations.

	circumstances." Source: http://www.hhs.gov/medicare/appealsrpt.html#Intro VI. Feasibility of Precedential Authority Report to Congress Plan for the Transfer of Responsibility for Medicare Appeals March 2004 Developed under section 931 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, 117 Stat. 2066 (2003) Submitted by: The Secretary of Health and Human Services and The Commissioner of Social Security	
Prescriptions of controlled substances, drugs Business model required physicians to write. The pricing of drugs would be available. However, wholesalers can buy drugs off of drug stores, and not disclose the price.	**Cummings Offers Bill To Regulate Wholesalers Dealing In Medications.** The AP (5/23) reports that Rep. Elijah Cummings (D-MD) has introduced legislation resulting from his "investigating wholesalers accused of jacking up prices of crucial prescription drugs in short supply." The legislation "would prohibit wholesalers...from buying drugs from pharmacies," and "would require wholesalers selling any critical drugs that are in short supply to list a drug's selling price in its pedigree." Furthermore, it "would create a national database to which wholesalers would have to report the status of their state licenses." Modern Healthcare (5/23, Lee, Subscription Publication) reports that Cummings "said in a news release that more than half of the 'gray-market drug companies' being investigated were able to purchase drugs in short supply from licensed pharmacies."	Short supply indicates rationing. The free market would solve that problem, unfortunately there is no free market in health care.
Protect against unneeded services, Medicare had co-pays so beneficiaries / patients would consider whether they needed the services. But the industry stopped collecting co-pays decades ago.	**Panel Calls For Fast-Tracked Departure From Fee-For-Service Medicine.** The Washington Times (3/5/2013, Howell) reports, "The push to reform federal payments to doctors who treat Medicare patients picked up steam Monday when physicians released a study arguing that halting unneeded services could save hundreds of billions of dollars. A 19-page report released Monday by the National Commission on Physician Payment Reform adds a voice to the chorus of politicians in Washington who say entitlement reform is the key to restoring the nation's fiscal footing, and that doctors should be paid for quality of care instead of the number of services they provide." Among its recommendations, the commission "calls for the outright repeal of a 1997 Medicare payment formula, though Congress avoids it each year through the 'doc fix,' a fiscal patch that maintains physicians' payments from the government even when the formula calls for a cut." CQ (3/5, Reichard, Subscription Publication) reports that the National Commission on Physician Payment Reform called on Monday for "wider use of	Collect Co-pays, and unneeded services will stop. You don't need legislation.

	accountable care organizations and patient-centered medical homes be fast tracked as part of a five-year phaseout of fee-for-service payments." The panel says that "the current system in which doctors are paid for each service they provide discourages team-based care to improve efficiency and quality." The panel's co-chairs are former Senate Majority Leader Bill Frist and Steven A. Schroeder, the former chairman of the Robert Wood Johnson Foundation. The Hill (3/5, Viebeck) "Healthwatch" blog reports that the panel "also recommended repealing Medicare's sustainable growth rate (SGR) formula and paying for the move by cutting overutilization of Medicare services." Politico (3/5, Haberkorn) notes, "The commission's report tracks closely with the outline several other SGR proposals have embraced: repeal the SGR, establish several years of stability and put new payments models in place. But it provides yet another voice in a growing chorus of health experts who say the SGR and fee-for-service has to go." Modern Healthcare (3/5, Zigmond, Subscription Publication) explains further, "A year ago this month, the Society of General Internal Medicine convened the commission to suggest new ways to pay the nation's physicians that could improve patient outcomes and lower healthcare costs. In a report released Monday (PDF), the commission concluded that the problems of physician payment are based on systemic issues, such as the traditional fee-for-service payment model, and problems pertaining specifically to Medicare, including the sustainable growth-rate formula to pay physicians and the operation of the Relative Value Scale Update Committee (RUC), which makes recommendations to the CMS."	
Protect against unneeded services, Medicare had co-pays so beneficiaries / patients would consider whether they needed the services.	Branded Drugs Chalk Up a Win Under Health Law 4 Nov 2013 from Wall Street Journal by Jonathan D. Rockoff and Peter Loftus (Brand name or Patent holding) Drug makers scored a significant win last week in their effort to increase sales from the rollout of the health-care overhaul, when the Obama administration cleared a path for the companies to help pay patients' out-of-pocket costs of prescriptions. At issue was whether drug makers could help cover the cost of copayments on brand-name drugs for patients who get insurance through the overhaul's new insurance exchanges. The pharmaceutical industry spent about $4 billion on copayment assistance to patients in private health plans in 2011, according to an estimate by Amundsen Group, a consulting firm. But the subsidies have drawn the ire of health plans and pharmacy-benefit managers, who say the aid undermines the use of copayments to steer patients	Look for fraud to explode in the drug market.

	toward lower-price generic drugs. Federal law bars drug makers from giving copayment assistance to patients insured by federal programs such as Medicare and Medicaid. The law considers the aid an illegal kickback that encourages unnecessary spending. Until last week it had been unclear whether that prohibition applied to insurance sold through the new online marketplaces, where people can get federal subsidies to help pay for coverage	
Protection against useless work is for patients to pay co-pays for their services. Thus physicians receiving kickbacks would not flourish if patients could judge their own care, by contributing to it.	**Judge Rejects Orthofix International's Medicare Fraud Settlement.** Bloomberg News (9/7, Feeley, Lawrence) reports, "Orthofix International NV (OFIX)'s settlement of federal regulators' accusations that the maker of bone-repair products defrauded Medicare by paying kickbacks to doctors was rejected by a judge." US District Judge William G. Young in Boston remarked, "It seems in this case the court's hands ought not be tied. I have extreme unease of treating corporate criminal conduct like a civil case." The piece notes that it is "unclear whether Young's refusal to accept the plea also scuttles Orthofix's agreement to pay $34.2 million to resolve civil claims first raised in a whistle-blower's lawsuit that the company defrauded the federal Medicare program through payments to doctors who used its bone-growth stimulators."	The government has had laws against kickbacks for a century and a half, but people still try it.
Provider numbers were to track suppliers and physicians as they made claims to Medicare.	**Houston Doctor In Medicare Fraud Trial For Prescribing Unneeded Home Healthcare.** The Houston Chronicle (5/23, Langford) reports federal data presented in the case of Dr. Ben Echols, who is accused of Medicare fraud, shows he "prescribed costly home health care to hundreds of patients who didn't need it - the majority of whom he never examined - resulting in more than $5.2 million in phony Medicare claims." All of the home healthcare requests came from Family Healthcare Services and Houston Compassionate Care, and "the second day of testimony in Echols' trial...focused on how the two companies outmaneuvered Medicare through unsophisticated paperwork sleights-of-hand." That included submitting paperwork to Medicare under another physician's Medicare number "according to testimony from US Health and Human Services Office of Inspector General agent Korby Harshaw."	One physician one number.
Provider numbers were to track suppliers and physicians as they made claims to Medicare	**One company which provides a blood suction product throughout the nation has over 240 provider numbers. This makes it difficult to track usage and claims.**	Limit one provider number per tax ID number.
Relying on co-pay and	But other locals have to budget their health care, pay co-pays, and watch what	All may park and all

deductibles to monitor usage, Congress adopted Medicaid with reimbursements at a rates 'sufficient to enlist enough providers' to ensure that care available under Medicaid is similar to that available to other local residents.	they spend. Dual eligibles do not have that need or incentive. **Bella Defends Plan For Dual Eligibles.** CQ (5/2/2012, Adams, Subscription Publication) reports that Melanie Bella, director of the federal Medicare-Medicaid Coordination Office, appearing in a panel discussion at the American Enterprise Institute "faced tough questions...about an Obama administration plan to allow states to move up to 2 million patients into managed care." Federation of American Hospitals president and CEO Chip Kahn said that "beneficiaries have paid payroll taxes into Medicare...and should be able to choose how to get their care just as other Medicare seniors do." Georgetown Public Policy Institute professor Judy Feder also said, "This low-income population is being treated differently because it is a low-income population." Bella said that "all of the beneficiaries will have a chance to opt out of the program if they wish." She defended the program, pointing out that "the current system isn't working well for the group that receives both Medicare and Medicaid." Kaiser Health News (5/2, Barr) reports, "Bella said that questions about how fast to move are legitimate, but that it's important for officials to act with urgency to get new models off the ground."	must pay, is on the Arlington parking meter. Dual eligibles should also have co-pays.
Relying on co-pay and deductibles to monitor usage, Congress adopted Medicaid with reimbursements at a rates 'sufficient to enlist enough providers' to ensure that care available under Medicaid is similar to that available to other local residents.	**Supreme Court Sends California Medicaid Case Back To 9th Circuit.** McClatchy (2/23/2012, Doyle) reports that the Supreme Court "on Wednesday kept alive the possibility that California doctors, pharmacists and senior citizens can challenge the state's Medicaid reimbursement cuts," but "the closely divided court didn't definitively side with the doctors. Instead, citing the complexity of the cases and some changed circumstances, justices ordered more arguments before a lower appellate court." McClatchy notes, "The 5-4 decision kicks the set of California Medicaid reimbursement cases back to the 9th US Circuit Court of Appeals, which had sided with the doctors, pharmacists and senior citizens." The New York Times (2/23/2012, A13, Liptak, Subscription Publication) reports, "A federal law requires states that participate in the program, which provides health care to poor and disabled people, to pay rates 'sufficient to enlist enough providers' to ensure that care available under Medicaid is similar to that available to other local residents. The question for the court was whether the providers and Medicaid recipients were themselves entitled to sue over the move." The AP (2/23/2012) reports, "The facts of the case have changed significantly since it first came to the Supreme Court. California originally put	Try co-pays and deductibles rather than across the board rate cuts. McClatchy's analysis that but "the closely divided court didn't definitively side with the doctors. Instead, citing the complexity of the cases and some changed circumstances, justices ordered more…" is disingenuous or ignorant. As the Doctors won at the lower level, keeping the case alive is a defeat for the winners

	cuts in place without federal approval. In recent months, however, the US Health and Human Services Department endorsed the reductions." The Hill (2/23, Pecquet) reports in its "Healthwatch" blog, "Plaintiffs had argued that the state violated the federal Medicaid statute by approving deep cuts that would hurt patients' access to care, and the 9th Circuit Court of Appeals recognized their right to seek redress. The question before the high court was whether the cuts could be struck down under the Supremacy Clause of the Constitution, which declares that federal statutes trump state law when the two are at odds. The justices however ruled 5-4 that because the federal Medicaid agency has signed off on the cuts since the suits were first filed, the lower court should reexamine the case 'in light of the changed circumstances.'" Also covering the story are Reuters (2/23), NPR (2/23, Rovner) "Shots" blog, and Modern Healthcare (2/23, Subscription Publication).	(doctors), and a victory for the losers (California), or Doctors lost and California won on the Supreme Court ruling.
Schools of Medicine. 1960 U.S. census had about 180 million residents.[28] About 1.5 million population per medical school.	The 2010 population is estimated at 310 million, with 163 million age 25 to 64.[29] About 3 million population per medical school. In 1965 it was about 200 million with the same number of medical schools.	Open 200 medical schools or 1,657 new schools. See Years to Equilibrium for the cost for expanding medical physician training.
Self-insurance and 3rd party insurer. All are insured, either by a 3rd party insurer, or by self-insurance. When Medicare was adopted, the medical costs for 3rd party insurers and the self insured were the same. Insurers, wanting to sell insurance, went to providers and negotiated a two tier system of billing, cheaper for the insurance company, and the provider accommodated the two tier by doubling or tripling or charging ten times the cost to the self insured.	**Second Insurer Suing California Surgery Facilities Over Billing.** The AP (6/20/2012) reports, "United Healthcare Services has filed a $39 million lawsuit against" Bay Area Surgical Management, "claiming the firm overbilled the insurance carrier and offered doctors financial incentives for patient referrals." The move "is similar to a $20 million suit Aetna" previously brought against the company, which manages five outpatient surgery centers. The San Jose Mercury News (6/20, Krieger) reports the Aetna suit alleges "that the company is making millions of dollars and enriching local doctors by sidestepping state and federal laws meant to protect patients and control costs." However, "Bay Area Surgical Management strongly denies the allegations, saying that they are inaccurate --- and represent part of a larger strategy by the two insurers to force the company to sign a contract that sets very low reimbursement rates for patient care."	Have one tier of charges for all, those with 3rd party insurance, Medicare, or Medicaid, and those who are self-insured. The insurers will resist as this has been the incentive for pulling members into insurance.

Medicare then set its fee schedule and Medicare approved amount, not ever expecting to pay what the provider might charge.		
Shortage of medical schools student seats, and preventing new schools from opening, and governments keep hospitals from adding beds, and monopolies exist in medicine, expect increased costs.	**AAMC: US Will Be Lacking More Than 60,000 Doctors By 2015.** The Wall Street Journal (6/29/2012) "Health Blog" reports that according to the Association of American Medical Colleges, the US will be lacking more than 60,000 physicians necessary by 2015 to serve all the new patients that the Affordable Care Act will bring into the US healthcare system. Dr. Atul Grover, public policy officer for that group, told the Health Blog, "We have no idea how we're going to deal with that demand." Reuters (6/28/2012) reports on the decision regarding Medicaid. The changes in the ACA were expected to reach about 16 million people, but if states decide not to expand Medicaid eligibility rules, then far fewer would benefit. But administration officials said that they expect states to expand the rules because the federal government will pay the additional cost for three years and 90 percent after that. Several governors are quoted saying the cost is beyond the resources of their states.	More like 2 million. At 16 million patients for 60,000 physicians the patient physician ratio is 266 patients per physician, which is similar to Stamford Connecticut., but 4 times more patients than with the Veterans Administration health care system. Also to maintain a 266 patient to physician ratio, for the entire population of 320 million would require 1,200,030 physicians about 450 thousand MORE than practicing in the US. Or, put another way, the Medicaid patients will have 160 fewer patients competing for physicians (266 to 1) as the NON Medicaid population (426 to 1).
Shortages of medical schools student seats, and new schools cannot open, and governments keep hospitals from adding beds, and monopolies exist in	**CMS Projects Growth In Healthcare Spending Due To Aging, ACA.** The Wall Street Journal (6/13/2012, Radnofsky, Subscription Publication) reports on a Centers for Medicare and Medicaid Services forecast of US healthcare spending published online yesterday in the journal Health Affairs. CMS says that spending will increase in 2014 as the Affordable Care Act is fully implemented and though the growth rate is expected to decline after that, it	Open up 1,000 new medical schools (with 20 to 100 seats per class per year), open up hospitals, get the fee schedules out for people to know costs,

medicine, expect increased costs.	would remain higher than in recent years. While spending growth rates were under 4 percent in both 2009 and 2010 and are expected to stay at that level through 2013. In 2014, it is expected to rise to 7.4 percent due to increased coverage under the ACA. In the following years, the rate is expected to decline to an average of 6.2 percent. The report credits most of the growth in spending to an aging population and only 0.1 percent to the ACA. The AP (6/13/2012, Alonso-Zaldivar) reports in a story appearing on over 240 news sites, "Despite a recent easing of medical costs, the nation's health care spending will keep outpacing economic growth for the foreseeable future." And "by the beginning of the next decade, health care spending will be growing roughly 2 percentage points faster than the overall economy, 'which is about the same differential experienced over the past 30 years,' said the report from Medicare's nonpartisan Office of the Actuary." But "Obama has argued that his overhaul would begin to 'bend the cost curve' to more affordable levels." The Washington Times (6/13/2012, Cunningham) reports, "The US will spend slightly more on health care over the next decade than it would have had President Obama's Affordable Care Act not passed." The law "is expected to add $478 billion to health care costs over the next decade, driving up average spending by one-10th of a percent faster than if the law had never been passed." In response, "Republicans said the data proves the health care law won't solve the problem of ballooning health care costs," but "the administration defended the law," with HHS Secretary Kathleen Sebelius saying that "Americans' out-of-pocket expenses will be less beginning," adding, "That's real money back in the pockets of millions of Americans." The Washington Examiner (6/13/2012, Klein) reports in its "Beltway Confidential" blog, "When President Obama began pushing national health care legislation in 2009, he argued that reform was needed to rein in the unsustainable growth in health care spending that was crippling the budgets of businesses, states and the federal government. But a new government actuarial study finds that as a result of the law, health care spending will be $478 billion higher over the next decade than it would have otherwise been had no law been passed." And "about 50 cents of every dollar of health care spending in the United States will be financed by government by 2021." In its defense, the ACA "would cover 30 million more Americans, while adding 0.1 percent to average annual health care spending growth." Reuters (6/13/2012, Morgan) notes that that growth rate had been just under 7 percent for most of the previous decade. It quotes CMS economist Sean Keehan, "We attribute a lot of this [current low rates of growth] to the lingering	stop monopolies.

	effects of the recession and also the modest recovery after the recession, with the effect that consumers are being cautious about using healthcare goods and services." The story also quotes HHS Secretary Sebelius saying, "Once implemented, the report shows that national health spending growth is projected to be lower than it would have been without the health care law." The Financial Times (6/13/2012, Rappeport, Subscription Publication) reports that the ACA will not result in lower healthcare spending, though the rates of increase are lower than has been true in the past. CQ (6/13/2012, Reichard, Subscription Publication) reports, "Depending on who you talk to, the health care law either is a luxury the nation can't afford or a pretty good deal. Ten-year spending projections government economists issued Tuesday provide analysts on both sides of the debate statistics they can cite to depict the overhaul the way they want." Bloomberg News (6/13/2012, Wayne) reports, "An aging population, improving economy and President Barack Obama's health-care overhaul will push spending on medical services to almost 20 percent of US gross domestic product by 2021." But "Health and Human Services Secretary Kathleen Sebelius said in a blog post that the law 'is helping control health costs and expand coverage, and ensure better health and better health care, for all Americans in the next decade and well beyond.'" Politico (6/13/2012, Dobias) reports the growth rate is "a tad slower -- 0.1 percentage point slower -- than it would have been without the controversial health care law." Yet the story quotes John Poisal, deputy director of the National Health Statistics Group at CMS saying, "The average growth rate over the entire projections is 5.7" percent while "our pre-ACA projection is 5.6." CNN Money (6/13/2012, Sahadi) reports, "Health reform provisions going into effect in 2014 include an expansion of eligibility for Medicaid; a mandate that all individuals be insured; and federal subsidies for low- and middle-income Americans purchasing policies on state-based insurance exchanges." Modern Healthcare (6/13/2012, Evans, Zigmond, Subscription Publication) also covers the report.	
Social Security was to begin at life expectancy. In the 1930s, life expectancy was about 65 so that only the elderly who made it that far would participate. Medicare	Life Expectancy is now 85. Many more participate. All participate longer.	Return entry into Medicare to life expectancy.

adopted the age in 1965. Neither SSA nor Medicare were planned for the general population pre-life expectancy.		
Student medical school seats rationed, also ration hospital beds, the Congress adopted a cost cutting panel.	**Bipartisan Support Grows For Repealing IPAB.** In its "Healthwatch" blog, The Hill (3/1, Pecquet) reports the Senate is facing "increasing pressure" to repeal the healthcare law requirement for "a Medicare cost-cutting panel." House Republicans were joined by two Democrats in pressing a subpanel on Wednesday to eliminate the Independent Payment Advisory Board (IPAB), referred to by opponents as a "rationing board." A vote of 17-5 "underscored the bipartisan support for repealing the board, which Obama has made the centerpiece of his efforts to reduce Medicare spending. It also provided evidence the legislation could have a shot at passing the Senate." In an election year, the Hill says that if a vote to repeal the panel came to the Senate, many Democrats "would be in a tight spot." The Washington Times (3/1, Cunningham) quotes "Rep. Frank Pallone Jr., ranking member of the Energy and Commerce Committee's health subcommittee," who remarked, "Let me be very clear. My vote in support of abolishing IPAB is not related to my support for the Affordable Care Act." Pallone argued that "he opposes the panel because it potentially could undermine Congress' authority by allowing 15 medical experts appointed by the president to recommend cuts in provider payments if Medicare costs grow faster than a targeted rate." CQ (3/1, Bade, Subscription Publication) also reports this story	Let co-pays and co-insurance ration usage.
Torts and malpractice insurance were rare and relatively cheap.	**Malpractice Cases Take Years To Resolve, Though Nearly All Favor The Physician.** Reuters (5/24/2012, Norton) reports on a study of 10,000 medical malpractice claims during the years 2002-2005 published online May 14 in the Archives of Internal Medicine. The study found that a little over half (55 percent) result in lawsuits. Of those, over half are dismissed; most of the remaining suits are resolved before a verdict, with under five percent resulting in a trial verdict. Of those decided at trial 80 percent favor the physician. Dismissed cases took an average of 20 months to resolve, while those decided at trial took an average of 39 months if they favored the physician and 44 months when they favored the patient.	Still relatively rare, but much more time consuming and not cheap.

Uninsured patients are billed at twice to ten times the rate of insured patients, leaving a lot of room for intimidation.	**Chicago Mayor Calls On Minnesota AG To Stop Investigation Of Accretive Health.** The Minneapolis-St. Paul (MN) Business Journal (5/9, Stych, Subscription Publication) reports, "Chicago Mayor Rahm Emanuel seeking to stop an investigation by Minnesota Attorney General Lori Swanson of Accretive Health, the Chicago-based company that's drawn criticism from its debt-collection practices at Minnesota hospitals." Emanuel said that Swanson should "cease efforts to publicly prosecute this matter and rather try to resolve the matter privately." Swanson responded, "This is a law enforcement matter," adding, "Unfortunately, Accretive appears to address it as a political one." The story notes that "US Health and Human Services Secretary Kathleen Sebelius said that agency had begun looking into debt-collection practices in hospital settings, though she didn't mention Accretive by name." Crain's Chicago Business (5/9, Wang) reports, "Mr. Emanuel does not address Ms. Swanson's allegations that the company used high-pressure tactics to collect fees from patients of a Minneapolis-based client."	This applies to the e uninsured who get the steep bills.
US Has fewer medical schools now than a century ago, but 6 times the number of law schools. New York has 12 medical schools and 1800 insurance companies.	**Report: New York's Doctor Shortage Expected To Get Worse.** The Buffalo (NY) Business First (2/15/2013, Drury, Subscription Publication) reports in its "Morning Roundup" blog that, according to a report by the Healthcare Association of New York State (HANYS), "New York needs more than 1,200 physicians across the state, especially in rural areas, and the shortage is only expected to get worse if the state is to meet the federal health reform requirements." New York State, not including New York City, will need 1,200 new physicians, "with nearly a third of the demand coming for primary care doctors." The report adds, "32 percent of facilities had to either reduce or eliminate services due to the shortage, with three quarters of respondents north of New York City indicating that at times their emergency departments had no coverage for certain specialties, resulting in the need to transfer patients to other hospitals."	Open 1000 medical schools, nation wide and 66 in New York (with 6.6 percent of the population). Train more physicians.
US was more rural, less urban. Elderly were cared for by family. They lived at home.	More urban, less rural. Elderly don't live with their family, the elderly have moved to assisted living. Medicare subsidizes assisted living but not family care.[30]	Don't subsidize assisted living. Encourage / subsidize home care. Cheaper to keep them room and board at a Ritz

		Carleton hotel.
Veterans Administration healthcare had been around since after the Civil War	**VA May Have Paid Billions To Vets Enrolled In Medicare Advantage.** USA Today (6/27, Zoroya) reports, "The Department of Veterans Affairs spent an estimated $13 billion to care for veterans whose health coverage was already paid for by Medicare -- a case of the taxpayer paying twice, according to research published" in the Journal of the American Medical Association on Tuesday. Federal law "prohibits...VA from recouping expenditures from Medicare-funded health programs." On Tuesday, VA "issued a statement...saying that even if the law were changed, allowing reimbursement would only add administrative complexity that would impede care." The statement reads, "As an example, VA would have to comply with Medicare rules and policies for veterans, which would leave VA administering two systems of care: Medicare's and VA's." Reuters (6/26, Seaman) noted that in a statement, the Centers for Medicare and Medicaid Service (CMS) said the study in the Journal of the American Medical Association "identifies overpayments that may not actually exist. Payments to Medicare Advantage plans are already lower based on how often veterans use VA facilities for treatment."	Lessons can be learned from the VA.
Veterans Affairs, Department of, set a patient to physician ratio of 50 to 1, later lowered the ratio to 60 patients to one physician. The VA trains a fourth of all physicians.	The ratio of patients to physicians is about 413 to 1.nationwide. (310 million divided by 750,000 physicians. So the care is diluted about 7 fold from the care offered by the DVA to the veterans.	Hire and train an additional 4.25 million physicians. Do the same for nurses, pathologists, and other health care professionals.
Whistle blowers should be Plan C for discovering fraud, after patients, after insurance and companies.	**WellCare Settles Four Whistle-Blower Lawsuits.** Modern Healthcare (4/4, Kutscher, Subscription Publication) reports, "WellCare Health Plans, Tampa, Fla., has settled four whistle-blower lawsuits alleging that it violated the federal False Claims Act. As part of the settlement, WellCare will pay the US and nine states $137.5 million, plus interest, over a three-year period," and it "could also face a $35 million payment if it is sold or sees a change of control within three years of the agreement." However, "a news release from the US attorney for the Middle District of Florida in Tampa noted that the settlement is not a determination of liability." Also covering the story is the AP (4/4). ***WellCare Whistle-Blower Will Receive About $21M In Settlement.*** The	$137 million. $21 million.

	Tampa Bay (FL) Times (4/4, Harrington) reports, "Whistle-blower Sean Hellein will receive nearly $21 million for triggering a successful federal inquiry into Medicare and Medicaid fraud at his former Tampa employer, WellCare Health Plans." The Times adds, "Hellein in late February withdrew his objections to a pending $137.5 million civil settlement with WellCare. But the size of his payout was unclear until Tuesday, when US Attorney Robert O'Neill announced the settlement of all four lawsuits initiated by whistle-blowers."	
Whistle blowers should be Plan C for discovering fraud, because they take decades and heavy 8 figure litigation	**DaVita Announces $55 Million Settlement In Epoetin Alfa Case.** Reuters (7/5/2012, Venkatesan) reports that DaVita Inc. has agreed to a $55 million settlement of a lawsuit brought by a patient at one of its dialysis clinics regarding its use of Epogen (epoetin alfa) to control anemia for those patients suffering from chronic kidney failure and end stage renal disease. The AP (7/5/2012) reports, "The lawsuit was filed in 2002 and is based on a whistleblower's claim that DaVita overused Epogen, an anemia drug made by Amgen, over a 10-year period. DaVita says its physicians did nothing wrong and stand by their anemia management practices, but the company says the agreement is in the best interest of its shareholders." Further coverage appears in the Denver Post (7/5/2012, Booth, Osher), Dow Jones (7/5/2012, Chaudhuri), and Modern Healthcare (7/5/2012, Subscription Publication).	10 years to settle, never went to trial.
World War 2 health insurance was a means to avoid wage and price limitations, necessary to control inflation during the war effort. Health Care was a bonus and had little or no public policy influence. Such as, it did not discourage or prevent use of alcohol or tobacco, or hobbies such as gun collecting, or sky diving. These risky issues were left to life insurance actuaries.	Medicare adopted that Blue Cross Blue Shield World War Two model, of health coverage. But since 1966, going where the money is, surveys and data mining has expanded to include surveys on broad policy topics, such as gun ownership. A veteran and medicare beneficiary gave this statement: "When I had my gangrene gallbladder taken out and spent 10 days in the hospital for what should have been an overnight stay … . I had home nurse visits for two weeks and was asked if I had guns in the house."	Apparently the Home health did not ask about bath tubs (drowning in water), knives (cutting), electrical appliances (risk of electrocution), stairs (risk of falling), fireplaces (risk of open flame and fire), burning of incense (ditto), open windows on upper floors (risk of falling out the window), or motorcycles (risk of head injury) or skateboards (ditto), or surf boards (ditto and drowning), a host of

		other risky situations which are so common as to be ignored. It is a heavy burden to make Medicare into the social policy survey and collection source for marginally irrelevant life styles
World War 2 health insurance was a means to avoid wage and price limitations, necessary to control inflation during the war effort. It was a bonus and had little or no public policy influence. Such as getting cheap drugs.	Study: Med Students Fail To Select Cheapest Medicare Part D Plan. Reuters (10/15/2013, Doyle) reports a study focused on Medicare Part D plans demonstrated that new doctors have had difficulty wading through insurance options to find the least expensive plan. Enrollees choose from at least 30 plans, and only 5% of Medicare beneficiaries in the study chose the least expensive one. Andrew Barnes of the Virginia Commonwealth University School of Medicine says this affects approximately 13 million elderly individuals nationwide. When 70 medical students and residents were asked to select the least expensive plan for a hypothetical patient from a list of three to nine plans, less than half were able to choose correctly. When all participants received nine options, only one third chose correctly.	We've come full circle from using health benefits as a means to avoid World War 2 wage and price controls, to physicians requesting government impose price controls on insurers, and being unable to figure out those price or cost controls.
World War 2 health insurance was a means to avoid wage and price limitations, necessary to control inflation during the war effort. It was a bonus and had little or no public policy influence. Such as, it did not discourage or prevent use of alcohol or tobacco, or hobbies such as gun collecting, or sky diving. These risky issues were left to life insurance actuaries.	**Cuomo Endeavors To Salvage Plan For Out-Of-Network Healthcare Charges.** The Wall Street Journal (4/27, A17, Gershman, Subscription Publication) reports that New York Gov. Andrew Cuomo is currently trying to salvage a proposal to overhaul out-of-network medical charges as physicians and health insurers engage in an intense lobbying battle over the plan. According to the Journal, physicians are worried that the new proposal will not work unless legislators intervene to impose stricter price controls on insurers. At the same time, insurers are opposing the plan on the grounds that a reimbursement mandate could backfire because many employers, especially smaller ones, may find it even more difficult to afford out-of-network coverage.	We've come full circle from using health benefits as a means to avoid World War 2 wage and price controls, to physicians requesting government impose price controls on insurers, for the health benefits which were supposed to circumvent the controls in the first place.

Competition among hospitals was assumed. Doctors versus Hospitals. Mayo Clinic and Cleveland Clinic, Johns Hopkins were all physician owned clinics.	**Concerned About Costs, Congress Pushes Curbs on Doctor-Owned Hospitals** By ROBERT PEAR Democrats moving to impose new restrictions on these for-profit hospitals have carved out exemptions for a few institutions represented by influential senators and well-connected lobbyists.[31]	Federal intervention to protect 5,000 hospitals, publicly traded on the Stock exchanges, against competition from physicians, while costs increase twice rate of inflation.
Competition among physicians was assumed.	HEALTH / HEALTH CARE POLICY | July 7, 2008 **Doctors Press Senate to Undo Medicare Cuts** By ROBERT PEAR Ads by the American Medical Association blame Senate Republicans for a 10.6 percent cut in payments to doctors who care for older Americans.[32]	The AMA supported Burwell in the King v Burwell suit to expand subsidies to the 35 states which did not open exchanges.
Competition opposes monopoly. Federal and state regulations on insurance and Federal control of health has created monopolies.	**Administration Files Antitrust Suit Against BCBS Of Michigan.** The New York Times (10/19/2010, B1, Pear) Business Day section, "The Justice Department sued Blue Cross Blue Shield of Michigan on Monday, asserting that the company, the state's dominant health insurer, had violated antitrust laws and secured a huge competitive advantage by forcing hospitals to charge higher prices to Blue Cross's rivals." This "civil case appears to have broad implications because many local insurance markets, like those in Michigan, are highly concentrated, and Blue Cross and Blue Shield plans often have the largest shares of those markets." In this instance, "the Obama administration said that Blue Cross and Blue Shield had contracts with many hospitals that stifled competition, resulting in higher health insurance premiums for consumers and employers." The Detroit News (10/19/2010, Shepardson, Burden) reports, "The Justice Department filed suit against Blue Cross Blue Shield of Michigan today, arguing the health care giant used its market dominance to boost prices for its competitors, resulting in Michigan consumers paying higher prices for health care and health insurance." The Justice Department "is seeking an injunction to block the practice, but isn't seeking to recoup what it alleges are overcharges to consumers." According to the Washington Post (10/19/2010, Hilzenrath), the	Return to a free market, and remove Federal restrictions on health insurance.

	Administration argues that "in some cases, Blue Cross's contracts required hospitals to charge other insurers significantly more than they charged Blue Cross, the federal antitrust suit said. In other cases, Blue Cross agreed to increase the prices it pays hospitals -- boosting costs for its own customers -- in return for commitments that other insurers would be charged no less, the lawsuit said." Consequently, "'consumers in Michigan are paying more for their healthcare services and health insurance,' Christine Varney, the assistant attorney general for antitrust matters, said in a statement." The AP (10/19/2010, Yost), the Detroit Free Press (10/19/2010, Ashenfelter, Spangler), the Wall Street Journal (10/19/2010, Catan, Johnson), and Dow Jones Newswire (10/19/2010, Kendall) also report the story.	
Exclusions and limitations would be known to the insured – patient, who is responsible for co-pay.	**Wisconsin Mandate For Easy-To-Read Health Insurance Policies Discarded.** The Milwaukee Journal Sentinel (5/7/2011, Boulton) reported that anyone who has "suffered through reading an insurance policy might welcome the idea of listing all of the **exclusions and limitations...in one section**"; and that is exactly what pending state regulation, a "vestige of the [Gov. Jim] Doyle administration," would have done. However, earlier this year, Wisconsin Insurance Commissioner Ted Nickel "found that an emergency exists and that the new regulations must be scrapped." The Office of the Insurance Commissioner determined that implementing the new regulations "significantly exceeded the anticipated **costs for the insurance industry**."	Print the exclusions and limitations in a convenient location, in case the insured wants to understand the insurance policy. Easy to Read.
Genetic testing was on no ones radar in 1065.	**BUSINESS** | April 23, 2008 **Congress Near Deal on Genetic Test Bias Bill** By ANDREW POLLACK Lawmakers are close to an agreement to clear the way for a bill prohibiting employers and insurers from discriminating on the basis of genetic tests. [33]	False positives are 20% of all slide readings, false negatives another 20%, for breast cancer, so 40% of breast cancer reads are in error. How much for genetic testing?
Insurance rate increase.	**Angoff Criticizes Connecticut Regulators Over Insurance Rate Increases.** CQ HealthBeat (10/19, Reichard) reports, "The top federal overseer of the health insurance	

	industry admonished Connecticut regulators Monday for not doing more with the million dollars they were awarded in August to toughen reviews of proposed rate increases." Jay Angoff, director of the Office of Consumer Information and Insurance Oversight at HHS, "scolded the regulators for approving a big rate hike by the insurer Anthem without holding a hearing, validating its proposed rates or publicly disclosing any data filed by Anthem or the regulators' own analysis of the data." CQ notes, "HHS usually doesn't go public with its unhappiness about how states use federal grant money," yet "in the case of proposed insurance rate hikes, the department apparently won't be holding back." The Hartford Courant (10/19) quotes Angoff as saying, "The consumers of Connecticut expect and deserve transparency and a fact-based rationale as to why their rates are increasing." Notably, the "Obama Administration wants Connecticut insurance regulators to reconsider rate hikes of as much as 47 percent in Connecticut for some health plans offered by Anthem Blue Cross and Blue Shield In Connecticut." These "rates were approved last month by the Connecticut Insurance Department, but" on Monday, HHS "asked the department to hold a hearing on the rates and test Anthem's actuarial assumptions."	
Market would control costs, as people disliked health insurance rate hikes, they would change carriers.	This lead to negative or adverse selection, the sickest remain as rates increase to cover their costs.[34]	Open national insurance coverage across state borders.
Risks of drugs and adverse events must be known to physicians and patients. Diabetes treatment	**Les Laboratoires Denies Allegations Regarding Diabetes Medication-Risk Concealment.** Bloomberg News (5/8/2011, Torsoli) reported, "Les Laboratoires Servier, France's second-biggest drugmaker, denied allegations by government investigators that the company concealed the risks of a drug now suspected of having caused the **deaths of as many as 2,000 people**." A government investigative agency "said in a Jan. 15 report" that Les Laboratoires depicted benfluorex hydrochloride "as a diabetes treatment, when in reality it was a 'potent' appetite suppressant closely related to fenfluramine, a component of the diet-drug combination fen-phen." The medication was sold in France for 33 years until it was pulled from the market in 2009. The investigative agency did not "ask the company to provide clinical data that could have led to more accurate conclusions," Les Laboratoires said.	It took 2 years from the time the drug was pulled in 2009 for the government investigation to catch up.
State insurance commissioners would monitor their licensed companies, and approve	**Angoff Criticizes Connecticut Regulators Over Insurance Rate Increases.** CQ HealthBeat (10/19/2010, Reichard) reports, "The top federal overseer of the health insurance industry admonished Connecticut	The market competition fails with government approved rate costs.

insurance rates. Connecticut regulators approve rate hikes of 47 percent, for the two big companies.	regulators Monday for not doing more with the million dollars they were awarded in August to toughen reviews of proposed rate increases." Jay Angoff, director of the Office of Consumer Information and Insurance Oversight at HHS, "scolded the regulators for approving a big rate hike by the insurer Anthem without holding a hearing, validating its proposed rates or publicly disclosing any data filed by Anthem or the regulators' own analysis of the data." CQ notes, "HHS usually doesn't go public with its unhappiness about how states use federal grant money," yet "in the case of proposed insurance rate hikes, the department apparently won't be holding back." The Hartford Courant (10/19) quotes Angoff as saying, "The consumers of Connecticut expect and deserve transparency and a fact-based rationale as to why their rates are increasing." Notably, the "Obama Administration wants Connecticut insurance regulators to reconsider rate hikes of as much as 47 percent in Connecticut for some health plans offered by Anthem Blue Cross and Blue Shield In Connecticut." These "rates were approved last month by the Connecticut Insurance Department, but" on Monday, HHS "asked the department to hold a hearing on the rates and test Anthem's actuarial assumptions."	

Alcohol and tobacco use were about 60 – 70% of population.	Alcohol use is up to 80%, tobacco use is down to about 30%.	Neither use should be rewarded or encouraged.
Appeals to Judges would require an amount in controversy jurisdiction. Every appeal, no matter how small, would be heard. The Office of Medical Hearings and Appeals spends an average of $5,000[35] on each hearing. Each appeal costs an average of $2,500.	No one understands the concept of amount in controversy for jurisdiction for a Judge hearing, so it is little enforced. If a claimant, according to the Medicare Appeals Council, bills out $2,000, even though the Medicare fee schedule is only $20 (and the claimant must accept the $20 in full payment, and no more), the appeal can be taken to Federal Court and the Court of Appeals.	Need transparent co-pay, deductible, benefit period, fee schedule, medicare approved amount, and prior payments. All these go to amount in controversy.
Base line budgeting was adopted in the 1970s by Congress so funds for agencies and departments automatically increase every year without further debate or vote.	**House GOP Bill To Reduce Funding For Food Stamps, Medicaid.** Reuters (5/8/2012, Lawder) reports that House Republicans advanced legislation on Monday that would	Budget process in Congress needs to repeal the base line budgeting and actually vote on expenditures.

Any reduction in the automatic increase is a cut or slash.	slash almost $380 billion from social programs such as food stamps, child tax credits, and Medicaid healthcare for the poor. Leaders said that the cuts are necessary to further deficit-reduction goals and protect national security. Democrats noted their opposition to the legislation. **The AP (5/8/2012, Taylor) reports**, "There's no companion legislation moving in the Democratic-controlled Senate, and the proposal doesn't stand a chance of making it to President Barack Obama's desk for signature. But the vote was a symbolic swipe at Obama in an election year focused on the economy." CQ (5/8, Subscription Publication) provides "a summary of health-related provisions that key committees approved for inclusion in the plan.	
Benefit periods would spread out costs. 90 days of hospital stays would b paid with increasing co-pay and after that plus 60 days of life time allowance, all costs would be paid by the patient. Part B has annual period. Benefit period directly impacts co-pay and deductible. Co-pay and deductible impact motivation for spending money on services and products.	No provider/supplier independently tracks the benefit period for Part A. They check data banks which are not up to date. Even Medicare Judges cannot find this out. No one, the Judges asks, seem to know!	Make benefit period usage transparent – i.e. provide the information to the beneficiary without having to sue the provider or supplier, or receive explanation of benefits statements which are incomprehensible.
Business model focus was on the supplier and provider and beneficiary. Gradually, over time, the focus went to the insurance carrier, who became the gate keeper of funds. But they work on cost plus, meaning the cost of the service plus their profit. The more that is spent, the more the profit.	Representatives Wally Herger of California and Tom Latham of Iowa." Those "would prohibit insurers from imposing annual or lifetime limits on spending for covered services. And they would generally prohibit insurers from canceling or rescinding coverage after a person became sick." New York Times (4/4/2012, Pear, Weisman, Subscription Publication)	Redirect the focus from insurance to the millions of daily decisions by the beneficiaries.
Business model was for the 1st day of Part A hospitalization to have a deductible of circa $1,050, so people might consider do they really need to hit the ER for a cold or chest pain?	**More Medicare Patients Being Held For "Observation" Rather Than Being Admitted.** Scripps Howard News Service (6/21/2012) reports, "Faced with financial penalties from Medicare if they run patients in and out too frequently, many hospitals around the country are holding off admitting many of them in the first	This change is back to the co-pay model from 1966, because Part B has a 20% co-pay and deductible of $130 annually.

	place." These hospitals are "instead...holding more patients for 'observation' -- several hundred thousand more in 2009 than two years before." This "change has come as Medicare implements tougher policies aimed at preventing frequent, repeat hospitalizations for the same medical problems, a pattern that costs the federal health system for the elderly and disabled more than $15 billion a year."	
Business model was simple, tax revenues paid or subsidized claims. Then insurers learned they could sell policies – Medigap, health insurance, and do quite well. Tax credits obfuscate the relationship between revenues and expenses.	**Critics Object To Rules On Health Subsidies.** The National Journal /Kaiser Health News (4/17/2012, Appleby, Subscription Publication) reports, "Consumer advocates, physician groups, and several Democratic lawmakers are fighting a quiet battle over a key benefit in the health care law: tax credits to help millions of people buy insurance. At issue is a section of the law that outlines when low- and moderate-income employees can opt out of their employer's coverage and instead get federal subsidies to buy insurance through new state-based marketplaces called exchanges." According to the article, "consumer advocates oppose the rule because it bases affordability on how much employees would pay to cover themselves, not on the cost of covering their entire families. As a result, they say, many workers will be unable to afford family coverage, yet their spouses and children will be ineligible to get help to buy insurance	Insurance never delivered a baby, gave a shot, made a diagnosis. Nor has any tax credit.
Charitable hospitals staff were more stable with less turnover. They may have been healthier.	For profit hospitals will hire more competitively, either paying more or less, depending on the available health care specialty needed. Thus a sick employee can endanger many more than before.[36]	Open 200 new medical schools.
Claims would be processed within a month. The status of benefit period would be up to date and an effective means to calculate co-pay and deductible.	Claims can be filed within a year of date of service. No one knows what are the benefit period remaining days for co-pay.	Reduce claims filing to 30 days.
Co-pay and deductibles were to control over utilization for unnecessary services. But to encourage use of the Medicare, seniors were told its free and covers	**States Offering High-Deductible Plans To Lower Healthcare Costs.** CQ (10/26/2012, Norman, Subscription Publication) reports, "High-deductible health insurance plans are	This example shows if the deductible goes up, costs come down.

everything (unless you read the fine print).	catching on in states struggling to contain escalating costs among their own employees, according to a brief the National Governors Association released Thursday." In 2012, almost half of the states offered this insurance, "which normally combines a high-deductible plan with a tax-preferred Health Savings Account (HSA)." The article profiles two states that are relying on this method, Connecticut and Indiana.	
co-pay was adopted to avoid useless and meaningless expenses in health care, with the practical belief that patients would not spend their own money if they received no benefit. But co-pays were quickly swallowed by medi-gap policies or waived (illegally), or no effort was made to collect the co-pay.	**Some Employers Apply Value-Based Insurance To Medication.** NPR (5/9, Andrews) reports in its "Shots" blog that some employers are adopting value-based insurance design so that drug costs to patients are based on benefits. The change involves "lowering copayments for medicines to manage chronic conditions like diabetes, high cholesterol and high blood pressure." And "some employers are thinking about adapting the approach for pricier specialty drugs, such as those used to treat rheumatoid arthritis, multiple sclerosis and cancer." To do that, it must determine who is a good candidate for the medication and then what the relevant copayment might be.	Co-pays don't need to be lowered, they are seldom paid anyway.
Co-pay was the model to control over utilization. Part A inpatient had a $1050 plus first day deductible. But that isn't being collected. Part B observation status has a 20% co-pay.	**Hospitals Struggle Over Admitting Medicare Patients; Patients Forced To Pay.** Modern Healthcare (5/16,2012 Carlson, Subscription Publication) reports, "The threat of ceaseless auditing and penalties [from the Centers for Medicare & Medicaid Services] is causing many hospitals to reclassify Medicare patients as less costly 'observation' cases, and the people receiving the care say the confusion change leaves them on the hook for medical bills that the government ought to cover." As a result, "patients are fighting back with a class-action lawsuit" with hopes to overturn the CMS rule allowing observation status. A July 7, 2010, letter from acting CMS Administrator Marilyn Tavenner addressed hospital concerns about hardship from the tough scrutiny. "There has been no change in CMS policy for how	Everyone pays something every time was the original business model.

	hospitals should approach such cases," she wrote.	
Co-pay was the model to control over utilization. Part A inpatient had a $1050 plus first day deductible. But that isn't being collected. Part B observation status has a 20% co-pay.	**Atlantic Health Pays $9 Million, Settling Some Medicare Whistle-Blower Allegations.** Modern Healthcare (6/22, Carlson, Subscription Publication) reports Atlantic Health System and its Overlook Hospital entered into a settlement agreement under which they'll "pay $9 million and enter a five-year corporate integrity agreement to resolve whistle-blower allegations that they admitted Medicare patients into the hospital who should have been treated in less-expensive settings." Neither the company nor the hospital admitted liability. In a whistle-blower suit, "Paul Tahlor and Margaret Marino alleged that between 2002 and 2009, the hospital treated Medicare patients in the hospital who should have been outpatients, and also improperly transferred patients to skilled-nursing facilities who didn't qualify for that level of care." The settlement only covers "the inpatient upcoding allegations." **The Newark (NJ) Star-Ledger (6/22, Dingers) reports Department of Health and Human Services Inspector General Daniel Levinson said, "Billing Medicare for unnecessary inpatient services steals from taxpayers," adding, "it also requires hospitalizing people who don't need it, causing inconvenience, discomfort and worse**	Everyone pays something every time was the original business model.
Co-pay will limit the unnecessary health costs. However it is not being collected.	**President Trump Needs To Keep His Promises No Matter How Hard The Haters Squeal.** https://townhall.com/columnists/kurtschlichter Kurt Schlichter **Mar 02, 2017 12:01 Townhall.com** "Well, does Freddie Freeloader have a cell phone? How about a big screen? Is there an Xbox in his apartment? Because if so, then what Freddie really wants is not for us to pay for his health insurance. He could pay for that if he wanted. He wants us to pay for his toys, and the normals are sick of sweating so that some shiftless couch-tater	

	doesn't have to."[37]	
Co-pays dropped off, and rates soared, efforts to control fraud shifted to computers.	**Senator Expresses Disappointment With $77 Million Medicare Fraud-Detection System.** **The AP (2/24/2012, Kennedy, Alonso-Zaldivar) reports, "Debuting last summer, a $77 million computer system to detect Medicare fraud before it occurs had prevented just one suspicious payment by Christmas," saving US "taxpayers exactly $7,591." Legislators "had expected the system to finally allow Medicare to stanch a $60-billion-a-year fraud hemorrhage." However, "when other benefits of the system are taken into account, such as cases referred to investigators and changes to payment software that result in automatic denial of suspect claims, the potential savings in the first six months of operation easily exceed $20 million, Medicare officials indicated in a Jan. 27 letter to" Sen. Thomas R. Carper (D-DE) who had expressed disappointment in the lack of results**	Apparently the software can't be designed to detect fraud in any meaningful pattern. Solution is to return to the copay.
Competition, an open and free market, was expected when Medicare was adopted circa 1966, physicians and hospitals set their charges to accommodate the free market. Although it had been 50 years since medical education had shut down med schools and rationed seats,. But the government was not setting fee schedules. Over time, the government set fees, paying specialists 4 times what a general practice would obtain, under paying OBs to deliver babies. Guess what? Physicians started to specialize and avoid the low paying general practice.	**Representatives To Release Bipartisan Plan To Replace Medicare Doctor Payment System.** CQ (5/9/2012, Ethridge, Subscription Publication) reports that Rep. Allyson Y. Schwartz (D-PA) "has gained a GOP cosponsor in her effort to repeal and replace the formula that dictates physicians' reimbursements from Medicare." Schwartz, along with Rep. Joe Heck (R-NV), who is also a physician, are set to announce details of their proposed legislation tomorrow morning. "The broad outlines of their bill, as described by a statement from Schwartz's office, resemble a draft proposal that Schwartz unveiled in November" which "would stabilize the current payment system and provide increases in payment rates for primary care and specialty physicians. It also would create a period of testing and evaluating new payment models to identify the best practices and delivery options, then institute a transition period to move to those new models." **Bill Would Replace Medicare's Reimbursement**	Open up 1,000 medical schools, allow the market to determine hospital beds, and gradually the supply and demand law would solve these problems (i.e. of Congress passing a bill to exempt physicians from fee cuts).

	Formula. The Hill (5/10/2012, Viebeck) reports in its "Healthwatch" blog, "Reps. Allyson Schwartz (D-Pa.) and Joe Heck (R-Nev.) introduced a bill Wednesday to reform how Medicare pays healthcare providers and to avoid a cut to reimbursement rates on Jan. 1." The proposed measure would replace the current reimbursement formula "with a new system of payment models," as well as "give doctors small boosts in payment rates for four years." The Wall Street Journal (5/10) reports in its "WashWire" blog that the proposed legislation is supported by the American Medical Association. In a statement, AMA head Peter Carmel remarked that it was "an important step in the right direction," adding, "This legislation is consistent with proposals put forth by the AMA." CQ (5/10, Ethridge, Subscription Publication) also reports this story	
Computer programs were already expected to be the means for efficiencies in Medicare by 1966, well into the Space program, space satellites, and nuclear age. Hand written or typed records limited audits and made oversight tedious and expensive.	**Lack Of Interoperability Among Computerized Health Records A Barrier To Use.** Bloomberg BusinessWeek (6/22, Leonard, Tozzi) reports, in a lengthy feature article titled "Why Don't More Hospitals Use Electronic Health Records?" that "three years after the enactment of the Hitech Act, doctors and hospital administrators say there is little interoperability...among computerized health records." In fact, "some would rather lose Medicare funding than buy software now." However, "without the technology, it's difficult to see how the American health-care system can be restructured into something more affordable and equitable than the broken one that exists."	There are plenty of simple programs to keep records digitized, such as progress notes, prescriptions, scanning, admissions, discharges, lab results, etc.
Co-pays are the front line to limit or prevent fraud, including unnecessary tests	**Physician Found Guilty Of Fraud.** Modern Physician (3/16/2012, Carlson, Subscription Publication) reports that "Dr. Jaswinder Chhibber, 43, was found guilty of five counts of healthcare fraud and four counts of making false statements involving healthcare benefits, according to a news release (pdf) from the US attorney's office in Chicago." Chhibber was "convicted	If patients had skin in the game with co-pay they would not want useless tests.

	of...crimes related to the submission of fraudulent bills to Medicare and Blue Cross and Blue Shield of Illinois for medically unnecessary diagnostic tests." According to the clinic's employees, "Chhibber frequently ordered echocardiograms, electrocardiograms, nerve conduction studies, and carotid Doppler and abdominal ultrasounds and then altered patient charts to justify charges for the tests."	
Co-pays are the front line to limit or prevent fraud, including unnecessary tests	**Since 1980, personal out-of-pocket spending on insurance premiums and co-payments have declined from 23% to 11%;**[38]	If patients had skin in the game with co-pay they would not want useless tests.
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. But co-pays were dropped for Medicaid and are a marketing tool for Medigap plan coverage. Fraud includes counterfeit drugs.	**Costs of expanded audits aimed at Medicare fraud hit health-care firms** http://articles.philly.com/2014-07-28/business/52094475_1_medicare-fraud-medicare-spending-medicaid-services Outpatient Therapy In fee-for-service Medicare, which allows health-care providers to bill for individual services and is the program under which outpatient therapy is provided, improper payments were estimated at $36 billion, or 10.1 percent of total expenditures in that category.[39]	
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. But co-pays were dropped for Medicaid and are a marketing tool for Medigap plan coverage. Fraud includes counterfeit drugs.	**Fake Bevacizumab Was Imported From Overseas.** On the CBS Evening News (4/4.2012, story 2, 2:30, Pelley), chief investigative correspondent Armen Keteyian reported that "the Food and Drug Administration alerted healthcare professionals that 120 vials of fake Altuzan, which contained no active ingredient, had entered the US from distributers in the UK, after being purchased from wholesalers in Turkey." Keteyian added, "According to British authorities, 82 of the counterfeit vials were shipped to the US by River Reese Supplies, located here in the UK, and owned by Canadian businessman Tom Haughton.	If the beneficiaries pay, they will watch and report any medicines which are

	Haughton is under investigation for shipping counterfeit Avastin into the US." On its front page, the Wall Street Journal (4/5, A1, Faucon, Whalen, Subscription Publication) reports that overseas drug suppliers are attracting attention after another batch of fake bevacizumab was identified in the US. The AP (4/5) reports, "Doctors bought the counterfeits through Richards Pharma, a UK-licensed distributor that also does business as Richards Services, Warwick Healthcare Solutions and Ban Dune Marketing Inc." On Wednesday, "British regulators said...that Richards Pharma imported 120 packs of the fake Altuzan from Turkey" and "thirty-eight packets were shipped directly to the US, while the rest were sold to another UK distributor who then shipped them to the US." According to the AP, "UK authorities were notified of the fake product by the FDA on March 28, according to a statement from the country's Medicines and Healthcare Products Regulatory Agency."	
Co-pays were used Blue Cross and Shield during WWII to act as governor against unnecessary expenses, fraud, and over use. But co-pays were dropped for Medicaid and are a marketing tool for Medigap plan coverage. Fraud includes counterfeit drugs	**Attorney Says Metamizole Contributed To Demjanjuk's Death.** The AP (6/14/2012, Rising) reports former Ohio autoworker John Demjanjuk's attorney, Ulrich Busch, "filed a complaint with Bavarian prosecutors claiming that" the pain medication metamizole administered to Demjanjuk's "helped lead to his death as he awaited an appeal of his conviction on Nazi war crimes." Busch is seeking "an investigation of five doctors and a nurse on suspicion of manslaughter and causing bodily harm." While metamizole "is one of the most commonly used pain medications in hospitals in Germany and many other countries around the world," it is "banned in the US and many other nations over safety concerns."	Foreign standards seem below U.S. standards for safety.
Cost containment was important, so co-pays were to encourage frugality in	**No amount is too small for the claimant to pursue. Legislation Would Streamline Medicare's Secondary-**	Medicare already ignores small sums, it ignores large sums, as well.

consumption, to avoid over use (even though the Government paid 80% of Part B claims)	**Payer Process.** Politico (3/27/2012, Dobias) reports on "the Medicare secondary-payer process -- a tedious name for a billion-dollar headache." The effort to have Medicare collect from other insurers when they are responsible for coverage is called "clumsy," and "Legislation to fix it, known as the SMART Act -- Strengthening Medicare and Repaying Taxpayers Act -- has been introduced in both the House and the Senate." The measure has "bipartisan support, but it's still not clear" it has "the momentum to get something enacted this year." It "would require Medicare repayment amounts to be fully disclosed to beneficiaries before a final settlement," and "would also put a three-year time limit on claims and **prevent Medicare from pursuing amounts so small** that it costs more money to administer than is repaid."	
Costs were to be open and available to patients and everyone. Insurers like the disguised or hidden fees so as to make their sales easier.	**Insurers' Switch To Medicare Rates Said To Hurt Patients.**[40] On its front page, the New York Times (4/24/2012, A1, Bernstein, Subscription Publication) reports, "Despite a landmark settlement that was expected to increase coverage for out-of-network care, the nation's largest health insurers have been switching to a new payment method that in most cases significantly increases the cost to the patient." While the 2009 settlement was expected to "increase reimbursements by as much as 28 percent" by setting up an objective public database of pricing, called FAIR Health, many companies have since switched to calculating reimbursements "based on Medicare rates, that usually reduces reimbursement substantially." The insurance companies blame "exorbitant doctors' fees," but "the new realpolitik of reimbursement is leaving millions of insured families more vulnerable to catastrophic medical bills, even though they are paying higher premiums, co-payments and deductibles."	Sunlight on costs and fees.

Costs were to be open and available to patients and everyone. Insurers like the disguised or hidden fees so as to make their sales easier. Working on a cost plus basis, the insurers make more when the health community charges more, and when the insurance beneficiary spends more.	**Study: Health Insurers Often Fail To Negotiate Effectively With Hospitals.** The Washington Post (5/9, Kliff) "Wonkblog" reports that a new study published in the journal Health Affairs argues that health insurers often are not sufficiently aggressive in their negotiations with hospitals and other providers. According to the blog post, the study found that in many cities, "small physician practices were joining large physician practices, and large physician practices being bought up by hospitals. And this is giving them an edge over insurers." The story adds that insurers often do not negotiate effectively because of "the risk of losing a must-have hospital that won't contract with a health plan that expects to pay less for hospital services."	Insurers have no incentive to limit these cost, who expected this anyway?
Deductibles can control costs and profit the insured.	**Consumer-Directed Health Plans May Restrain Costs, But May Reduce Care.** The AP (5/8/2012, Alonso-Zaldivar) reports in a story appearing on at least 230 news sites, "It's the hottest trend in job-based health insurance: plans that give you a personal savings account for medical bills but also require you to pay a hefty share of costs before coverage kicks in." As the AP notes, "such 'consumer-directed' plans could save billions for employers, providing relief from high health care costs," a study published in the journal Health Affairs concludes. The story adds, however, that "there's a warning flag, a risk that workers will forgo needed care, even preventive services covered at no extra cost to them." The Hill (5/8, Viebeck) "Healthwatch" blog reports that, according to a study from the RAND Corporation, "the wide adoption of market-based healthcare plans like health savings accounts (HSAs) could significantly lower US healthcare costs in the short run." Specifically, the "study concluded that if the plans' market share rose to 50 percent, healthcare costs in the United States could drop by $57 billion annually." However, "the question remains whether the plans' cutbacks in care would lead to poorer health and higher costs later, study authors said." The story	This was the experience between the 1940s and 1960s, that patients held back spending to stay below the annual deducible This is the old name for the new consumer-directed health plan.

	is also covered by Reuters (5/8, Subscription Publication) and the National Journal (5/8, Fox, Subscription Publication).	
Dentures were the norm and expectation, in 1965, and folks had diseased teeth pulled. Medicare does not cover dental work (except in accident or reconstruction due to cancer, etc). Remember FixODen[41]t and Poligrip?[42]	Living another generation into their 80's, folk want to keep their teeth. Dental carries are also a health hazard for cardio risk, as the infection of rotten teeth constantly drains microorganisms down the throat into the body.	Include dental care, as therapeutic to prevent heart disease, and drop powered wheelchairs.
Durable medical equipment was unregulated. DME had to show reasonable and necessary. Use was assumed.	Not required that patient in fact uses the DME. DME is rented for 15 months plus maintenance of one month twice a year.	Require monthly certification by the patient of use.
Durable medical equipment was unregulated. DME had to show reasonable and necessary.	FDA approves 1-2% for safety and efficacy. The rest are unregulated, as to whether they work or not.	Require retrospective respective review.
Fee schedules would inform patients of what things cost. Perhaps they could do some comparison shopping.	No transparency, the fee schedules from Medicare are not available to the public.	Make them available.
Fraud of unnecessary services was to be avoided by copays.	**The trend is to pay all costs, leaving the claims open for fraud, such as dialysis[43] and diagnostic tests.[44]**	open 1,000 medical schools.
Free tooth care? it will be used. Virtually nobody is born with perfect teeth.	**Employers, Insurers Push For Cutting Back Essential Benefits.** CQ (1/24, Reichard, Subscription Publication) reports, "The growing concern among insurance analysts that coverage will be unaffordable in the new health care exchanges might create a fresh opportunity for federal officials to be persuaded to trim requirements in the final essential health benefits rule, which expected out in February or March." A group representing employers and insurers, known as the Change the Essential Health Benefits Coalition "held a news briefing Wednesday to highlight six recommendations for shaping the rule in a way they say makes coverage less costly." The changes they want in the final rule include "scaling back requirements for pediatric dental and vision benefits," and	Originally dental services were left out of Medicare. Dental care should be weighed as to benefits such as scooters, power wheel chairs, palliative care, placebo care, etc.

	"backing off a requirement that plans cover one or more prescription drugs in each drug category." Modern Healthcare (1/24, Zigmond, Subscription Publication) reports that the Essential Health Benefits Coalition's membership includes the National Retail Federation, the U.S. Chamber of Commerce, America's Health Insurance Plans, the American Osteopathic Association and the Pharmacy Care Management Association. At Wednesday's news conference in Washington, Neil Trautwein, the coalition's chairman, "stressed affordability and said a major concern for the group is that the final essential health benefits rule does not put the cost of coverage beyond the reach of the nation's small businesses."	
Health care records would improve with technology, such as digitized records, or electronic monitoring. Dictation tape recorders permitted physicians to record information to be transcribed and corrected for records. Four decades later, children to IM (instant messaging), teens have blackberries, cell phone use is two thirds of the population. Digitized records prevent medical errors. **1 million people are killed or injured by medical errors annually**[45]	Electronic and digitized records have been adopted by the Veterans' Affairs, but not by most hospitals or physicians. The routine are hand written scribbled notes. These are paid 95% of the time without review, so why go to expense of digitized copies for the 5% reviewed, just take the chance those will be covered anyway.	Give a years notice, then remove all undigitized reports from consideration of coverage. I.E. Make digitized records mandatory.
Hospitalization was for acute problems, not the routine. This meant more people avoided nosocomial infections at hospitals (disease spread at a hospital) by not going to the hospital.	For 3/4ths of the week, the emergency room has become the location for all maladies, resulting in increased mixture of disease and infection.[46]	Open 200 new medical schools.
Hospitals could NOT open even if they had a sponsor, or donor to foot the bill.	Hospitals need a certificate of need, thus rationing the beds, and setting up oligopolies, or monopolies.	Let the market decide where hospitals will open. Do away with the certificate of need.
Hospitals discharged patients for home or assisted rehabilitation. Rest homes were available for the weakest without other choices.	Acute care hospitals move patients to their Inpatient rehabilitation facility to keep the business in house and keep the beds filled.	Break up the monopoly. Reduce payment to affiliate care.

Hospitals were non profit, charitable, with volunteers. Now hospitals are for profit	**For-Profit Hospital Trend Could Spread Across New Jersey.** The NJ Spotlight (5/16, Fitzgerald) reports that the majority "of New Jersey's 72 acute care hospitals are nonprofits, with just a handful owned by for-profit companies." However, "the for-profit trend could spread as many hospitals continue operating near the breakeven point while facing the need for capital to modernize their aging physical plants and invest in medical technology." In a few instances, "hospitals in financial trouble have been rescued by for-profits: Bayonne Medical Center filed for bankruptcy in 2008 and was acquired by a for-profit company that has since acquired the ailing Hoboken University Medical Center and is now taking over bankrupt Christ Hospital in Jersey City."	Open more hospitals The review process is anti-free market. You can regulate cleanliness, by why regulate beds? I didn't know the nonprofit hospitals paid a tax?
Hospitals were non profit, charitable, with volunteers. Now hospitals are for profit.,	**New Hampshire Lawmakers Push Incentives For Hospitals To Open Near Massachusetts.** On its front page, the Boston Globe (5/11/2012, A1, Weisman) reports, "New Hampshire lawmakers are pushing incentives for so-called destination hospitals to open along the state's southern border, hoping to build a specialty health care hub that draws patients from Massachusetts." This "effort initially aims to attract a national for-profit hospital chain, Cancer Treatment Centers of America, by eliminating a state review process and exempting it from a tax nonprofit hospitals pay." According to the Globe, "Sponsors hope to eventually add kidney care, spine surgery, and other specialized services - all drawing business from out of state."	Open more hospitals The review process is anti-free market. You can regulate cleanliness, by why regulate beds? I didn't know the nonprofit hospitals paid a tax?
Hospitals were non profit, charitable, with volunteers. Now hospitals are for profit,	**Illinois Yet To Take Action On Several Hospitals' Tax Exemption Applications.** The AP (5/10, Johnson) reports, "Following through on a promise, Illinois Gov. Pat Quinn announced more than two months ago that the state would resume denying tax exemptions to hospitals that operate more like businesses	Open more hospitals The review process is anti-free market. You can regulate cleanliness, by why regulate beds? I didn't know the nonprofit hospitals paid a tax.

	than charities." However, "the state has taken no action on 17 pending tax exemption applications, despite calls from advocates to make hospitals live up to their missions and the demands of municipal officials who believe they are losing valuable revenues from hospitals that don't deserve tax breaks." According to the AP, "the silence from the Department of Revenue raises concerns that the decisions are embroiled in wider negotiations in Springfield between the state and hospitals, and that the Democratic governor may be feeling pressure from the state's influential hospital industry, a top contributor to political campaigns."	
Hospitals were non profit, charitable, with volunteers. Now hospitals are for profit,	**IRS Outlines How To Implement New Requirements For Tax-Exempt Hospitals In ACA.** Modern Healthcare (6/23, Subscription Publication) reported, "The Internal Revenue Service issued 94 pages of proposed regulations (pdf) outlining proposals for how to implement new requirements for tax-exempt hospitals in the Patient Protection and Affordable Care Act." The ACA "created a new section of IRS rules known as 501(r), under which hospitals must meet four new requirements in order to retain or earn tax-exempt status." According to Modern Healthcare, "Not-for-profit hospitals must now publicly post their financial assistance policies for patients, including eligibility criteria and the basis for charged amounts."	The paper work ever mounts higher.
If its free, it will be used. Virtually nobody is born with perfect teeth.	**Utah Proposes To Reduce CHIP Dental Benefits.** The Salt Lake (UT) Tribune (3/1, Stewart) presents a proposal by Utah State Representative Jim Dunnigan (R) to limit the dental benefits offered under the Children's Health Insurance Program. The benefits are modeled after a widely used private plan in the state and after receiving "'an inordinate number' of orthodontia claims," officials realized the plan included "coverage for braces and other teeth-straightening treatments." With limited funding in CHIP, Dunnigan hopes to change the benefits to allow	Originally dental services were left out of Medicare. Dental care should be weighed as to benefits such as scooters, power wheel chairs, palliative care, placebo care, etc.

	"'medically necessary' orthodontic care" only. The proposal is part of a provision in Dunnigan's omnibus health reform bill that passed in the House and awaits a vote in the Senate	
Independent pathologists or physician groups provided services to hospitals PRE-1965 Medicare. The groups would use economies of scale, exceptional expertise, and experience to read slides, make diagnoses, perform tests, and report back to the hospitals which drew the samples.	Hospitals brought all outside work in house to control costs and increase profits, and avoid competition. Who knew if the technician reading the slide had 30 years experience or 30 hours of experience? False Negatives and False positives shot way up, but unnoticed. Example Los Angeles in 1971, Hospitals went from private to public ownership (stock market) and withdrew path work from the independent pathologists.	Break open the monopolies.
Insurance is regulated by states, who are closest to the needs of the public.	This lead to oligopoly power. Being dissatisfied with state regulation, a trigger of 10% has been added to the regulations.[47]	Let market run the rates.
Interns,. States educate medical students, first at medical schools, then as interns, then as residents, and then as specialists. If states needed more physicians, they would open schools to train them. The states would be responsive to the needs of their taxpayers and residents in allocating resources between graduate and professional education. College education is usually subsidized half to 90% above tuition and out of pocket costs, i.e. tuition and fees only cover 10% to half of the cost of a college degree.	Poaching Interns. States under seat their medical schools, then with money thus saved, expand their post graduate intern and residency programs.[48] They poach trained MDs from competing states. California has 3,000 annual medical school graduates, and 6,000 internships. The rest coming in from out of state.	Stop Systemic Poaching. Open 200 more medical schools. Require states to graduate enough medical school seats for intern / residency slots.
Little of no lobbying in Washington or states by physicians, providers or hospitals.	Political lobbying changes medical coverage.[49]	Political Lobbying is most effective with rationing or shortages.
Many Physicians made house calls. Remember Marcus Welby MD?[50] Or Made for Each Other?[51]	Physicians do not make house calls. Hospitals (or Medicare Management Plans) manage patient care.	Open 200 new medical schools.
Market for resident training would increase numbers of residents.	The increase in demand from Medicare didn't increase physicians, it increased physicians' income.[52]	Open a thousand new medical schools.

Market forces would remediate excess use.	Industry wide practice of secret pricing, and predatory pricing destroyed confidence in the market.[53]	Publish all fee schedules.
Medicaid was a safety net. The net has stripped off the net for children.	**Judge Rejects Orthofix International's Medicare Fraud Settlement.** Bloomberg News (9/7, Feeley, Lawrence) reports, "Orthofix International NV (OFIX)'s settlement of federal regulators' accusations that the maker of bone-repair products defrauded Medicare by paying kickbacks to doctors was rejected by a judge." US District Judge William G. Young in Boston remarked, "It seems in this case the court's hands ought not be tied. I have extreme unease of treating corporate criminal conduct like a civil case." The piece notes that it is "unclear whether Young's refusal to accept the plea also scuttles Orthofix's agreement to pay $34.2 million to resolve civil claims first raised in a whistle-blower's lawsuit that the company defrauded the federal Medicare program through payments to doctors who used its bone-growth stimulators."	Budgets are needed allocate resources.
Medical school graduates were in equilibrium, replacing physicians who retired, died. The physician supply would expand with the population growth.	The U.S. hasn't trained enough new physicians to replace existing physicians for a century, much less expand physician numbers for a population which has added 150 million folks.	Open 200 more medical schools.
Medicare appeals system (circa 2005) was to provide a data base with 1,700 fields of information. The system was required for use by the Office of Medicare Hearings and Appeals to collect data on 31,000 appeals (2007) for Centers for Medicare and Medicaid Services.	Not one of 1700 fields was for benefit period, co-pay, deductible, fee schedule, Medicare approved amount, or prior payments on a claim.	Put in 6 more fields, required to establish Judges' jurisdiction. Round up to 1800 fields. These are so many fields that nothing would be done, except entering data in fields – no hearings or appeals.
Medicare appeals system (circa 2005) was to provide a data base with 1,700 fields of information. The system was required for use by the Office of Medicare Hearings and Appeals to collect data for Centers for Medicare and Medicaid Services.	The MAS information s is not available to the Medicare Appeals Council or Department Appeals Board, the 5th level of review.	The MAS information can't be very important, then if the next 4 levels of appeal have no access to the data.
Medicare appeals system has 9 levels of	1)initial claim, (2) redetermination decision (3)	Few know how many levels are involved to

review.	reconsideration decision (4) over $130 amount, hearing before Administrative Law Judge decision (5) Medicare Appeals Council decision (6) over $1260 amount, U.S. District Court decision (7) US Court of Appeals decision (8) US Supreme Court decision (9) Act of Congress	weed through 2300 claims a minute.
Medicare appeals system. If a claim is approved for coverage (for payment), there is extremely small chance of review – one in ten million. If a claim is denied, it can be appealed for review.	The 4th review of a claim at the Administrative Law Judge provides for a hearing. The Judge can exercise summary judgment and pay (or cover) the claim with out the hearing. The Judge cannot deny the claim without the hearing, unless the appellant waives hearing (few do so). Combine this procedural pressure which is the equivalent of keeping an elbow leaning on the scales of justice, with the assignment for FY2012 of about 1200 claims per Judge, (which works out to hearing, reading, writing, deciding one claim every 75 minutes) the pressure is to pay cases under summary judgment to keep up with the work load.	Solution is to give summary Judgment authority to the Judges for denials as will as approvals. If you want to change the leaning of the elbow on the scales of justice, change Summary Judgment for denials, and require a hearing for approvals.
Medicare assumed a stable financial system. What happens when it isn't? Ask Greece.	**Greek Crisis Prompts Pharmacists To Charge Customers Full Price Of Medicine.** The Washington Post (6/14/2012, Birnbaum) reports Greece's citizens "are feeling the harsh effects of their government's running out of money," and one aspect of this is that "pharmacists who are owed millions of euros by the government insurance system" have started requiring "clients pay the full sticker price for medicine." Pharmacists are taking this step not only because they are not being paid by the government, but because medical suppliers, "wary of extending credit in euros only to be repaid in weaker drachmas if the country gets booted out of the currency union, are demanding cash before they make shipments." However, with high unemployment and little credit, "many people are doing without their drugs."	Greece is heading to a barter economy like Zimbawe, Chile, Brazil, Germany, post Civil war south, and the United States under the Articles of Confederation.
Medicare assumed a steady growth in number of physician from medical schools. This never happened.	**Hospital-Based Physicians Exhibit Unprofessional Behaviors, Survey Finds.** **In its "Capsules" blog, Kaiser Health News (6/14/2012, Rau) reports on results from a new survey published in the Journal of Hospital Medicine revealing ." Further,**	Physicians have to triage their work on it won't get done.

	"62 percent said they had mischaracterized a routine test as 'urgent' to get it done faster," while nine percent transferred patients unnecessarily to lighten their patient load	
Medicare assumed technology would reduce costs for health care. But 4 decades later, hospitals and physicians rely on paper records and scribbles and pen and ink for medical records.	**California Reports Reaching EHR Milestones.** Modern Healthcare (5/10, Kutscher, Subscription Publication) reports, "In a biennial report, the California Health Information Partnership and Services Organization [CalHIPSO], a not-for-profit group focused on electronic health-record adoption, said it has reached a number of milestones to expand EHRs in the state." CalHIPSO, "a joint venture between the California Primary Care Association, the California Medical Association and the California Association of Public Hospitals and Health Systems" said that "it has earned $65 million in federal stimulus funds, and is in the process of selecting a second round of vendors, growing its initial list of seven." And "more than 7,700 providers in the state have started the process of adopting EHRs."	If Medicare didn't pay hand written claims the health industry will switch.
Medicare expected most health care would be through non profit hospitals and physicians with a motive of care. Both would discuss costs with patients. Soon the hospitals became for profit. The result was transparency of price (also negotiated by insurance companies) was painted over so few know what it costs to get health care. Costs are left to BILLING.	**Moody's Report Warns Of Rising Costs, Dwindling Funds At US Nonprofit Hospitals.** Reuters (5/9) reports that a new Moody's Investors Services report says that costs will rise, while funds will become more scarce, at US nonprofit hospitals. Thus, the nonprofits will have to significantly reduce spending. The report is called "Doing More with Less."	Return to the market economy for health care.
Medicare expected most health care would be through non profit hospitals and physicians with a motive of care. Both would discuss costs with patients. Now 60% of hospitals are nonprofit.	**Report: Nonprofit Hospitals Seizing Patients' Wages To Collect Medical Debts.** 3,500-word story co-published with NPR, ProPublica (12/19/14) reports on the use of lawsuits and wage garnishment by some hospitals to collect on medical debts. The piece says that while no one tracks how many hospitals sue their patients and how frequently,	Return to market economy.

	"ProPublica and NPR found hospitals that routinely did so in Kansas, Oklahoma, Nebraska, and Alabama, as well as Missouri." The article examines one hospital, Heartland Regional Medical Center in St. Joseph, Missouri, that has its "very own for-profit debt collection agency." The agency, Northwest Financial Services, filed more than 11,000 lawsuits from 2009 and 2013. During that period, "the company garnished the pay of about 6,000 people and seized at least $12 million—an average of about $2,000 each." Nonprofits, "which make up nearly 60 percent of U.S. hospitals, have a history of aggressive debt collection," according to ProPublica.	
Medicare expected t most health care would be through non profit hospitals and physicians with a motive of care. Both would discuss costs with patients. Soon the hospitals became for profit. The result was transparency of price (also negotiated by insurance companies) was painted over so few know what it costs to get health care. Costs are left to BILLING.	**Louisiana Hospital Officials Cautious About Governor's Refusal To Expand Medicaid.** The New Orleans Times-Picayune (7/6, Alpert) reports, "Louisiana hospital officials are taking a wait-and-see attitude toward Gov. Bobby Jindal's refusal to expand Medicaid eligibility as called for in" the federal health reform law. While hospital officials in "other states...are lobbying their governors and legislatures to move forward with the Medicaid expansion, Louisiana hospital administrators and representatives are being cautious." According to the Times-Picayune, "hospitals are worried the expanded Medicaid participation authorized under the health overhaul law...would lead the federal government to significantly reduce compensation to hospitals for providing care to the uninsured."	Return to the market economy for health care. The lobbying says much about the expectation of profit if the government guarantees the payments. Nothing is said about opening more medical schools and adding student seats to accommodate the expansion.
Medicare thought most health care would be through non profit hospitals and physicians with a motive of care. Both would discuss costs with patients. Soon the hospitals became for profit. The result was transparency of price (also negotiated by insurance companies) was painted over so no one knows what it costs. It is left to BILLING.	**Study: Price For Appendix Removal Varies Widely Across California Hospitals.** The CBS Evening News (4/23/2012, story 11, 2:10, Pelley) reported, "Surgery to remove a ruptured appendix is very common but a study out today found the price of such a common procedure can vary widely depending on the hospital." On ABC World News (4/23, story 8, 2:15, Sawyer), ABC's Dan Harris reported that Dr. Renee Hsia "launched	This results in price fixing between insurance companies who want insurance business and the medical industry which wants monopoly profits. Release cost agreements between insurance companies and hospitals, physicians, therapists. Light is the best disinfectant.

	a study, examining what thousands of patients all over California paid for their appendectomies." The New York Times (4/24, Rabin) "Well" blog reports that "according to the report published Monday in the Archives of Internal Medicine, fees for a routine appendectomy in California can range from $1,500 to - in one extreme case - $182,955. Researchers found wide variations in charges even among appendectomy patients treated at the same hospital." The AP (4/24, Tanner) reports, "The researchers and other experts say the results aren't unique to California and illustrate a broken system." According to Dr. Hsia, "there's no system at all to determine what is a rational price for this condition or this procedure."	
Medicare thought most health care would be through non profit hospitals and physicians with a motive of care. Both would discuss costs with patients. Soon the hospitals became for profit. The result was transparency of price (also negotiated by insurance companies) was painted over so few know what it costs to get health care. Costs are left to BILLING.	*Hospitals Support Medicaid Expansion In Pennsylvania.* The Pittsburgh Tribune-Review (10/16/2013 Nixon) notes that the fact that an increasing number of people went without insurance in Pennsylvania in 2012 "should add urgency to proposals to reduce the state's number of uninsured, including Gov. Tom Corbett's alternative to expanding Medicaid," according to The Hospital & Healthsystem Association of Pennsylvania. The **state has at least 240 hospitals that would benefit financially** from Corbett's alternative or expansion. The Corbett Administration opposes expansion but is encouraged by the approval of a similar proposal by Arkansas late last month	The for profit hospitals have a strong incentive to benefit financially for every expansion of government run health.
Medicare was adopted in 1966, the country had a half century experience on the Sherman Act (anti-trust) which outlawed a number of monopolistic practices, price fixing, tie-ins, market control. These were assumed to apply to the health market. Example: Pre antitrust acts, railroads charged more for short haul (where they had monopoly power) than	**California Physicians Sue Aetna Over Out-Of-Network Policies.** The AP (7/5/2012) reports that the California Medical Association, the Los Angeles County Medical association and other physicians "are suing Aetna, alleging the health insurer denies patients access to out-of-network physicians." The suit "alleges false advertising, breach of contract, unfair business practices and intentional, negligent interference with health care providers."	The out of network physicians did not have discounted rates. But insurers often promise 'you can keep you own doctor.' This has apparently lead to price hikes. Bring in transparency, how much do things cost in health care?

long haul, where competition often applied Health insurers negotiate sweet heart rates with hospitals and physicians, win win as more people desired health coverage insurance, to get access to the discounts.	The Wall Street Journal (7/5/2012, Weaver, Subscription Publication) reports that some of the physicians suing the company were sued by it in February for inflating their bills. The suit is presented as one of the challenges faced by managed care companies trying to rein in costs and in turn being accused of choosing profits over patient care. The Los Angeles Times (7/4, Terhune) reports, "The California Medical Assn., the largest physician group in the state, and more than 60 individual doctors sued health insurance giant Aetna Inc. as part of a growing legal battle over what patients are charged when they go outside an insurer's network. ... The suit alleges that the insurer illegally threatens doctors and patients who want to use out-of-network medical providers and then cancels the contracts of some physicians who persist in those referrals." But "an Aetna spokeswoman said doctors are referring people to out-of-network facilities that they own - without informing patients about this conflict of interest." Bloomberg News (7/3, Pettersson) reports that Aetna spokeswoman Cynthia Michener said, "We have sued some of these same doctors and surgery centers named in this suit for their egregious billing practices," adding "This is a countersuit disguised as a class-action lawsuit." The Long Beach (CA) Press-Telegram (7/4, Abram) reports that regarding the suit, Rocky Delgadillo, CEO of the LA County Medical Association, said, "Doctors are standing together united, which is very rare." The Los Angeles Business Journal (7/5/2012, Crowe) reports, "The lawsuit pertains to Aetna's higher-cost preferred provider organization (PPO) and point-of-service (POS) policies, which are marketed as giving members with greater flexibility to get care from out-of-network providers." KCBS-TV Los Angeles (7/5/2012) reports, "Company officials said it was 'troubling that the California Medical Association and other county medical associations would support this type of egregious behavior	

	from physicians' and that the insurer's actions 'protect our members from the small number of doctors who are putting profits ahead of patient care.'" Reuters (7/5/2012, Clarke) and Modern Healthcare (7/5/2012, Subscription Publication) also cover the story.	
Medicare was for health care. Other agencies were for health research, such as CDC, NIH. New agencies included the AHRQ..	Medicare pays for research and experiments, and clinical trials..	Leave research payment to those agencies able to monitor protocols and results.
Medicare would not be a rationed health care system. States, governments, employers would participate according to ability.	As Universal coverage was implemented in Massachusetts in 2006, increased demand with rationed supply - its residents pay more, up to double, for less access to health care.[54]	Ration.
Medicare would review and audit therapy claims.	**AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com]** Sent: **Wednesday, December 22, 2010 6:51 AM** **Medicare Not Taking Full Advantage Of Claims Database To Spot Potential Fraud Cases.**[55] "Secrets of the System" series, the Wall Street Journal (12/22, A1, Schoofs, Tamman) focuses on Medicare's payment policies regarding physical therapy, which cost the government $3.5 billion two years ago. Unfortunately, even when physical therapy providers are identified by Medicare as having questionable billing practices, Medicare still continues to pay claims, sometimes for years. The Journal points out that Medicare is not taking full advantage of its own data from its claims database to spot potential fraudulent billing practices. What's more, Medicare is legally forbidden from publicly disclosing actual billing data from individual healthcare professionals in order to protect their privacy. This lack of transparency makes it even harder for law enforcement officials to prosecute healthcare-related fraud cases.	Not enough auditors, better is to open 1,000 medical schools.
Medigap plans which cover Co-insurance have fogged or hidden the relationship	Result - Beneficiaries are scared of the “donut hole’ and can’t knowingly compare costs. This works to the	Set an annual out of pocket cap for Part B at the amount of the Medigap plan, say

between co-pay, over utilization, fraud prevention, palliative care (i.e. placebo) and monopoly pricing.. This means that Overwhelmingly, Medicare beneficiaries don't know and don't care how much something costs, whether it will do any good, or whether it is even legal, since the Medigap plan pays the co-insurance.	advantage of those who want lots of 'healthy' insureds (90%) paying premiums to cover those who are 'ill'. But then the healthy are enticed into products and services they would not otherwise use (i.e. they didn't know they needed) because the benefit is there. The Medigap plans (non HMO) rune hundreds of dollars a month in addition to the Medicare Part B premium.	$3600 per year. Then tell insureds, you can drop the Part B Medigap which is the same cost, and if you don't reach the out of pocket you can keep the difference you did not spend on the Medigap insurance. This gives beneficiaries an incentive to monitor their usage.
Medigap plans which cover Co-insurance have fogged or hidden the relationship between co-pay, over utilization, fraud prevention, and palliative care (i.e. placebo) and monopoly pricing.. For Part A, hospitalization, these cover costs after 100 days benefits, depending on the service, which could be substantial, but is usually very rare, as the benefit period restarts after 60 days out of Part A.	Run the statistics to find just how many, out of the 45 million beneficiaries, actually run OUT of Part A benefits. This means, in a Part A benefit period, who actually runs through the 100 days benefit, who actually ever pays for the post period balance? I think it is none, except for those on Medicaid who have no incentive to pay attention to Part A benefit periods. This post 100 day period so scares beneficiaries into believing they must have Medigap insurance against the impossibility of a Part A. Once they have the supplement, they have no incentive to monitor their usage.	If the remote on unattainable possibility of Part A liability does not really exist, then change the law to an out of pocket cap for Part A. Then beneficiaries can plan. The goal is to return usage to the Business model that the patient pays a little each time, and won't stay in the hospital bed longer than needed, or get surgery or treatment, which is elective and unneeded. When the beneficiary is back in the market, and can save money on an individual basis, monopoly will be reported so it can be prevented.
Medigap plans which cover Co-insurance have fogged or hidden the relationship between co-pay, over utilization, fraud prevention, palliative care (i.e. placebo) and monopoly pricing..	**Business Owners Frequently Encounter Difficulties In Navigating Health Insurance.** The New York Times (5/9, Gardella) "You're the Boss" blog reports that many business owners have difficulty sorting through the complexities of health insurance when deciding on what kind of health benefits to offer their employees. The blog post mentions that different insurance brokers often tell business owners of different complications in choosing insurance plans, such as the need to decide on a plan based on the number of employees and on the percentage of employees who opt for insurance. ***Ohio Businesses Urged To Prepare For Period Of Healthcare Disruption.*** The Cincinnati Enquirer (5/9, Peale) reports on its website, "Ohio businesses should prepare for an expensive and time-consuming period of	Return to the original model of co-pay and participation.

	disruption when dealing with health care, Ohio Lt. Gov. Mary Taylor said Tuesday." In a speech to the West Chester-Liberty Chamber Alliance, Taylor said "that could include higher premiums, confusion among employees about how to get coverage and new fees to support a health care exchange," and it "probably can't be avoided, regardless if the Supreme Court overturns the federal health care reform law or a new president tries to unwind many of the reforms next year." Some Employers Apply Value	
Monopolies? But Medicare created monopolies by pricing the private care out of the service market. (i.e. paying 4 fold what a private item is available for.)	HHS IG Finds Medicare Overpaying For Back Braces. The AP (12/19/2012, Alonso-Zaldivar) reports, "You can find it on the Internet for $250 or less. But if Medicare is paying, a standard-issue brace for back patients costs more than $900." According to a report by the HHS inspector general, "Medicare paid an average of $919 for back braces that cost suppliers $191 apiece." In response, "Medicare Administrator Marilyn Tavenner said the findings provide valuable insight into the inner workings of her program." Industry representatives "say the reimbursement set by Medicare goes beyond just equipment cost, also including fitting and education," yet "investigators found that for one-third of claims, suppliers did not report any fitting and adjustment help."	Medicare rules require fitting and adjustment and education, and certificate of medical necessity, progress notes, special dating, codes, codes, more codes, etc.
Non profits would manage hospitals. But the non profit got out of the business and the cost of a new bed construction is $2.8 million per bed (2012)	**Yale, St. Raphael's Merger Would Solve Problems For Both Hospitals.** The Hartford (CT) Courant (2/29, Chedekel) reports, "The proposed merger of Yale-New Haven Hospital and the Hospital of Saint Raphael solves problems for each of the hospitals: Yale needs at least 140 new patient beds in the next five years, and St. Raphael's is facing a projected $8 million shortfall in 2013, according to the Certificate of Need application filed with the state this month." That "application, received by the Office of Health Care Access (OHCA) Feb. 9, lays out an ambitious merger plan that would spare Yale-New Haven the expense of constructing a fifth 'bed tower,' estimated to take five years and cost	140 times $2.8 million is $400 million. Stop restricting construction and let the market rule. No more certificates of need.

	about $400 million." The plan "also would provide St. Raphael's with both financial stability and the retention of its Catholic directives for reproductive services and end-of-life care."	
Overutilization of unnecessary services was to be avoided by copays.	The trend to pay all costs for all participants. The prescription donut hole, from 2002, was filled in 2010. Previous to 2002, drugs were covered under Part B and A provisions.[56]	open 1,000 medical schools.
Patients could be treated at home. This avoided nosocomial infections at hospitals (disease spread at a hospital)..	No house calls by physicians. Home health by rehabilitation therapists[57].	Open 200 new medical schools.
Patients could be treated at home. This avoided nosocomial infections at hospitals (disease spread at a hospital)..	Special diseases are transferred at the hospital, i.e. Clostridium Difficile, and MRSA.[58]	Open 200 new medical schools. (i.e. keep patients at home.
Patients could get prices on services, products, equipment, or drugs in advance. So informed, they could choose between optional and necessary services, find ways to budget expenses, and prioritize obligations.	The payment system is set to match product or service code with a diagnostic code for computer convenience. It is unintelligible to the public.	Require the provider / supplier to give codes to patients to enter into internet sites for prices.
Patients could go to any physician who would treat them. Payment would be limited by Medicare fee schedule.	***Provisions Focus On Prescription-Drug Abuse.*** The Charleston (WV) Daily Mail (5/24/2012, Hunt) reports, "West Virginia Sens. Jay Rockefeller and Joe Manchin are taking aim at curbing prescription drug abuse and doctor shopping in a bill that should come up for a vote in the US Senate in the coming days." Their planned measure would be included in the FDA user fee reauthorization. "Rockefeller, chairman of the Senate Finance Subcommittee on Health Care, has already included a provision in the bill calling for a study of the tools available to doctors, nurses and drug prescribers to help them identify doctor shopping." Manchin offered an amendment now approved to change hydrocodone containing medications from Schedule III narcotics to Schedule II.	So much for the patient selecting a physician.

Patients were supposed to know how much thing cost. But patients are kept from knowing costs for the health care, including waste, service pricing, administrative costs, 'red tape', and overutilization.	**IOM Says US Health System Wastes $750 Billion Annually.** The AP[59] (9/7/2012, Alonso-Zaldivar) reports the Institute of Medicine issued a report finding that "the US health care system squanders $750 billion a year -- roughly 30 cents of every medical dollar -- through unneeded care, Byzantine paperwork, fraud and other waste." The conclusion drawn is that while both "President Obama and Republican Mitt Romney are accusing each other of trying to slash Medicare and put seniors at risk ... deep cuts are possible without rationing, and a leaner system may even produce better quality." That's because the IOM's "one-year estimate of health care waste is equal to more than 10 years of Medicare cuts" under the ACA and "more than enough to care for the uninsured." The report also "identifies six major areas of waste: unnecessary services ($210 billion annually), inefficient delivery of care ($130 billion), excess administrative costs ($190 billion), inflated prices ($105 billion), prevention failures ($55 billion) and fraud ($75 billion)." The Washington Times (9/7/2012, Cunningham) reports in its "Inside Politics" blog, "The report highlighted flaws that have long plagued the US health care system, which is relatively slow to adopt new technologies, lacks incentives for doctors and hospitals to keep costs down and doesn't encourage all of a patient's providers to coordinate care." ABC News[60] (9/7/2012, Wong) in its "Medical Unit" blog says that "the money squandered on services that failed to improve Americans' health could have provided health insurance for more than 150 million workers or covered the salaries of all of the nation's first responders for more than 12 years." Author Dr. Mark Smith, president of the California HealthCare Foundation, said, "We're spending money in ways that don't seem to improve people's health." ***Improvement Available With Existing Technologies, Tools.*** Bloomberg News (9/7/2012, Wayne) says the report	Enforce co-pay, and this wastes will come down.

finds that healthcare "needs stronger government leadership to coordinate practices as the Affordable Care Act increases burdens on caregivers." Recommendations include "fully adopting electronic medical records, ushering drug discoveries into use faster and improving physician training," which Bloomberg sums up as "better training and sharing of information."

The San Francisco Chronicle[61] (9/7/2012, Colliver) says the report also found that "tens of thousands of deaths could be averted through better care," and that "improving quality and lowering costs are not only possible but could be done with tools and technologies that exist."

CQ (9/7/2012, Reichard, Subscription Publication) reports, "Wasted money isn't the only issue. 'By one estimate, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state,' the IoM said." It also said that "achieving higher quality at a lower cost requires no less than transforming all of US health care into a 'learning' system." Also, "IoM officials pointed to concrete examples of systems that are doing what they recommend, such as Denver Health in Denver Colorado and the Virginia Mason health system in Seattle Washington."

The Business Courier of Cincinnati (9/7/2012, Ritchie, Subscription Publication) in its "CincyBiz" blog says, "To fix the system, the report prescribed: better use of data; payment systems that reward quality and value; adoption of electronic health records and mobile technologies; and transparency about the costs and outcomes of care."

The Daily Mail (UK) [62](9/7/2012) reports, "The report's main message for government is to accelerate payment reforms, said panel chair Dr. Mark Smith."

Modern Healthcare (9/7/2012, McKinney, Subscription Publication) reports, "In the 382-page report, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, an 18-member expert panel argues for a set of improvement

	strategies that panel members say will make information more accessible, engage patients and their families and make care more equitable."	
Patients were supposed to know how much things cost. But patients are kept from knowing costs for the health care.	**North Carolina Governor Seeks To Make Hospital Prices, Bills More Transparent.** The Charlotte (NC) Observer (5/14, Garloch) reports, "Making hospital prices and bills more transparent is among the goals set out last week in NC Gov. Bev Perdue's proposed budget for next year." Perdue "also wants to make it easier for low-income and uninsured patients to find out about hospital charity care policies." The governor, "in her budget proposal...asked the legislature to allocate $100,000 to the NC Institute of Medicine for a study that would lead to recommendations that would help patients better understand hospital prices and bills."	Publish fee schedules for procedures, bed use, hospital care.
Physicians were assumed to increase in response to market (i.e. normal) growth.	**Medical School seat limits, mean states compete for physicians.**[63]	open 1,000 medical schools.
Political pressure to expand services and borrow and spend money is stronger than the resistance to be frugal.	**Rep. Roskam, Sen. Wyden Back Premium Support Concept For Medicare.** CQ (3/7, Reichard, Subscription Publication) reports, "Rep. Peter Roskam, R-Ill., and Sen. Ron Wyden, D-Ore.," both of whom "spoke at a conference sponsored by the Federation of American Hospitals," are in favor of "a premium support concept for Medicare but...don't necessary agree on all the details of an overhaul of the program." Rep. Roskam pointed out "that his fellow House Republicans have, in effect, said they are willing to be held **politically accountable** for big changes to the program," as evidenced by their support of the Ryan plan last year." Wyden is pushing a national 'conversation' this year that can lead to legislation in 2013 overhauling the program.	More legislation? The original legislation was never implemented.
Sherman Act (anti-trust) which outlawed a number of monopolistic practices, price fixing, tie-ins, market control. When Medicare was adopted in 1966, the	Hospitals, physicians and others began setting rates. Monopoly rates. Insurers negotiated discounts. The 'discounts' provided strong marketing incentives for buying health insurance, which was actually pre paid	Set ONE price for all, insured and uninsured, and the pressure is removed to qualify for the 'discount' negotiated by the insurers. Of course, expect major push

country had a half century experience with anti-trust. Anti-trust was assumed to apply to the health market. Example: Pre antitrust acts, railroads charged more for short haul (where they had monopoly power) than long haul, where competition often applied.	health, as opposed to the risk based insurance for life and casualty. As decades went by the spread of the discounts became multiples, so that the price 'charged' was 2, 3 or 10 times what the discount authorized. The anti-trust prohibitions were not enforced. Now, a person going for a 2 night stay at a hospital can get a bill of $50,000, even though Medicare's discount is $5,000. These kinds of spreads are the norm, rather than the exception.	back from the insurers. But since the government's tax dollars have stepped in to cover 40% of the population, there is no longer a right for insurers to demand this marketing advantage
Social security taxes in the 1960s were about those raised from medicare, under 2% each, so the revenues were about the same.	Congress learned it could cut income taxes, but raise social security taxes without public complaint. This was the true flat tax, without deduction for children, charitable contributions, medical expenses, catastrophe, tax credits, or anything else to lower the revenue stream. Thus social security is about 13% up to about a hundred thousand in wages and medicare has no cap.	Suggestions are to put these taxes in individual accounts for retirement, and give ownership to the
State regulation of life insurance companies and the life insurance cross guarantee of coverage avoids government subsidies and rescue of insurance companies.	Life and health Insurance companies avoided the financial melt down in 2007 to 2009, without trillions of government subsidies. Insurers also raised rates. One congressman sees this as collusion and exemption from federal anti-trust business.[64]	If it ain't broke, don't fix it. Health insurance is highly competitive because it is lucrative. Connecticut has 1800 insurance companies and 2 medical schools. To bring down high costs, open 1,000 medical schools.
Student physicians as recently as the 1960s, entered medical training after 90 hours or 3 years of college work, 4 years for MD DO, worked 2 years as interns, and 3 years as residents for 12 years of post high school expense, delayed satisfaction, and personal outlay.	By late 1980s, the competition to get a seat required a 4 year diploma, often a masters 1 or 2 years, then 4 years for MD DO, train 4 years as interns, 4 years as residents, or 16 to 18 years of post high school expense, an increase of one third.	Open 200 physician schools, more seats means less "competition" permits entry after 3 years of college, saves a year, increases output by 8%.
veteran's health care system is the largest trainer of physicians, over one fourth of all U.S. trained physicians go thru the V.A. It also negotiates its own prices for supplies.	**Rep. Bonamici Joins Calls For Medicare To Negotiate Lower Prices For Medications.** In its "Healthwatch" blog, The Hill (2/29, Pecquet) reports, "Liberal Democrats appear to have a new ally in their calls for Medicare to **negotiate drug prices.** In her first question at her first budget committee hearing on Tuesday, Rep. Suzanne Bonamici (D-Ore.) asked the Medicare actuary how much the federal government could save if Medicare could use its market clout to negotiate lower	Follow the VA business model and limit the number of drugs. For Part D.

	drug prices, such as the Department of Veterans Affairs does." The drug industry, however, "points out that...VA is able to achieve its savings only because it limits the number of drugs available to beneficiaries	
veteran's health care system is the largest trainer of physicians, over one fourth of all U.S. trained physicians go thru the V.A. It also negotiates its own prices for supplies.	**Utah Supreme Court Has Revives Lawsuit Alleging Drug Pricing Scheme.** The Salt Lake (UT) Tribune (6/21, Manson) reports, "The Utah Supreme Court has revived a lawsuit that accuses pharmaceutical companies of engaging in a drug pricing scheme that led to overpayments from the state's Medicaid program." About four years ago, "the Attorney General's Office filed suit in 3rd District Court...accusing 17 companies of violations of the Utah False Claims Act and fraudulent misrepresentation." At the time, "in dismissing the case, 3rd District Judge Tyrone Medley ruled that the state had failed to make its claims "with particularity" and to provide critical elements of the alleged scheme."	Negotiated prices would avoid these violations Medicaid should be separately managed and funded from Medicare. .Or, separate out Medicaid from the Centers for Medicare and Medicaid Services.

Accounting and auditing models would prevent fraud.	**CVS Settles Claims Of Improper Medicare Billing.** The Star-Ledger (1/12, Todd) reports, "The US Attorney's Office has agreed to a $969,230 settlement with CVS pharmacies in New Jersey and New York to resolve allegations that they billed the federal health care program for prescriptions filled by a pharmacist excluded from participating in the programs." The US alleges "that between September of 2005 and July of 2009, a CVS pharmacy based in New Jersey and two in Albany, NY submitted claims to Medicare and TRICARE for prescription drugs filled by Athanasios Mastrokostas at the stores. ... Neither a release from the US Attorney's Office nor a statement from CVS/Caremark explained why Mastrokostas was excluded from the federal programs." CVS said "it was unaware of the exclusion at the time the company hired Mastrokostas."	Rely on whistleblowers who risk their jobs. This should be plan F in preventing fraud. The whistleblowers may never come forward, may die, may never have the information.
Accounting and auditing models would prevent fraud. This does not seem to be working, as claims dating back over a	**McKesson To Pay $190 Million To Settle Claims Of Overcharging Medicaid.** Bloomberg News (4/27, Voreacos) reports, "The settlement,	Rely on whistleblowers who risk their jobs. This should be plan F in preventing fraud. The

decade are pending. Transparency in pricing was assumed. The patients would watch their expenses because they had a co-pay. But Medicaid dropped that model.	unsealed today in federal court in New Jersey, came in a False Claims Act lawsuit filed by a whistle-blower and joined by the US Justice Department. They claimed McKesson defrauded the Medicaid program by falsely reporting inflated prices of drugs, causing the government to set higher reimbursement rates." The AP (4/27) reports in a story appearing on over 400 news sites, "Federal authorities say wholesale drug distributor McKesson Corp. will pay more than $190 million to settle claims that it led Medicaid to overpay for drugs by reporting inflated prices to a publisher." Officials charged that "McKesson marked up the average drug prices it reported to publisher First DataBank by 25 percent between 2001 and 2005." Because "most state Medicaid programs use First DataBank information to determine what they pay for drugs," those programs "ended up paying too much for a variety of brand-name pharmaceuticals that McKesson sells." McKesson rejected the charges but "said it settled to avoid the costs and uncertainty of litigation." Dow Jones Newswires (4/27, Rubin, Subscription Publication) reports that McKesson continues to say that it believes the allegations are without merit, but in a statement said, "When we weighed our conviction that we did not violate any laws against the inherent uncertainty of litigation, we determined that this settlement was in the best interest of our employees, customers, suppliers and shareholders." Modern Healthcare (4/27, Carlson, Subscription Publication) reports, "In addition to the $190 million McKesson Corp. has agreed to pay to settle federal allegations of prescription-drug price inflation, the company reported in securities filings that it has set aside $173 million to settle similar claims from state attorneys general."	whistleblowers may never come forward, may die, may never have the information. Publish the prices. Let the public know. But no one is watching Medicaid claims, because the government is paying 100%.
Accounting and auditing models would prevent fraud. This does not seem to be working, as claims dating back over a decade are pending. Transparency in pricing was assumed. The patients would watch their expenses because they had a co-pay.	**Health costs exceed housing costs.** **Milliman Medical Index: Family Healthcare Costs To Exceed $20,000 Annually.** The Milwaukee Journal Sentinel (5/16, Boulton) reports on data from the annual Milliman Medical Index that expects healthcare costs for a family of four to reach $20,728 this year, with employers	Bring in competition with more medical school seats.

But Medicaid dropped that model.	picking up $12,144 and employees paying the remaining $8,584. The cost "works out to about $1,727 a month," more than the average monthly mortgage payment of $1,670. The index expects health care costs to rise 6.9% this year. "That is the lowest increase in the 10 years of this study. Yet it is more than triple the current rate of inflation." The Los Angeles Times (5/16, Terhune) "Money & Co." blog reports, "Miami was the most expensive of the 14 cities surveyed, at $24,965, Milliman found, and Phoenix was the cheapest, at $18,365." The Huffington Post (5/16, Young) reports, "Spending on physician services will reach $6,647 and spending on hospital stays will rise to $6,531, making them the two biggest components of a typical family's annual health care expenses, the report says." The federal health law "'has had only a limited effect' on health care costs, the report" says. Forbes (5/16, Nance-Nash) also covers the story	
Charitable church ran hospitals, other insurers were non-profits.	Non profit insurers start paying board members for overseeing the management of the insurers.[65] The "non-profits' begin to look like the usual public company.	Decide if management, which is paid, is to select its director supervisions for non profits, or not.
Co pays and deductibles would provide incentives to patients to monitor their care and expenses. But once co pays were abandoned, no one monitors the charges.	USA Today (2/23, Kennedy) reports, "About 36% of the almost $16 billion recovered by the Justice Department in health care whistle-blower fraud cases has come since 2009, records show, which reflects an increased focus on fighting fraud." The piece continues, "A bipartisan coalition backed strengthening the False Claims Act in 2009, and the Obama administration pushed for more money and tougher fraud-fighting provisions in the 2010 health care law, said Tony West, an assistant attorney general in the Justice Department's civil division. ... Health and Human Services Secretary Kathleen Sebelius said last week that her budget included an additional $300 million to take on health care fraud.	Return to co pays, instead of relying on whistleblowers who risk their jobs, or have to wait until they are fired, and have a grudge.
Co-pay was to discourage unnecessary procedures.	NextCare Settles False Claims Lawsuit For $10 Million. Modern Healthcare (7/3, Carlson, Subscription Publication) reports, "Medical clinic owner NextCare has agreed to pay $10 million and enter a five-year corporate integrity agreement to settle whistle-blower allegations that it billed federal and state healthcare programs for	No one collects the co-pay, so the patients don't complain.

	unneeded allergy and flu-virus testing and inflated expenses for urgent-care services." The settlement resulted from "a False Claims Act lawsuit from former employee Lorin Cohen, who will share in $1.6 million from the settlement for bringing the allegations to light, according to a statement from the Justice Department**."** The Arizona Republic (7/3, Wiles) reports, "The settlement with the federal government and various state attorneys general involves allegations that the privately owned company submitted false claims to entities including Medicare and the Medicaid programs run by Arizona and four other states. ... The claims involved inflated billing and unnecessary tests for allergies, respiratory problems and the H1N1 flu virus, the government said."	
Co-pay would encourage beneficiaries to monitor care, so it was helpful, appropriate, reasonable and necessary, safe and effective. Once co-pay was ignored, or covered by medigap, then beneficiaries no longer monitored the services. Elderly were moved to nursing homes, their family, if any, were unavailable during the day for health care. Nursing home monitoring shifted to Medicaid, with reduced monitoring.	**HHS OIG: Nursing Homes Overbilled Medicare By $1.5 Billion In 2009.** In continuing coverage, CQ (11/14/2012, Adams, Subscription Publication) reports on a new HHS Office of the Inspector General investigation, which found that "almost one-fourth of the claims that skilled nursing facilities filed in 2009 were wrong, leading Medicare to make $1.5 billion in inaccurate payments to the facilities in 2009." Most of the overbilling came because "facilities claimed more than they were entitled to receive," a process known as "upcoding." Other "claims were inaccurate because the services involved should not have been reimbursed at all by Medicare." CQ notes that this report "brings unwanted attention to an industry that Congress is scrutinizing as it looks for ways to save money in Medicare and reduce deficit spending." Modern Healthcare (11/14/2012, Barr, Subscription Publication) reports that stemming from the "problems found with SNF billing," the OIG made six recommendations to CMS in its report: "increase and expand SNF claims reviews; use its fraud prevention system to identify SNFs that are billing for higher paying RUGs; monitor compliance with new therapy assessments; change the current method for determining how much therapy is needed to ensure appropriate payments; improve the accuracy of SNF reporting; and follow up with SNFs that billed in error." According to the article, "CMS concurred with all six recommendations," and has already begun to implement them. The Los Angeles Times (11/14/2012, Terhune) notes that "the	The waste appears to be 6%, but the cost of claw back eats up the recovery. Upcoding is another name for over utilization. The defense to over utilization was supposed to be co-pays, to wit the patient would not want to pay part of a bill for unnecessary service.

	$1.5 billion in improper payments represented nearly 6% of the $26.9 billion paid overall to skilled-nursing facilities in 2009.	
Co-pay would encourage beneficiaries to monitor care, so it was helpful, appropriate, reasonable and necessary, safe and effective. Once co-pay was ignored, or covered by medigap, then beneficiaries no longer monitored the services. Elderly were moved to nursing homes, their family, if any, were unavailable during the day for health care. Nursing home monitoring shifted to Medicaid, with reduced monitoring.	**Patient Rights Quality of Care -Federal Data: 20% Of US Nursing Homes Administer Antipsychotics Inappropriately.** On its front page, in the first part of a two-part story, the Boston Globe (4/30, A1, Lazar, Carroll) reports, "Federal data show that roughly 185,000 nursing home residents in the United States received antipsychotics in 2010 contrary to federal nursing home regulators' recommendations -- often elderly people...who have Alzheimer's or other dementias." The medications, "which are intended to treat severe mental illness such as schizophrenia, can leave people in a stupor." What's more, "the US Food and Drug Administration has issued black-box warnings -- the agency's most serious medication alert -- about potentially fatal side effects when antipsychotics are taken by patients with dementia." A separate Boston Globe (4/30, Carroll) piece explains the methodology used by the Globe in arriving at its conclusions. "The Boston Globe examined data on more than 15,600 nursing homes across the nation for its investigation of antipsychotic drug overuse. The information was supplied by the US Centers for Medicare & Medicaid Services, 19 months after a Freedom of Information Act request was submitted." The first set of data involved "the percentage of long-term residents without a psychosis or related condition who received antipsychotics contrary to federal nursing home regulators' recommendations," while "the characteristics of each home, such as staffing levels, number of patients on Medicaid, and the number reported by staff to have behavioral problems" made up the second set of data. According to the USA Today (4/30, Eversley) "On Deadline" blog, "At more than one in five US nursing homes, anti-psychotic drugs are administered to people who do not have a condition that warrants their use, the Globe reports." However, "members of the nursing-home industry...told the Globe the drugs are sometimes necessary to keep people from hurting themselves and/or others." In fact, "Frank Grosso, vice president of pharmacy services at Genesis Health Care, owner of more than 200 nursing homes, told the news organization that sometimes patients are given lower doses than	Collect a co-pay and inappropriate treatments will grind to a halt.

	someone with a psychosis and the data do not reflect that."	
Co-pay would encourage beneficiaries to monitor care, so it was helpful, appropriate, reasonable and necessary, safe and effective. Once co-pay was ignored, or covered by medigap, then beneficiaries no longer monitored the services. No beneficiary would order products or services they did not need if they paid 20% of the price.	**Medicare Fraud Scheme Involving Power Wheelchairs Detailed.** The Washington Post (8/17/2014, Fahrenthold) columnist David A. Fahrenthold details a Medicare fraud scam involving motorized wheelchairs. Fahrenthold notes that, although "Medicare has spent $8.2 billion to procure power wheelchairs and scooters for 2.7 million people" since 1999, "the federal government does not know how much of that money was actually paid to scammers." He claims that the scam is "a painful and expensive example of why Medicare fraud works so often."[66]	Stop 100% payments. Make providers and suppliers swear to collecting copays. Start the 20%.
Facilities were non-profits, run by churches, religious orders, fraternal organizations, colleges, local governments, etc.	**Investment banking bought up and consolidated the non-profits, who left the business.** **Study Notes Disparity Between For Profit, Nonprofit Nursing Home Charges To Medicare.** The New York Times (1/15, Span) "This New Old Age" blog reported, "Facilities operated for profit are far more likely to classify patients as needing the highest levels of care, and therefore to collect the biggest payments from Medicare, than nonprofits, according to a recent report by the inspector general's office of the Department of Health and Human Services. Tellingly titled 'Questionable Billing by Skilled Nursing Facilities,' the government study looked into how often nursing homes seek reimbursement for the costliest levels of care and found a huge increase in just two years." One expert noted that "nonprofits don't have to pay dividends or protect stock prices; they may be more apt to invest their returns in services and care." The Times noted, "And as a bonus, that choice may help save taxpayers a bundle as well."	Converting all providers to non profits (which isn't going to happen).
In the 1960s, health coverage was employer based, with the Blues dealing direct without brokers.	Insurance brokers and agents now handle the insurance accounts.[67]	The complexity of the law drives consumers to brokers. Simplify.
Medicare Advantage plans provide coverage with a fixed cost of approximately $650 per patient per month.	Some comparisons suggest MA's cost more than the rest of medicare, so the 2010 amendments reduced payments. Instead of decreasing fees, 2011 bonuses restored lost revenues.[68]	Decide whether MA plans are in or out.

No medical devices regulated in 1966, so no recalls.	About 1 percent of medical devices are approved by the FDA. Recalls are few.[69]	Regulate devices like drugs. This has never been done for 99% of the 300,000 devices on the market.

Adverse events go to the FDA Reporting of problems by Medicare patients would be simple..	**FDA: Nearly 16,800 Concerns Reported In A Decade Regarding Hip Implants.** Bloomberg News (6/22, Edney) reports that according to a report from the Food and Drug Administration, "almost 16,800 adverse events associated with metal-on-metal hip implants were reported in the US from 2000-2011." Bloomberg notes that the FDA document found that reports of adverse events regarding the implants "almost quadrupled to 682 in 2008 from the year earlier, and rose again after a unit of Johnson & Johnson (JNJ) began recalling hip devices in 2010."	Recalls are useful.
Beneficiaries, with out of pocket costs called co-pays were to monitor their care, and not pay for fraud or abuse or waste. This model was never implemented. Instead, the auditors are trying computer models.	**GAO Details Medicare Efforts To Cut Fraud And Abuse.** CQ (4/24, Norman, Subscription Publication) reports, "A Government Accountability Office report (pdf) released late Monday afternoon by Senate Democrats documents new ways in which the Medicare program is moving proactively to curtail fraud and abuse, including new screening procedures that categorize providers based on the potential risk that they'll defraud the government." And "by the end of 2012, the Centers for Medicare and Medicaid Services (CMS) also plans to contract with companies approved by the Federal Bureau of Investigation to conduct criminal background checks, including fingerprinting, on providers and suppliers viewed as high-risk	At least try the Medicare business model.
Beneficiaries, with out of pocket costs called co-pays were to monitor their care, and not pay for fraud or abuse or waste. This model was never implemented. Instead, the auditors are	**Penis Pump Company Accused Of Medicare Fraud.** The Washington Times (6/20, Dinan) reports that the HHS inspector general said in a new report that the Kansas-based Pos-T-Vac company "may have paid out as much as $4.2 million in potentially fraudulent Medicare claims for penis	At least try the Medicare business model.. If patients were told what forms to expect or they would not be covered, they would monitor the suppliers, o decline the benefit.

trying computer models	pumps, and the auditors are asking the company to refund the government the money." The "inspector general said it sampled 100 claims...and found improprieties in more than half of payments for what are known as 'male vacuum erection systems.'" The report said, "Pos-T-Vac submitted unsupported claims because it lacked adequate internal controls to ensure that it collected and maintained the required documentation."	
Beneficiaries, with out of pocket costs called co-pays were to monitor their care, and not pay for fraud or abuse or waste. This model was never implemented. Instead, the auditors are trying computer models	**Duplicate ID for patients overpayments.** **Audit Of Utah Medicaid Cases Finds Errors Cost The Program $1M Last Year.** The Deseret (UT) News (6/20, Finley) reports, "An audit of Medicaid cases presented to the Utah Legislature Tuesday found that while Medicaid eligibility is well-managed, errors cost the program $1 million last year, with room for another million in savings if efficiencies are put in place." After "auditors reviewed 245 eligibility cases," they "found that about five percent contained errors." **The Salt Lake (UT) Tribune (6/20, Stewart) reports, "The audit suggests Workforce Services could do a better job at avoiding duplicate ID numbers for clients, which can lead to overpayments." The audit "also recommends that the Utah Department of Health start issuing a single, plastic Medicaid ID card, instead of the multiple monthly paper cards it issues now. Doing so could save taxpayers up to $1.4 million a year**	At least try the Medicare business model.. If patients were told what forms to expect or they would not be covered, they would monitor the suppliers, o decline the benefit.
Elderly, seniors, and disabled Quality of care.	CMS Administrator Dr. Donald Berwick said, "The American healthcare system is not currently performing the way it needs to. It's broken." [70]	
Hospital care would be adequate or comparable to available standards.	AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com] **Sent:** Tuesday, November 16, 2010 7:32 AM **Study: One In Seven Hospitalized Medicare Patients Harmed.** The New York Times (11/16/2011, B3, Wilson) reports, "One of every seven Medicare beneficiaries who is hospitalized is harmed as a result of problems with the	Collect co-pay from benes, so they will each watch their care carefully.

	medical care there, according to a new study from the Office of Inspector General for" HHS, which also "said unexpected adverse events added at least $4.4 billion a year to government health costs and contributed to the deaths of about 180,000 patients a year." In response to the findings, "Dr. Carolyn M. Clancy, director of the federal Agency for Healthcare Research and Quality, said the adverse events were affecting hospital patients at an 'alarming rate' and promised to work to improve it." And, "Dr. Donald M. Berwick, administrator of the Centers for Medicare and Medicaid Services, said it would aggressively pursue recommendations to broaden the definition of adverse events, monitor and prevent them." USA Today (11/16/2011, Rubin) reports, "The study is the first of its kind aimed at understanding 'adverse events' in hospitals -- essentially, any medical care that causes harm to a patient, according to the Department of Health and Human Services' Office of Inspector General." Notably, "patients in the study, a nationally representative sample that focused on 780 Medicare patients discharged from hospitals in October 2008, suffered such problems as bed sores, infections and excessive bleeding from blood-thinning drugs, the report found."	
Medicare use Tracking by providers suppliers would be as simple as looking up their name.	Medicare issues Primary Appellant Identification Number (i.e. Provider Identification Numbers or Codes) and tracks usage with this number. One supplier has about 200 different codes to bill Medicare with, so tracking the usage requires entering and tracking 200 different numbers. Not User friendly.	Consolidate each appellant to one number.
Medicare's reasonable and necessary assumes safe and effective for medical devices.	The FDA reviews safety and effectiveness for one percent of the devices, the other 99% are FDA cleared or grandfathered for marketing without science and review. .	Require the FDA to review the cleared devices, or withdraw Medicare coverage until the devices go back through the PMA process.[71]
Physicians made house calls.	Consolidation by hospital corporations, from non profit to profit, and public to private, has created monopolies for health care services. Or Physicians have stopped making house calls.	AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com] **Sent:** Monday, November 15, 2010 7:38 AM **Health Reform Provision May**

		Increase Number Of Physicians Making House Calls. USA Today /The Wilmington News Journal (11/14, Ratnayake) reported, "There are about 4,000 doctors who make house calls in the United States, a number that is expected to grow if a provision in the health care reform bill is successful. Known as the Independence at Home Act, the provision is intended to encourage more doctors to make house calls by allowing them to share in any savings if they can prove they reduced hospital use, improved quality care and left patients satisfied with their treatment." Notably, the "program will focus on the sickest and oldest patients," and "if doctor-supervised home-visit teams are able to reduce the projected annual medical costs of their at-home patients by at least 5%, those savings would be split between the medical organizations and" CMS, "which would implement the program." The Los Angeles Times /Orlando Sentinel (11/12, Shrieves) reported, "Around the country, health insurers, doctors' practices and hospitals are experimenting with different ways to control the rising costs of Medicare. In St. Petersburg, for example, health insurer Humana operates Humana Cares, a national telephone call center that links nurses and social workers to Medicare Advantage patients with chronic illnesses." The "pilot programs are an attempt to get ahead of health-care overhaul and one of its potentially new setups: Accountable care organizations." (But why make the physician justify this? Use co-pay, the patient will tell the physician to stop coming if it costs and there is no benefit.
Physicians would be paid competitive rates to attract service, and could so plan (staff, equipment, training, office space)	Primary care physicians get a third of specialty care, so physicians are avoiding primary care. If you don't pay, you don't get.	Pay all the same primary and specialty? Not practical. Or open a thousand medical schools so primary care are abundantly available.
Physicians would be paid competitive rates to attract service, and could so plan (staff, equipment, training, office space)	**Physicians can't plan, as rules now call for quarter cuts in fees. CMS Finalizes Physician Payment Rule.** American Medical News (11/15, Silva) reports, "Payments for primary care services and certain surgical procedures will improve under the Centers for Medicare & Medicaid Services final 2011 physician fee schedule issued Nov. 2.	**Set rules for 2 years at least. AHLA Member Services [HealthLawDaily@ahla.custombriefings.com]** Sent: **Wednesday, November 17, 2010 7:36 AM Baucus Pledges To Prevent**

	Patients also will receive new wellness benefits and lower co-pays," but "the rule calls for Medicare physician payments to be slashed by 25% -- 23% on Dec. 1 and 2% on Jan. 1, 2011." CMS Administrator Donald M. Berwick, MD, said, "Broad physician participation for Medicare is essential to ensuring that beneficiaries continue to have access to care, and physician engagement is critical to our efforts to strengthen the quality of care. ... Medicare needs to be a strong, dependable partner with physicians -- and that means the SGR must be fixed." Meanwhile, "in a statement, the American College of Radiology said it was 'very disappointed' that CMS finalized this policy."	**23% Medicare Physician Reimbursement Cut.** CQ Today (11/17, Ethridge) reports, "A top Senate Democrat pledged Tuesday that lawmakers would find a way to avert a 23 percent cut in reimbursement rates to physicians who treat Medicare enrollees, but he declined to offer details." Finance Chairman Max Baucus (D-MT) "said he wanted to block the scheduled cuts, slated to take effect Dec. 1, for as long as possible, but it seemed unlikely that the Senate would be able to muster the support for the 13-month postponement being advocated by physician groups and the White House." Notably, "groups including the American Medical Association, the AARP and the Medicare Rights Center want lawmakers to provide the longest reprieve possible from the cuts, and have been warning that uncertainty could drive physicians from the Medicare program and make it more difficult for beneficiaries to see their physicians."
Physicians would be paid competitive rates to attract service, and could so plan (staff, equipment, training, office space). Medical School seats would expand as the country grows.	**House Committee Moves Forward With Plan To Overhaul SGR.** A handful of beltway publications carry stories Wednesday on a new bill, out of the House Energy and Commerce Committee, which would permanently overhaul the oft-derided Medicare physician payment formula, known as the Sustainable Growth Rate or SGR. As the Washington Times (5/29/2013, Howell) reports, House Republicans on Tuesday released a draft bill which would "repeal the ill-defined way physicians are paid under Medicare in a bid to finally end the annual Capitol Hill scramble to find extra cash to pay the doctors." The House Energy and Commerce Committee "said it would scrap the sustainable growth rate formula, which was supposed to limit payments to doctors who treat Medicare patients but which lawmakers have deemed too draconian and have delayed each year for more than a decade." The Hill (5/29/2013, Baker) "Healthwatch" blog notes that the proposal "does not address the most controversial aspect of a permanent 'doc fix' — how to pay for it."	**Medical school seats have not expanded. Technology has made physicians more efficient, hiding the shortage of professionally trained and educated care givers.**

	CQ (5/29/2013, Ethridge, Subscription Publication) reports that "lawmakers are asking provider groups and other stakeholders for feedback, and the measure contains several questions and blank spaces." The Energy and Commerce Health Subcommittee plans to hold a hearing on the draft legislation June 5. Modern Healthcare (5/29/2013, Zigmond, Subscription Publication) reports that Representative Michael Burgess (R-TX), vice chairman of the Health Subcommittee, seems "excited about the draft legislation." He said in a phone interview that the legislation "strikes a balance for older physicians who have only known a traditional fee-for-service model and newer doctors who are starting their careers when models such as accountable care organizations and bundled payments are taking off."	
Prior authorization gave time for second opinions and would reduce overutilization.	Can't get prior authorization enforced. See the curb on medical imaging.[72]	
Self interest assumes people would try to stay well, rather than be sick.	**Few Medicare Patients Take Advantage Of Annual Wellness Visit.** The Sun Sentinel (FL) (4/3, Lade) reports, "Medicare, long criticized for kicking in only once people got sick, last year started paying primary care physicians to talk to their senior citizen patients once a year about staying healthy." But "an analysis released recently by the Centers for Medicare and Medicaid Services showed only 8 percent of the 2.4 million elder and disabled Floridians on Medicare Part B, which pays for doctor's visits, had the new wellness screening in 2011." Overall, "2.3 million of traditional Medicare's 35 million participants had their wellness visit last year, or about 6 percent	. **Some complained that if Medicare wouldn't pay, the people wouldn't go. Maybe they don't want to.**

Health Care by the Numbers

Adverse Drug Reactions, beginning in 1955 became a concern, with studies evolving to 1963.[73]	2 million Adverse Drug Reactions injuries annually (2001).[74]	Medicare either tracks or stops coverage.
Adverse Risk selection, the sickest will take insurance, the healthy will not, was the purpose of broad based coverage.	The sick wait for free coverage. Pre existing conditions are not the reason they don't want insurance, it is the cost of the insurance.[75]	Open 200 medical schools, so physicians can treat patients and not insurance policies.
Co-pays are to control excessive services or spending. If the patient doesn't want to pay the co-pay, then the patients objects and stops.	**New York Institutions For Mentally Disabled Billing CMS At Rate Of $2 Million Per Patient Annually.** The Wall Street Journal (4/7/2011, A19, Gershman,) reports that in New York state, institutions for the mentally disabled are billing the Center for Medicare & Medicaid Services at a rate of about $2 million per patient annually, a rate more than triple the amount it actually costs to house these particular Medicaid patients. What's more, by accepting matching funds from the federal government, the state is able to garner about $1 billion extra per annum, which it uses as a subsidy for other budget items. An unnamed spokesperson from the CMS told the Journal that CMS is now holding discussions with New York state officials about how the state sets reimbursements. The Journal quotes Sen. Chuck Grassley (R-IA) as saying the situation in New York state "requires closer scrutiny.[76]	Co-pay would stop this. The rate figures about $5 thousand per day.
Continuing Medical Education for practicing physicians was local. Figures for costs, if any, are hard to obtain.	$2 Billion a year (2008) is spent on Continuing Medical Education.[77]	Delete CME requirements. Make optional or voluntary.
Continuing Medical Education for practicing physicians was local. Figures for costs, if any, are hard to obtain	Half ($1 Billion) a year (2008) is funded by manufacturers of drugs, biologics, and medical devices.	Delete CME requirements.
Cost containment, overutilization, fraud prevention, waste limitation, medical advancement and research have never been tried, certainly not implemented. These include co-pay, free market pricing,	**Senate Plans Vote On Ryan Medicare Plan.** The Hill (5/16, Baker, Viebeck) "Healthwatch" blog says the Senate's scheduled vote Wednesday on Rep. Ryan's budget plan gives Democrats another opportunity to place Republicans on the record when	Implement the medicare business plan.

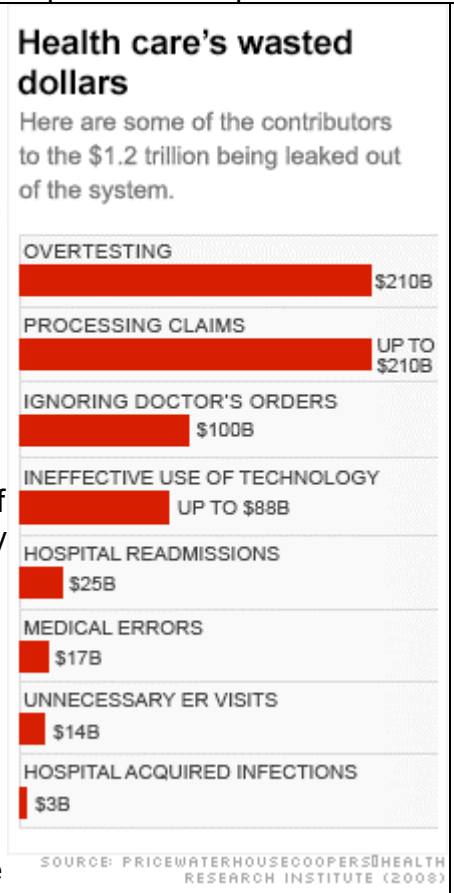
free market education and medical school seats.	it comes to the controversial proposal to partially privatize Medicare. Democrats "charge that the plan would 'end Medicare as we know it,' but the GOP is largely united behind the proposal, saying it's the only serious way to avoid Medicare's looming insolvency." Meanwhile, on Tuesday, Louisiana Gov. Bobby Jindal unveiled a healthcare blueprint for the Republican Governors Association, a plan that mostly mirrored national GOP priorities, with the exception of this line: "Those needing help to afford their care should get that help via refundable tax credits to subsidize the cost of private coverage rather than building another government-run health plan."	
Cost containment, overutilization, fraud prevention, waste limitation, medical advancement and research have never been tried, certainly not implemented. These include co-pay, free market pricing, free market education and medical school seats.	**House Democratic Lawmakers' "NEWT Bill" Would Close Medicare Tax Loophole.** The Hill (1/24, Viebeck) "Healthwatch" blog reports, Democratic lawmakers in the House "are bringing back a bill to prevent some workers from avoiding Medicare taxes." On Tuesday, Rep. Charles Rangel (D-NY), alongside Reps. Jim McDermott (D-WA), Chris Van Hollen (D-MD) and Earl Blumenauer (D-OR), reintroduced the Narrowing Exceptions for Withholding Taxes (NEWT) Act, which "was first introduced by former Rep. Pete Stark (D-Calif.), who accused Newt Gingrich of exploiting the Medicare loophole to save $69,000 in 2010." The NEWT bill "requires S-corporation shareholders to label all income from their business as earnings from self-employment, ensuring that money is subject to the 2.9 percent Medicare tax." Explained Rep. Rangel, "Some self-employed individuals have organized their businesses in such a way that their earnings, what you and I would call 'wages,' can technically be called 'profits' and therefore are not subject to Medicare tax."	The intention of the S Corporation is to flow through all revenues and expenses to be reported on the owner's 1040 return. This proposal to report S corporation income as wages changes Medicare as we know it.

Cost containment, overutilization, fraud prevention, waste limitation, medical advancement and research have never been tried, certainly not implemented. These include co-pay, free market pricing, free market education and medical school seats.	**Mostashari Offers Five Ways Government Can Promote New Technology In Medicine.** The Boston Globe (5/16, Conaboy) reports on an interview with Dr. Farzad Mostashari, National Coordinator for Health Information Technology, who "was in Boston yesterday to speak at the Health 2.0 conference about his vision for what the government can do today to pave the way for new technologies in health care." Mostashari spoke of "five things government can do to foster innovation." They are "investing in academic research and development;" offering "a space for identifying new ideas;" collection and provision of data; "smart regulation" that does not offer "an advantage to the biggest players;" and promoting competition. He "also talked about the successes and challenges the government has faced in creating a national system of electronic health records in which hospitals and doctors can easily share information with each other." He argues that by working for a standard, government can ensure ease of communication.	
Disability was a temporary condition, which can be reviewed every two years. The reviews, at the state level, are not happening. Disability claimants are on Medicare 2 years after applying.	**"17-Fold" Increase In Americans Claiming Disability Examined.** ABC World News (4/23, story 9, 2:00, Sawyer) reported on "a wave of disability scams sweeping the nation, costing taxpayers billions." According to ABC, "Eight and a half million Americans are on disability right now, a 17-fold increase over the last four decades. ... Critics say it's because the government now allows payment for ailments such as persistent anxiety and chronic fatigue, but fraud alone cost taxpayers more than $10 billion a year."	Put disability in a separate program, don't call it Medicare.
Disabled were not planned for Medicare which was for Seniors, 65 and over. Like Social Security, the old people held onto	**Little Conversation On How To Control Disability Insurance Payments.** A front-page Business section story in the New York	Put disability health care in a separate program, don't call it Medicare

jobs to provide for old age, as pensions were untrustworthy. They could move out of their jobs, retire, if they had some further support with Social Security. But the cost of health care hung over their heads like an avalanche waiting to happen, so Medicare came along to correct that.	Times (4/25, B1, Porter, Subscription Publication) reports that while disability insurance payments "are growing out of control," fixing the program "inspires hardly any discussion." Mark Duggan, an economist at the Wharton School of the University of Pennsylvania, remarked, "The health of nonelderly Americans is improving consistently, and we have more technology to help people at work. Yet every year the fraction of people on this program is growing." The Times notes that growth "is not simply about demography. Rather, it is driven by two other factors: a job market that has become tough to navigate for workers with low skills, especially men, whose jobs have gone abroad or been taken by machines; and a basic flaw in the disability program that discourages people from ever working again."	
Drug Ads were presented to Physicians, not to patients.	$11.4 Billion (1996) in Direct to Consumer drug ads, increasing to $29.9 Billion in 2005.[78]	Changed the monopoly that physicians had on drug knowledge and use.
Drugs have always been big business.	$275 Billion in annual revenues of regulated drugs for 2008.[79]	Don't cover off label use or over the counter.
Drugs have always been big business.	$550 Billion pharmaceutical sales.[80]	Don't cover off label use or over the counter
Durable medical equipment (devices) were to be approved like drugs, perhaps a retrospective review process.	3% of devices are approved for safety and efficacy which takes 1200 hours of FDA review. 97% are cleared as similar to products sold before 1976, which takes 20-30 hours of FDA review.[81]	Require approval.
Employer health coverage. 74% of employers with over 200 employees, had full health coverage in 1980[82]	18% of employers with over 200 employees, had full health coverage in by 2005. Bottom fell out.	Open 200 new medical schools.
Employer health coverage. 2/3d of retirees for employers with over 200 employee had full health coverage in 1988[83]	1/3d of retirees for employers with over 200 employee had full health coverage in 1988. Dropped by half.	Open more medical schools.
Food and Drug Act of 1906 prohibited interstate commerce of mislabeled and adulterated drugs and food.	3 million incorrect or ineffective drug prescriptions annually.[84]	Charge the hospital / care cost to the provider/supplier.
Generics are cheaper.	60% of prescriptions are generic drugs.	

Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided **More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.**	Down the drain: $1.2 trillion. That's half of the $2.2 trillion the United States spends on health care each year, according to the most recent data from accounting firm PricewaterhouseCoopers' Health Research Institute. What counts as waste? The report identified 16 different areas in which health care dollars are squandered. But in talking to doctors, nurses, hospital groups and patient advocacy groups, six areas totaling nearly $500 billion stood out as issues to be dealt with in the health care reform debate. **Too Many Tests** Doctors ordering tests or procedures not based on need but concern over liability or increasing their income is the biggest waste of health care dollars, costing the system at least $210 billion a year, according to the report. The problem is called "defensive medicine." "But any money that is spent on a patient that doesn't improve the outcome is a waste," said Garson. Some conservatives have suggested that capping malpractice awards would help solve the problem. President Obama doesn't agree; instead, his reform proposal encourages doctors to practice "evidence-based" guidelines as a way to scale back on unnecessary test	Co-pays will stop too many tests, if the patient wants to pay the co-pay
Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided by **More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.**	**You Forgot to Wash Your Hands!** Those ubiquitous dispensers of hand sanitizer are in hospitals for a reason: PricewaterhouseCoopers estimates that about $3 billion is wasted every year as a result of infections acquired during hospital stays. "The general belief is that hospitals are getting much better in managing this than they have in the past," said Richard Clarke, CEO of Healthcare Financial Management Association, whose members include hospitals and managed care organizations. Something as simple as hand-washing often can reduce the problem. "Sometimes doctors are the	Since the time of Semmilweis, washing your hands has been known to reduce infection.

	most difficult people to convince to do this," said Clarke. "The challenge here is that patients sometimes come in with infections which then spread in the hospital." The stimulus bill signed by Obama earlier this year includes $50 million for reducing health care-associated infections. Other areas of waste identified in the PricewaterhouseCoopers report included up to $493 billion related to risky behavior such as smoking, obesity and alcohol abuse, $21 billion in staffing turnover, $4 billion in prescriptions written on paper, and $1 billion in the over-prescribing of antibiotics. Copyrighted, CNNMoney. All Rights Reserved.	
Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided by **More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.**	**Those Annoying Claim Forms** Inefficient claims processing is the second-biggest area of wasteful expenditure, costing as much as $210 billion annually, the PricewaterhouseCoopers report said. "We spend a lot of time and money trying to get paid by insurers," said Dr. Terry McGenney, a Kansas City, Mo.-based family physician. "Every insurance company has its own forms," McGenney said. "Some practices spend 40% of their revenue filling out paperwork that has nothing to do with patient care. So much of this could be automated." Dr. Jason Dees, a family doctor in a private practice based in New Albany, Miss., said his office often resubmits claims that have been "magically denied." "That adds to our administrative fees, extends the payment cycle and hurts our cash flow," he said. Dees also spends a lot of time getting "pre-	Standardized health care forms would make sense. Why not have the state handle this.

	certification" from insurers to approve higher-priced procedures such as MRIs. "We're already operating on paper-thin margins and this takes times away from our patients," he said. Susan Pisano, spokeswoman for America's Health Insurance Plans, said "hundreds of billions" of dollars can be saved by standardizing procedures and using technology -- something the White House has mentioned as a key to health care reform.  "For that to happen, we need the technology," she said. "Doctors and hospitals must adopt the technology, and we have to develop rules for exchanging of information between doctors, hospitals and health plans." Pisano said the industry is launching a pilot program later this year that will allow physicians to communicate with all health plans using a standardized process.	
Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided by CNN	**Using the ER as a Clinic** More insured and uninsured consumers are getting their primary care in emergency rooms, wasting $14 billion every year in health care spending. "This is an inappropriate use of the ER," said Dee Swanson, president of the	The clinic which operates a 40 hour week is only open one fourth of the week's 164 hours. Hence the ER, which is 24/7. If there were more physicians, willing to make house calls, ER time would be

More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.	American Academy of Nurse Practitioners. "You don't go to the ER for strep throat." Since emergency rooms are legally obligated to treat all patients, Swanson said providers ultimately find ways to pass on the cost for treating the uninsured to other patients, such as to those who pay out-of-pocket for their medical care. Dees also took issue with consumers who don't get primary care for their diabetes or blood pressure on a timely basis, hence finding themselves in the ER. "Going to the doctor for strep throat would cost $65-$70. In the ER, it's $600 to $800," he said. The $787 billion stimulus bill signed passed by President Obama earlier this year includes allocates $1 billion for a wellness and prevention fund, including $300 million for immunizations and $650 million for prevention programs to combat the rapid growth in chronic diseases such as obesity and diabetes	reduced. Shortage of health care is this solution.
Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided by CNN. **More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.**	**Medical "Oops"** Medical errors are costing the industry $17 billion a year in wasted expenses, something that makes patient advocacy groups irate. "Do we have a good health IT system in place to prevent this?" asked Kim Bailey, senior health policy analyst with consumer advocacy group Families USA. Bailey suggested that processes such as computerized order entry for drugs and use of electronic health records (EHR) could help ensure that patients get the correct dosage of medications in hospitals. The stimulus bill calls for the government to take a leading role in developing standards by 2010 to facilitate the adoption of health information exchanges across the system, including patient electronic health records by 2014. Obama has repeatedly said that the use of technology in the health sector will help boost savings, enhance the coordination of care and reduce medical errors and	The patient's co-pay is the first time someone with skin in the game looks at the bill. If there are errors patients won't pay and will report. Then the mistake is on the hospital or practitioner.

	unnecessary procedures.	
Health Care's Six Money-Wasting Problems by Parija B. Kavilanz Monday, August 10, 2009provided by CNN. **More than $1.2 trillion spent on health care each year is a waste of money. Members of the medical community identify the leading causes.**	**Going Back to the Hospital** Bailey suggested that processes such as computerized order entry for drugs and use of electronic health records (EHR) could help ensure that patients get the correct dosage of medications in hospitals. Discharging patients too soon is a "huge waste of money," said Swanson "This happens a lot with elderly patients who are discharged prematurely because of insurance, bed unavailability or ageism," she said. Many times, patients also don't follow instructions for care after discharge. "So complications arise and they are readmitted in a week," Swanson said. PricewaterhouseCoopers estimates the cost of preventable hospital readmissions at $25 billion annually.. Among the reform plans, one proposal being considered is for Medicare to potentially penalize hospitals who readmit patients within 30 days of discharge.	So the diagnosis was wrong, and the patient returned to the hospital. That happens. If patients don't follow instructions, make them co-pay, they will think twice about running up more co-pay. Co-pay reduces waste.
Hospital business models changed from non profit to for profit, relying on bed occupancy.	**Moody's Report Finds Hospitals Would Suffer From Overturning ACA.** The Washington Post (4/6, Kliff) reports in its "Ezra Klein Wonkblog" blog, "Earlier Thursday, Moody's put out a report looking at how for-profit hospitals would fare should the Supreme Court overturn the health reform law. The short answer: Their credit ratings would get slammed." That's because "if you take away the mandate, you don't get the coverage expansion expected under the legislation," according to "Dean Diaz, a vice president at Moody's who focuses on for-profit hospitals and wrote the report." The report also notes that hospitals "have already made significant investments preparing for" the ACA's	Just what is the business model for hospitals? Use certificate of need as a barrier to entry for competition, and then control revenues or increase revenues as required.

	"implementation -- and are hoping the new law would salvage their ailing business model." At the same time, the ACA also includes "dialing back Medicare reimbursements for hospitals that can't reach certain benchmarks for productivity." Diaz concluded that the savings to hospitals in reducing uncompensated care would make up for Medicare cuts. Health Leaders Media (4/6, Tocknell) also covers the story.	
Hospitals were run by charities. They did not report public company quarterly earnings.	$1 to $3 million of billed charges can be incurred in 30-60 days of hospital care.[85]	Open 200 new medical schools.
Keyboards on personal computers, having replaced typewriters, are ubiquitous in education, business, and government – i.e. on every desk and in every home for Americans between the ages of 6 and 76.	Carpal tunnel syndrome has exploded so that, since about 1994, America has 500,000 carpal tunnel release wrist surgeries per year, the number one hand surgery.	Test keyboards and switch to muscle and finger friendly arrangements.
Medicare (original), devices were not regulated. 10 Years later in 1976, devices were regulated, and all 300,000 were grandfathered into marketing and hence sale and coverage by Medicare. The fiction was that if they were unsafe, the market would report it to the FDA, and the fiction was the FDA would eventually review all the devices, which never happened.	**House Sends Compromise FDA Bill To The Senate.** The AP (6/21/2012) reports the House "passed a major bill affecting the Food and Drug Administration that will increase inspections of drug manufacturing facilities overseas, while also funding review of new drugs at home." The bill gives the FDA "more flexibility to inspect sites in" other countries and "renews an agreement under which drug companies pay the FDA to review new products." Additionally, the agency will begin collecting "fees from generic drugmakers to speed up approvals of their therapies." The AP adds, "Other sections of the bill increase fines for drug counterfeiting and require drugmakers to notify the government earlier of potential drug shortages." CQ (6/21, Khatami, Subscription Publication) reports the bill also imposes on the FDA "a 270-day time limit...to respond to petitions related to generic drug approval." However, the bill "does not contain language from the Senate bill that would have earned	Medical devices were grandfathered in 1976, some 36 years ago. If they are safe, but not effective, they can be marketed.

	savings by prohibiting brand-name companies with a Risk Evaluation and Mitigation Strategy from denying samples of their drugs to generic companies." Politico (6/21, Norman) reports that while the bill "would give the FDA greater flexibility to reclassify problematic medical devices into a category that would require greater regulatory scrutiny," it does "not address what many patient advocates call a loophole -- a provision of current law that allows some medical devices to be approved for market based on their similarity to other devices, even if those devices have been recalled for safety reasons." Politico adds, "Both chambers have worked with remarkable speed and even bipartisanship on this bill, with a strong guiding hand from the pharmaceutical and medical device industries." The "Floor Action Blog" of The Hill (6/21, Kasperowicz) reports the bill was "easily approved" by the House. The Senate, "is expected to quickly approve" the compromise bill "and send it to the White House for President Obama's signature." Bloomberg News (6/21, Homan) reports, "The bill's supporters were trying to avoid controversial provisions so that President Barack Obama could sign it before Sept. 30, when user fees are scheduled to expire, and preferably before the Supreme Court issues its ruling this month on the 2010 health-care overhaul." Bloomberg adds that "the removal of a proposal requiring drug companies to put traceable identification numbers on all packaging, also known as track-and-trace, may be considered later in the year as separate legislation," but "its absence in today's compromise bill makes its prospects for approval doubtful in the near term." The Wall Street Journal (6/21, Burton, Subscription Publication) also covers this story.	
Medicare assumed a balance of physicians	**Carney, Sebelius Defend Medicare Bonus**	Take this $8 billion and open 80 new

to patients. But with no new medical schools, the doctor patient ratio has been adversely affected, i.e. more patients per physician. So in came the HMOs, who can lobby for bonuses..	**Demonstration Against GAO Report.** ABC News /OTUS News (4/24/2012, Tapper) reports on its website, "The White House Monday downplayed a Government Accountability Office report calling into question the effectiveness of bonuses distributed in a $8.3 billion demonstration program for Medicare Advantage." While "the GAO recommended that Health and Human Services Secretary Kathleen Sebelius cancel this bonus payment system ... White House press secretary Jay Carney immediately changed the subject to the $200 billion in projected savings from eliminating improper payments under the health care law," saying that "it was important to put the $8.3 billion 'in context ...And in fact we're phasing out over $200 billion in overpayments to Medicare Advantage plans on schedule.'" Sen. Orrin Hatch (R-UT) said that the bonus payment project "raises serious questions about the Obama Administration's use of taxpayer dollars for political purposes," adding that it "raises serious questions about whether the purpose of this demonstration was to mask the health spending law's cuts to seniors' Medicare benefits for political purposes." The Washington Times (4/24, Cunningham) reports that the GAO report found "that the administration is wasting billions on extra bonuses for health plans and should cancel them right away, fueling Republican complaints that President Obama is trying to postpone his health care law's unpopular Medicare cuts until after the election," and that "the bonuses will cost...almost three times what was intended." The story cites Sen. Hatch saying, "This is simply unacceptable." It also quotes Carney saying, "This demonstration project is simply a way to, we believe, ensure that these programs are as cost-efficient as possible." The Hill (4/24, Viebeck) reports in its	medical schools, to train 8,000 new physicians a year (100 students per school per class. In the 5th year the 8000 graduates will be pursuing post graduate specialties or requirements. .

	"Healthwatch" blog that GAO found the program "is an $8 billion waste of money," and "vindicated Republicans who have called the administration-backed initiative providing bonuses to certain insurers an extravagant political ploy." CQ (4/24, Norman, Subscription Publication) reports that the GAO said that the program "should be canceled...in a highly critical report (pdf)." The program "run by the Centers for Medicare and Medicaid Services (CMS) costs so much that it offsets much of the savings from private health plans that were included in the health care law." The program "already has drawn strong doubts from members of the independent Medicare Payment Advisory Commission as well as congressional Republicans." In response, "CMS officials said they would not cancel the demonstration project for Medicare Advantage plans and expressed disagreement with GAO's findings." Jim R. Esquea, assistant secretary for legislation at HHS, said, "CMS believes the demonstration supports our national strategy to improve the delivery of health care services, patient outcomes and population health."	
Medicare didn't understand motivation, such as free samples and how they redirect human activity. So when commercialization hit (replacing non profit hospitals), the costs increased.	**New York City Health Department Encourages Hospitals To Stop Giving Free Formula.** The New York Times (5/10, A26, Hartocollis, Subscription Publication) reports, "The New York City health department began a campaign on Wednesday to encourage hospitals to stop handing out...free formula, as a way, officials said, of encouraging more mothers to breast-feed." New York City Health Commissioner Dr. Thomas Farley "said that 90 percent of New York City mothers start off breast-feeding, but that by the time their babies are two months old, only 31 percent are still doing so exclusively." The Times adds, "The city's Health and Hospitals Corporation, which runs public hospitals,	The state can't stop free samples. But it shows how quickly and how fast motivation changes. The extra cost of formula is being paid by Medicaid, not by the parent. If NYC wants to encourage breast feeding, don't pay for formula at all.

	said that after it stopped giving out free formula and began extensive counseling of new mothers on breast-feeding, 35 percent of mothers were exclusively breast-feeding at eight weeks, up from 29 percent before the change."	
Medicare's coding and coverage influenced or set national standards for all other health insurance programs. **Control or base line** numbers.	**Reality Check**.	Proposal.
Million dollar hospitalization or health care claims were rare.	$1 million claims have tripled between 2004 and 2007, and increased ten fold since 2000.[86]	Open 200 new medical schools.
National institute of health has a library of 2.1 million studies and clinical trial, including co-morbidity research when a patient has two or more diseases at the same time.	As of about 2001, not a single study researched the co-morbidity between breast cancer and carpal tunnel syndrome, arthritis or burns, resulting in loss of tactile sensation of finger tips.	Tell the BSE practitioners who have carpal tunnel, not to rely on their finger tips.
No category for human genome drugs.	Sequence of human genome listed in 2003. $3.65 Billion in sales of Pharmacogenomic therapies.[87]	Don't cover off label use or over the counter
No statistics on costs for injury or deaths due to adverse drug reactions.	$180 Billion annual cost due to drug related morbidity and mortality.[88]	Charge the hospital / care cost to the provider/supplier.
No statistics on deaths due to adverse drug reactions.	100,000 deaths annually due to use of "properly" prescribed drugs.[89]	Medicare either tracks or stops coverage.
Nosocomial infection House calls by Doctors were available in the 1960s. House calls by physicians pretty much ended when Medicare made hospitals many times more profitable. When everyone comes to the hospital, all their germs, diseases, infections come with them. Disease is easier to spread at the hospital- no quarantines. '' A nosocomial infection is contracted because of an infection or toxin that exists in a certain location, such as a hospital. People now use nosocomial infections interchangeably with the terms health-	**CMS Unveils Data On Hospital-Acquired Conditions. CQ HealthBeat (4/7/2011, Reichard, n) reports,** "Federal officials announced Wednesday the release of data allowing consumers to learn how often patients in local hospitals acquire infections, develop bed sores or are harmed by gas or air bubbles entering blood vessels." Notably, information "on these and other 'hospital-acquired conditions' will guide consumers in picking hospitals and prod facilities themselves to make improvements, officials said." CMS Administrator Donald M. Berwick stated, "Any potentially preventable complication of care is unacceptable." He added that the agency is "working	Double or triple the number of physicians, so they can make house calls.

care associated infections (HAIs) and hospital-acquired infections.''	together with the hospital and consumer community to bring hospital acquired conditions into the forefront," and prevent patients from being harmed. The Hill (4/7, Millman) reports in its "Healthwatch" blog, "Medicare beneficiaries for the first time will have access to data about hospital-acquired condition (HAC) rates." For more than two years, CMS has "banned reimbursements for care resulting from HACs, and the healthcare reform law enacted a year ago requires the same policy to be extended to state Medicaid programs." The St. Louis Post-Dispatch (4/7, Bernhard) also covers the story	
Off label use of drugs was optional or experimental.	73% of off label drug use has little or no scientific support.[90]	Don't cover off label use. Consider it experimental
Off label use of drugs was optional or experimental. Remember Thalidomide?[91]	21% of all prescriptions are for off label drug use.[92] Consequently, clinical trials are skipped. Get it approved for one thing, then prescribe for all.	Don't cover off label use. Consider it experimental.
Off label use of drugs was optional or experimental. Sometime it became covered.	**Settlement On Off-Label Marketing Of Risperidone Said To Be Near.** The Wall Street Journal (6/21, Rockoff, Lublin, Subscription Publication) reports people familiar with the matter say the Justice Department and Johnson & Johnson are near a settlement following the investigation into the off-label marketing of the antipsychotic Risperdal (risperidone). A payment of $1.5 to $1.7 billion is being discussed as a settlement to the lawsuits, state investigations, and other probes; the company would avoid a felony charge, which could keep it from selling medicines to the government. On uncertainty is if the settlement is large enough to convince the state attorneys general to join the settlement.	Return off label to optional (not covered) or experimental.
Over the counter drugs was still pending Study of safety and efficacy in 1972.[93]	8,000 over the counter drugs are FDA regulated as of 2008.[94]	Use the prescription drug retrospective review for the model.
Parental drugs were little used.	10% annual increase with $132 Billion in sales by 2012	Find an alternative.

	for parenteral drugs.[95]	
Pre 2003 there was no category for human genome drugs.	10% of drug labels (2008) have pharmacogenonic information.[96]	Another category to anticipate huge growth in spending.
Pre existing conditions are a fear of health insurers. So how many are there? The GAO estimates a 400% range, which isn't very tight.	**GAO Finds Between 36 And 112 Million US Adults Have Pre-Existing Conditions.** The Hill (4/27, Baker) reports that a new report from the Government Accountability Office notes that "somewhere between 36 million and 112 million adults have pre-existing conditions." As the article explains, "President Obama's healthcare law requires insurance companies to cover people with pre-existing conditions," which marked a change from when insurance companies would be able to deny coverage to those with pre-existing conditions or offer plans not covering those conditions. According to the GAO, "hypertension, mental health disorders and diabetes are the most common ailments that could lead insurers to deny coverage." Modern Healthcare (4/27, Zigmond, Subscription Publication) notes that the number amounts to "between 20% and 66% of the US adult population."	Life insurers have dealt with pre existing conditions for centuries. If the GAO wants better statistics, ask the life insurance industry. Before the life insurers underwrite the policies, they have to get their hands around the health of the insured, pre-existing conditions, and which are mortal and which are not. The life insurance is true insurance. Health insurance is pre paid medical care, not really insurance at all as we know it.
Regular breast self examination is encouraged for the one in eight women over the age of 40 who will be so diagnosed, as early detection, means early treatment, which means much higher cure or remission.	BSE assumes normal tactile sensation in finger tips so as to detect small lumps, or foreign masses.	Normal tactile sensation is missing for patients with carpal tunnel syndrome, arthritis or burns on their fingers and hands.
Safety and efficacy for prescription drugs was still pending in 1966.[97] The review took until 1984. 2,225 products were effective.	3,000 prescription drugs are FDA regulated as of 2008.[98]	Use as a model for approving medical devices. Go back and review, like they did for drugs.

[1] "...growth rate from 7.2 percent ..."
http://www.acr.org/Hidden/Economics/FeaturedCategories/WhatsNew/NoImagingCutsinPresidents2009Budget.aspx
Rate Of Increase In Healthcare Spending Slows.

USA Today (3/4,/2013 Cauchon) reports, "Health care spending last year rose at one of the lowest rates in a half-century, partly the result of cost-saving measures put in place by the 2009 health care law, a USA TODAY analysis finds." USA Today adds, "Health care spending hit a record $2.67 trillion last year, but its share of the overall economy shrank, from 17.12% of gross domestic product in 2011 to 17.04%, because other parts of the economy grew faster, an analysis of Bureau of Economic Analysis data found." USA Today says that total healthcare spending "still rose 1.7 percentage points faster than inflation in 2012 because of an increased use of medical services, such as hospitals, home health care and drugs. However, even this extra demand for care was modest compared with past years, especially for an aging population."

[2] Medicare is 14%, Medicaid and SCHIP is 7%, together they are 21%

[3] $3 Trillion for FY 2009.
http://www.kff.org/medicare/upload/7750.pdf

[4] http://www.hhs.gov/budget/docbudget.htm#brief

[5]

http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3311&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=350
Friday, October 17, 2008 - CMS Office of Public Affairs 202-690-6145 **MEDICAID SPENDING PROJECTED TO RISE MUCH FASTER THAN THE ECONOMY** CUMULATIVE SPENDING ON MEDICAID BENEFITS PROJECTED TO REACH $4.9 TRILLION OVER 10 YEARS Under current law, spending on Medicaid is expected to substantially outpace the rate of growth in the U.S. economy over the next decade, according to a new annual report released today by the Centers for Medicare & Medicaid Services (CMS). The report projects that Medicaid benefits spending will increase 7.3 percent from 2007 to 2008, reaching $339 billion and will grow at an annual average rate of 7.9 percent over the next 10 years, reaching $674 billion by 2017. That compares to a projected rate of growth of 4.8 percent in the general economy. At this rate, Medicaid growth is projected to slightly exceed growth in overall health care expenditures, which is projected by CMS actuaries and economists to increase by 6.7 percent per year over the next 10 years, or over twice the rate of general inflation

[6] http://www.kff.org/medicare/upload/7750.pdf

[7] http://www.acr.org/Hidden/Economics/FeaturedCategories/WhatsNew/NoImagingCutsinPresidents2009Budget.aspx
"…the program's 75-year unfunded liability of $34 trillion …"

[8]

http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3311&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=350

- Average Medicaid enrollment is projected to increase 1.8 percent to 50 million people in 2008.
- During the next 10 years, average enrollment is projected to increase at an average annual rate of 1.2 percent and to reach 55.1 million by 2017.

- The estimated average cost of a person covered by Medicaid in 2007 is $6,120; however, per-enrollee spending for non-disabled children ($2,435) and adults ($3,586) was much lower than that for aged ($14,058) and disabled beneficiaries ($14,858), reflecting the differing health status of these groups.
- Medicaid represented 14.8 percent of all health care spending in the United States in 2006.
- Medicaid is projected to grow as a share of the federal budget from 7.0 percent in 2007 to 8.4 percent by 2013.
- Friday, October 17, 2008 CMS Office of Public Affairs

[9] Figure cite by United States Senate Committe on Finance, July 10, 2008, letter to American Psychiatric Associtation, included in FDLI Advetising and Promotion Conference September 2008, Washington D.C. Instead of 94 million , apparently due to dual eligibility, 7 -14 million are counted more than once.

[10] http://assets.opencrs.com/rpts/RL34359_20080206.pdf

Medicare Budget Issues.

[11] Congress had 25 years of experience with the health insurance plans from the 40's and World War Two's wage controls. These models are used today, see the following. AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com]

Sent: Wednesday, November 17, 2010 7:36 AM

HHS Hopes To Streamline Exchanges, Avoid Problems.

Politico (11/17, Haberkorn) reports, "As the federal government and states start to put together the building blocks of the health care overhaul's insurance exchanges -- Orbitz- or Expedia-like Web programs with which to buy insurance -- they're trying to avoid the hiccups experienced in the only two states with similar exchanges already in place today." Joel Ario, HHS' director of the Office of Health Insurance Exchanges, said, "Putting up these state-based exchanges is a challenge," and "it's going to take a partnership with the states and a partnership with the insurance industry." Notably, "Ario's goal with the exchanges...is to have them work as well for the individual and small-group markets -- people who buy coverage on their own or through a small business -- as the employer-based system does for large-group coverage."

[12]

http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3311&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=350

As a partnership program, both states and the federal government pay for services to Medicaid beneficiaries. The federal government matches state expenditures based on a formula that yields subsidies ranging from 50 percent to as high as 83 percent. The average federal medical assistance percentage is 57 percent. However, even with federal support, states report they are struggling to meet their share of expanding Medicaid costs. State spending on Medicaid has remained relatively stable as a share of states' budgets, averaging about 20 percent from 1995-2007. However, some states such as Maine are already spending as much as 31 percent of their budgets on Medicaid, according to NASBO.

[13] https://townhall.com/columnists/anncoulter/2017/03/02/how-to-provide-universal-health-care-using-one-easy-trick-n2292807

The first sentence of Congress' Obamacare repeal should read: "There shall be a free market in health insurance."

Right there, I've solved the health insurance crisis for 90 percent of Americans. Unfortunately, no one can imagine what a free market in health care looks like because we haven't had one for nearly a century.

On NBC's "Meet the Press" this weekend, for example, Chuck Todd told Sen. Tom Cotton that his proposal to create affordable health care that would be widely available, "sounds good," but "do you understand why some people think that's an impossible promise to keep?"

(The "do you understand ...?" formulation is a condescension reserved only for conservatives, whose disagreement with liberals is taken as a sign of

stupidity.)
Todd continued: "To make it affordable, making it wider, I mean, that just seems like -- you know, it seems like you're selling something that can't be done realistically."
Dream Sequence: Chuck Todd on Russia's "Meet the Press" after the fall of the Soviet Union: "Do you understand why some people think that's an impossible promise to keep? To make bread affordable, making it wider, I mean, that just seems like -- you know, it seems like you're selling something that can't be done realistically."
It turns out that, outside of a communist dictatorship, all sorts of products are affordable AND widely available! We don't need Congress to "provide" us with health care any more than we need them to "provide" us with bread. What we need is for health insurance to be available on the free market.

CARTOONS | GARY VARVEL

With lots of companies competing for your business, basic health insurance would cost about $50 a month. We know the cost because Christian groups got a waiver from Obamacare, and that's how much their insurance costs right now. (Under the law, it can't be called "insurance," but that's what it is.)
Even young, healthy people would buy insurance at that price, expanding the "risk-sharing pools" and probably bringing the cost down to $20 or $30 a month.
In a free market, there would be an endless variety of consumer-driven plans, from catastrophic care for the risk-oblivious to extravagant plans for the risk-averse.
You know -- just like every other product in America.
You should visit America sometime, Chuck! The orange juice aisle in a Texas grocery store knocked the socks off Russian president Boris Yeltsin. (Imagine how cheap a double screwdriver must be in America!)
Just as there are rows of different types of orange juice in the grocery store -- and loads of grocery stores -- there will be loads of health insurance plans and insurance companies offering them.
Americans would finally be able to buy whatever insurance plans they liked, as easily as they currently buy flat-screen TVs, cellphones and -- what's that product with the cute gecko in its commercials? I remember now! CAR INSURANCE!

Evidently, insurance is not impervious to the iron law of economics that every product sold on the free market gets better and cheaper over time.
The only complicated part of fixing health care is figuring out how to take care of the other 10 percent of Americans -- the poor, the irresponsible and the unlucky. And the only reason that is complicated is because of fraud.
Needless to say, the modern nanny state already guarantees that no one will die on the street in America. The taxpayer spends more than a trillion dollars every year on Medicare, Medicaid and Social Security disability insurance so that everyone's health is taken care of, from cradle to grave.
Unfortunately, probably at least half of that sum is fraud.
Policing fraud is difficult because: (1) the bureaucrats dispensing government benefits believe there is no fraud and, if there is, it's a good thing because it redistributes income; and (2) we keep bringing in immigrants for whom fraud is a way of life. (See "Adios, America! The Left's Plan to Turn Our Country Into a Third World [**]hole.")
Consequently, after the first sentence establishing a free market in health insurance, the entire rest of the bill should be nothing but fraud prevention

measures to ensure that only the truly deserving -- and the truly American -- are accessing taxpayer-supported health care programs.

[14] Detroit Free Press. http://www.freep.com/article/20120511/NEWS03/120511056/Sterling-Heights-doctor-convicted-Medicare-fraud

Sterling Heights doctor convicted of Medicare fraud

An Oakland County doctor was convicted today for his role in a $6.7 million Medicare fraud scheme in which he billed the government for unnecessary neurological tests, including some that involved sending an electrical current through patients' arms and legs.

After a one-week trial, Jonathan Agbebiyi, 62, a gynecologist from Sterling Heights, was convicted by a federal jury in Detroit of one count of conspiracy to commit health care fraud, and six counts of health care fraud.

His scheme involved recruiting patients with prescriptions for various drugs, cash payments, and fast food, authorities said.Agbebiyi ran the scheme while a staff physician from 2007-2010 at three Livonia clinics: Blessed Medical Clinic, Alpha and Omega Medical Clinic, and Manuel Medical Clinic.According to the evidence presented at trial, Agbebiyi billed Medicare for unnecessary neurological tests on patients who were never referred by doctors, and never got follow-up care. The tests, which included sending electrical currents through patients' arms and legs, were administered by clinic employees who had no proper training to do so, prosecutors said."This doctor exposed patients to neurological testing solely to generate money for himself at the expense of the Medicare program," U.S. Attorney Barbara McQuade said. " We are grateful for the hard work that uncovered this betrayal of medical ethics and theft of taxpayer funds."Nine others involved with the three clinics have been convicted for their roles in the scheme. Agbebiyi will be sentenced August 13. He faces up to 10 years in prison on each health care fraud count, and a $250,000 fine.

1. A Federal Register notive Vol. 61, no. 238, December 10, 1996 page 65075 notes a Jonathan Agbebiyi, M.D. Revoctaion of registration by the DEA in Phoenix Arizona, and the license to practice medicine was revoked in Arizona. Federal Register | *Jonathan Agbebiyi, M.D.*; Revocation of Registration

[15] http://en.wikipedia.org/wiki/Flexner_Report

The **Flexner Report** is a book-length study of medical education in the United States and Canada, written by the professional educator Abraham Flexner and published in 1910 under the aegis of the Carnegie Foundation. Many aspects of the present-day American medical profession stem from the Flexner Report and its aftermath.

Many American medical schools fell short of the standard advocated in the Report, and subsequent to its publication, nearly half of such schools merged or were closed outright. The Report also concluded that there were too many medical schools in the USA, and that too many doctors were being trained. A repercussion of the Flexner Report resulting from the closure or consolidation of university training, was reversion of American universities to male-only admittance programs to accommodate a smaller admission pool. Universities had begun opening and expanding female admissions as part of women's and co-educational facilities only in the mid-to-latter part of the 19th century with the founding of co-educational Oberlin College in 1833 and private colleges such as Vassar College and Pembroke College.

No medical school can be created without the permission of the state government. Likewise, the size of existing medical schools is subject to state regulation;

The annual number of medical school graduates sharply declined, and the resulting reduction in the supply of doctors makes the availability and affordability of medical care problematic. **Closure of many medical schools** According to Hiatt and Stockton (p. 8), Flexner sought to shrink the number of medical schools in the USA to 31, and to cut the annual number of medical graduates from 4,400 to 2,000. A majority of American institutions granting M.D. or D.O. degrees as of the date of the Report (1910) closed within two to three decades. (No Canadian medical school was

deemed inadequate, and none closed or merged subsequent to the Report.) In 1904, there were 160 M.D. granting institutions with more than 28,000 students. By 1920, there were only 85 M.D. granting institution, educating only 13,800 students. By 1935, there were only 66 medical schools operating in the USA.
Between 1910 and 1935, more than half of all American medical schools merged or closed. This dramatic decline was in some part due to the implementation of the Report's recommendation that all "proprietary" schools be closed, and that medical schools should henceforth all be connected to universities. Of the 66 surviving M.D. granting institutions in 1935, 57 were part of a university. An important factor driving the mergers and closures of medical schools was that all state medical boards gradually adopted and enforced the Report's recommendations.

[16] http://en.wikipedia.org/wiki/Medical_College_Admission_Test
The Physical Sciences section assesses problem-solving ability in general chemistry and physics and the Biological Sciences section evaluates these abilities in the areas of biology and organic chemistry. The Verbal Reasoning section evaluates the ability to understand, evaluate, and apply information and arguments presented in prose style. The Biological Sciences section most directly correlates to success on the USMLE Step 1 exam, with a correlation coefficient of .553 vs .491 for Physical Sciences and .397 for Verbal Reasoning. [5] Predictably, MCAT composite scores also correlate with USMLE Step 1 success.[6]

[17] August 25, 2013
How to Charge $546 for Six Liters of Saltwater
By **NINA BERNSTEIN**
http://www.nytimes.com/2013/08/27/health/exploring-salines-secret-costs.html?_r=0&pagewanted=print

It is one of the most common components of emergency medicine: an intravenous bag of sterile saltwater.
Luckily for anyone who has ever needed an IV bag to replenish lost fluids or to receive medication, it is also one of the least expensive. The average manufacturer's price, according to government data, has fluctuated in recent years from 44 cents to $1.
Yet there is nothing either cheap or simple about its ultimate cost, as I learned when I tried to trace the commercial path of IV bags from the factory to the veins of more than 100 patients struck by a May 2012 outbreak of food poisoning in upstate New York.
Some of the patients' bills would later include markups of 100 to 200 times the manufacturer's price, not counting separate charges for "IV administration." And on other bills, a bundled charge for "IV therapy" was almost 1,000 times the official cost of the solution.
It is no secret that medical care in the United States is overpriced. But as the tale of the humble IV bag shows all too clearly, it is secrecy that helps keep prices high: hidden in the underbrush of transactions among multiple buyers and sellers, and in the hieroglyphics of hospital bills.
At every step from manufacturer to patient, there are confidential deals among the major players, including drug companies, purchasing organizations and distributors, and insurers. These deals so obscure prices and profits that even participants cannot say what the simplest component of care actually costs, let alone what it *should* cost.
And that leaves taxpayers and patients alike with an inflated bottom line and little or no way to challenge it.

A Price in Flux

In the food-poisoning case, some of the stricken were affluent, and others barely made ends meet. Some had private insurance; some were covered by government programs like Medicare and Medicaid; and some were uninsured.

In the end, those factors strongly (and sometimes perversely) affected overall charges for treatment, including how much patients were expected to pay out of pocket. But at the beginning, there was the cost of an IV bag of normal saline, one of more than a billion units used in the United States each year.

"People are shocked when they hear that a bag of saline solution costs far less than their cup of coffee in the morning," said Deborah Spak, a spokeswoman for Baxter International, one of three global pharmaceutical companies that make nearly all the IV solutions used in the United States.

It was a rare unguarded comment. Ms. Spak — like a spokesman for Hospira, another giant in the field — later insisted that all information about saline solution prices was private.

In fact, manufacturers are required to report such prices annually to the federal government, which bases Medicare payments on the average national price plus 6 percent. The limit for one liter of normal saline (a little more than a quart) went to $1.07 this year from 46 cents in 2010, an increase manufacturers linked to the cost of raw materials, fuel and transportation. That would seem to make it the rare medical item that is cheaper in the United States than in France, where the price at a typical hospital in Paris last year was 3.62 euros, or $4.73.

Middlemen at the Fore

One-liter IV bags normally contain nine grams of salt, less than two teaspoons. Much of it comes from a major Morton Salt operation in Rittman, Ohio, which uses a subterranean salt deposit formed millions of years ago. The water is local to places like Round Lake, Ill., or Rocky Mount, N.C., where Baxter and Hospira, respectively, run their biggest automated production plants under sterility standards set by the Food and Drug Administration.

But even before the finished product is sold by the case or the truckload, the real cost of a bag of normal saline, like the true cost of medical supplies from gauze to heart implants, disappears into an opaque realm of byzantine contracts, confidential rebates and fees that would be considered illegal kickbacks in many other industries.

IV bags can function like cheap milk and eggs in a high-priced grocery store, or like the one-cent cellphone locked into an expensive service contract. They serve as loss leaders in exclusive contracts with "preferred manufacturers" that bundle together expensive drugs and basics, or throw in "free" medical equipment with costly consequences.

Few hospitals negotiate these deals themselves. Instead, they rely on two formidable sets of middlemen: a few giant group-purchasing organizations that negotiate high-volume contracts, and a few giant distributors that buy and store medical supplies and deliver them to hospitals.

Proponents of this system say it saves hospitals billions in economies of scale. Critics say the middlemen not only take their cut, but they have a strong interest in keeping most prices high and competition minimal.

The top three group-purchasing organizations now handle contracts for more than half of all institutional medical supplies sold in the United States, including the IVs used in the food-poisoning case, which were bought and taken by truck to regional warehouses by big distributors.

These contracts proved to be another black box. Debbie Mitchell, a spokeswoman for Cardinal Health, one of the three largest distributors, said she could not discuss costs or prices under "disclosure rules relative to our investor relations."

Distributors match different confidential prices for the same product with each hospital's contract, she said, and sell information on the buyers back to manufacturers.

A huge Cardinal distribution center is in Montgomery, N.Y. — only 30 miles, as it happens, from the landscaped grounds of the Buddhist monastery in Carmel, N.Y., where many of the food-poisoning victims fell ill on Mother's Day 2012.

Among them were families on 10 tour buses that had left Chinatown in Manhattan that morning to watch dragon dances at the monastery. After eating lunch from food stalls there, some traveled on to the designer outlet stores at Woodbury Commons, about 30 miles away, before falling sick.

The symptoms were vicious. “Within two hours of eating that rice that I had bought, I was lying on the ground barely conscious,” said Dr. Elizabeth Frost, 73, an anesthesiologist from Purchase in Westchester County who was visiting the monastery gardens with two friends. “I can’t believe no one died.”

About 100 people were taken to hospitals in the region by ambulance; five were admitted and the rest released the same day. The New York State Department of Health later found the cause was a common bacterium, Staphylococcus aureus, from improperly cooked or stored food sold in the stalls. **Mysterious Charges**

The sick entered a health care ecosystem under strain, swept by consolidation and past efforts at cost containment.

For more than a decade, hospitals in the Hudson Valley, like those across the country, have scrambled for mergers and alliances to offset economic pressures from all sides. The five hospitals where most of the victims were treated are all part of merged entities jockeying for bargaining power and market share — or worrying that other players will leave them struggling to survive.

The Affordable Care Act encourages these developments as it drives toward a reimbursement system that strives to keep people out of hospitals through more coordinated, cost-efficient care paid on the basis of results, not services. But the billing mysteries in the food poisoning case show how easily cost-cutting can turn into cost-shifting.

A Chinese-American toddler from Brooklyn and her 56-year-old grandmother, treated and released within hours from the emergency room at St. Luke’s Cornwall Hospital, ran up charges of more than $4,000 and were billed for $1,400 — the hospital’s rate for the uninsured, even though the family is covered by a health maintenance organization under Medicaid, the federal-state program for poor people.

The charges included “IV therapy,” billed at $787 for the adult and $393 for the child, which suggests that the difference in the amount of saline infused, typically less than a liter, could alone account for several hundred dollars.

Tricia O’Malley, a spokeswoman for the hospital, would not disclose the price it pays per IV bag or break down the therapy charge, which she called the hospital’s “private pay rate,” or the sticker price charged to people without insurance. She said she could not explain why patients covered by Medicaid were billed at all.

Eventually the head of the family, an electrician’s helper who speaks little English, complained to HealthFirst, the Medicaid H.M.O. It paid $119 to settle the grandmother’s $2,168 bill, without specifying how much of the payment was for the IV. It paid $66.50 to the doctor, who had billed $606.

At White Plains Hospital, a patient with private insurance from Aetna was charged $91 for one unit of Hospira IV that cost the hospital 86 cents, according to a hospital spokeswoman, Eliza O’Neill.

Ms. O’Neill defended the markup as “consistent with industry standards.” She said it reflected “not only the cost of the solution but a variety of related services and processes,” like procurement, biomedical handling and storage, apparently not included in a charge of $127 for administering the IV and $893 for emergency-room services.

The patient, a financial services professional in her 50s, ended up paying $100 for her visit. “Honestly, I don’t understand the system at all,” said the woman, who shared the information on the condition that she not be named.

Dr. Frost, the anesthesiologist, spent three days in the same hospital and owed only $8, thanks to insurance coverage by United HealthCare. Still, she was baffled by the charges: $6,844, including $546 for six liters of saline that cost the hospital $5.16.

“It’s just absolutely absurd.” she said. “That’s saltwater.”

Last fall, I appealed to the New York State Department of Health for help in mapping the charges for rehydrating patients in the food poisoning episode. Deploying software normally used to detect Medicaid fraud, a team compiled a chart of what Medicaid and Medicare were billed in six of the cases.

But the department has yet to release the chart. It is under indefinite review, Bill Schwarz, a department spokesman, said, "to ensure confidential information is not compromised."

[18] http://usatoday30.usatoday.com/MONEY/usaedition/2012-11-06-Medicare-Kaiser-Health-News_ST_U.htm

Medicare asks some to make plan changes

Medicare officials are trying a novel approach during this enrollment season to gently nudge a half-million beneficiaries out of 26 private drug and medical plans that have performed poorly in the past three years.

t starts with letters telling seniors they're enrolled in a low-rated plan. "We encourage you to compare this plan to other options in your area and decide if it is still the right choice for you," the letter urges. About 375,000 Medicare Advantage plan members got letters, as did 150,000 drug plan members in 48 states.

The effort is the first time that Medicare officials have tried to steer beneficiaries away from some private drug and medical plans, while still allowing the plans to operate. Officials have also warned the plans that they might be canceled in the future. Instead of a typical government form letter, each was addressed to the individual by name and tells the beneficiary that her plan "has been rated 'poor' or 'below average'" because it earned less than three stars under Medicare's five-star rating system for three consecutive years. Yet, that might not be enough to catch their attention. "Some people don't change no matter how many letters you send them," says Leta Blank, program director for the Montgomery County, Md., Senior Health Insurance Assistance Program, which helps seniors evaluate coverage options. There are dozens of plans for sale in most counties. Even if a different plan is cheaper, studies have shown, few seniors change plans. "They are paralyzed. It's a very difficult issue," Blank says.

For many beneficiaries, plan ratings are not as important as price, restrictions on drugs and whether their doctors participate, she says. In addition to the letters, Medicare is making it harder for people to sign up for one of the 26 plans. If consumers search for plans on Medicare's plan-finder website, they can access and join other, better-performing plans electronically. But to join one of the 26, they must contact that company directly. Those plans also have a warning symbol next to their names to highlight their low ratings.

Seniors who pick plans with poor track records will have one chance to switch next year into a better plan. Medicare officials are considering mailing a reminder in February. Most of the roughly 13.3 million Medicare Advantage members and about 19 million drug plan enrollees are locked into plans for a year. But if beneficiaries stay in a low-rated plan, they eventually could be forced out. "We want to make it easy for beneficiaries to find and select the highest-quality plans, and discourage people from staying in chronically low-performing plans," said Isabella Leung, a Medicare spokeswoman. Notices don't explain that plans might be in trouble. In April, the Centers for Medicare & Medicaid Services, which oversees Medicare, warned insurers that plans scoring less than three stars over three years "have ignored their obligation to meet program requirements and (are) substantially out of compliance with their Medicare contracts over a period of time." Such plans can expect greater scrutiny, the letter says. "They should also expect CMS to initiate action to terminate their contract" after CMS confirms the low scores reflect violations of Medicare rules. CMS has prohibited one plan from enrolling new members.

Robert Zirkelbach, of America's Health Insurance Plans, an industry group, said the letter is "premature" because the ratings system is flawed. He says it's based on measures that don't sufficiently take into account, for example, plans serving a disproportionate number of beneficiaries with many chronic conditions or special needs, or who live in underserved areas. "It's important to make sure we get the measures right before we move on to these other steps."

Leslie Fried, director for policy and programs at the National Council on Aging, an advocacy group, said the letter didn't have to mention potential plan terminations. "The letter tells people what they need to know about the quality of their plan and that they should consider changing to a higher

performing plan," she said. If seniors ignore the warning, that's their choice, she said. Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a non-profit, non-partisan health policy research and communication organization not affiliated with Kaiser Permanente.

[19] **July 17, 2006 Hospital Chiefs Get Paid for Advice on Selling**

By WALT BOGDANICH

One recent sun-splashed afternoon, executives who run some of America's leading nonprofit hospitals met at a stately Colorado resort for an unusual mission: to advise companies confidentially on how best to sell their drugs, medical devices and financial services to hospitals.

The hospital executives were rewarded with more than a chance to indulge in a "harmonic" hot stone massage or mountainside golf.

They were also paid thousands of dollars for the advice they offered to dozens of companies, like Eli Lilly, Johnson & Johnson, Morgan Stanley and Citigroup. The hospital officials and their spouses received a free trip to the luxury resort, where they could join the Morgan Stanley Tennis Tournament or the GE Healthcare Barbecue. All of this came courtesy of the Healthcare Research and Development Institute, a for-profit company that is owned by about three dozen hospital executives, but underwritten by 40 or so of its handpicked corporate members, all suppliers to hospitals.

While the financial relationship between doctors and drug companies has come under intense scrutiny, much less is known about how hospital executives interact with companies that sell products as varied as syringes and financial services. In the case of the Healthcare Research and Development Institute, executives benefit from payments made by companies their hospitals do business with.

Founded five decades ago, the company, known as H.R.D.I., has maintained a low profile, despite an elite membership that one government official calls "the health care titans of America." Earlier this year, the institute declined to even say who belongs to it. But that is changing.

The Connecticut attorney general, Richard Blumenthal, is investigating whether the organization allows certain vendors to buy access to hospital leaders who are in a position to influence what supplies or services their institutions purchase. As a result, Mr. Blumenthal said, hospitals may not be getting the best deals, either in terms of cost or quality.

"At the very least it suggests insider dealings — an insidious, incestuous, insider system," said Mr. Blumenthal, who has issued more than 100 subpoenas, mostly to hospital suppliers, including several dozen last week.

H.R.D.I. officials say they are cooperating with Mr. Blumenthal's investigation and deny any sinister motives. Its members are merely "trying to improve products and services in health care — not more complicated than that," said Gary A. Mecklenburg, the group's chairman and a former chairman of the American Hospital Association, the industry's largest trade group.

But Mr. Mecklenburg's own background highlights the overlapping interests that he faces.

Mr. Mecklenburg not only runs a large nonprofit hospital, Northwestern Memorial in Chicago, but he also serves on the board of Becton, Dickinson and Company, a major supplier of medical devices to hospitals around the world, including his own. Becton, Dickinson pays the institute for marketing advice, and the institute pays Mr. Mecklenburg $50,000 a year, mostly for participating in two national conferences, according to the group.

A spokeswoman for Northwestern Memorial, Holli Salls, said that hospital board members had approved Mr. Mecklenburg's positions at both Becton, Dickinson and H.R.D.I., and that "he reviews his involvement with them annually." But those financial entanglements anger one of Becton, Dickinson's smaller rivals, a Texas-based manufacturer of syringe needles called Retractable Technologies, which sees them thwarting competition.

"This is not the kind of club that is likely to invite us to become a member, nor is it one that we'd care to belong to," said Thomas J. Shaw, Retractable's chief executive. "As a matter of policy, we do not engage in pay-to-play schemes."

Two years ago, Retractable reached a $100 million settlement with Becton, Dickinson after accusing it and several other companies of freezing Retractable out of many hospitals. The healthcare institute did not figure in the lawsuit, but several of its members ran companies that did.

If Retractable is not interested in joining the group, many others are. “We have a long waiting list of companies,” said Diane P. Appleyard, the president of the organization, which is based in Pensacola, Fla.

Only two competing companies in any specific field are generally allowed to join, according to the group. Mr. Blumenthal said limiting membership raised antitrust concerns, adding that his office was investigating whether companies used their membership to improperly divide sales territories. “These arrangements are more than just a bunch of corporate C.E.O.’s and health care executives enjoying golf games or cocktails,” he said.

Mr. Blumenthal’s inquiry builds on a lengthy examination of hospital buying practices by the Senate antitrust subcommittee. Rather than focus on consulting firms like H.R.D.I., the Senate has looked at companies or consortiums that buy supplies on behalf of groups of hospitals. Witnesses have described how vendors paid millions of dollars in “administrative fees” to the buying groups, prompting some critics like Mr. Shaw of Retractable to call them kickbacks.

An association of group purchasing organizations has since adopted an industry code of ethics, but some suppliers say it does not go far enough in ensuring competition in the marketplace. The Senate antitrust subcommittee is considering whether legislation is needed.H.R.D.I. is not alone in using hospital executives to advise suppliers. Ms. Appleyard says that a number of imitators have emerged in the last few years.

W. Hays Waldrop of Franklin, Tenn., said he arranged for hospital executives to advise suppliers through a company called the Institute of Healthcare Executives and Suppliers. Mr. Waldrop said he sold corporate memberships to vendors for about $30,000 a year. “It’s about nothing else but education and peer networking,” Mr. Waldrop said.

Becton, Dickinson, which is based in Franklin Lakes, N.J., is a member of a division of the institute called the Council of Supply Chain Executives. According to that council’s Web site, it offers suppliers “a unique environment to learn and gain direct access with leading supply chain executives, in both formal and casual settings.”

Mr. Waldrop said his groups differed from H.R.D.I. in that he, not hospital executives, owned them. He said hospital officials got only a small honorarium for consulting, though he declined to say how much. In addition, Mr. Waldrop said, he donates money in the names of those executives to their hospitals’ foundations.

Until recently, H.R.D.I. discouraged media coverage of its affairs. In April, Ms. Appleyard declined to name her organization’s members, saying she did not want a reporter bothering them. The company had earlier restricted access to its Web site after a reporter began questioning those members. But after Connecticut’s attorney general called the group a “secretive” network of “ethically questionable business arrangements,” during testimony in March before the Senate antitrust subcommittee, the company recently reopened its Web site to the public. “We decided we needed to stop not commenting,” Ms. Appleyard said.

The institute’s new policy of openness is apparently not shared by all of its members. Nearly a dozen corporate members either declined to comment or did not respond to requests to discuss their involvement. “I can’t respond for them,” Mr. Mecklenburg, the group’s chairman, said. “They are independent corporations and that’s their decision.”

Last May, more than 130 representatives from 40 health care companies were scheduled to attend confidential consulting sessions at the Broadmoor, a Colorado Springs hotel. When not attending the sessions, hospital chief executives and suppliers mingled at company-sponsored tennis, golf and social events.

Each year, H.R.D.I. holds two gatherings like the one in Colorado, where each corporate member gets a meeting of up to three hours with five or six chief executives, according to Mr. Mecklenburg..

“The range of those discussions can be very, very wide,” he said. “I would call this market research. What do you think of our strategy? What do you think of our product?” The hospitals’ leaders also serve as a sounding board for products or services under development, the group said.

Each company is also assigned a specific hospital executive, called a liaison. “The typical organization is paying $40,000,” Mr. Mecklenberg said. “It can be more, but that would not be typical.”
Additional access to hospital executives and their institutions can cost companies $55,000 a year or even more. For example, a special two- to three-day visit to a specific hospital costs $2,000 a person, according to H.R.D.I., which says most of that money is eventually passed on to the hospital.
The group’s Web site also states: “Other forms of individual or group training may be tailored to the corporate member’s specific needs and conducted at the place and time requested.”
It is unclear exactly how much hospital executives, who are the shareholders of the healthcare institute, earn annually for consulting at the two conferences. Asked to verify a report that some members earned as much as $50,000, Mr. Mecklenberg initially denied it. “Our observation and recollection is $20,000 to $30,000 a year,” he said. “It may be more than that but we don’t have data in front of us, but it’s certainly not $50,000.”
Days later, the organization said in an e-mail message that Mr. Mecklenberg himself had been paid $50,000, $18,000 of which was for his administrative work as chairman. The group said that for years he had donated his consulting income to his hospital’s foundation.
Mark Leahey, executive director of the Medical Device Manufacturers Association, said he was troubled by the fact that H.R.D.I. members had included leaders of organizations that negotiate major purchasing contracts on behalf of hundreds of nonprofit hospitals.
“These conflicts prevent innovative, cost-effective products from entering the market,” said Mr. Leahey, whose group has been a frequent critic of these large buying groups.
H.R.D.I. began a half-century ago when several hospital administrators started meeting informally at professional conferences “to share innovations and experiences,” according to the group’s Web site.
The organization’s mission changed, however, when a manufacturer complained in the early 1960’s that he had no reliable place to turn for impartial advice on product research. “Concerned that products and services sometimes arrived at the hospital without thoughtful evaluation and input from providers and patients, they recognized an opportunity to influence the development process,” the Web site states.
The institute’s Web site added that members had agreed that the group’s purpose was solely for education and the sharing of ideas “and is not for direct solicitation.”
Mary Williams Walsh contributed reporting for this article. The New York Times.

[20] http://www2.census.gov/prod2/decennial/documents/10107945v1pAch02.pdf
Population for the 1960 census.

[21] **http://www.washingtonpost.com/wp-dyn/content/article/2005/11/27/AR2005112700781_pf.html**
Medicaid Cutbacks Divide Democrats
House Condemns Provisions Crafted By Governors

By Jonathan Weisman Washington Post Staff Writer Monday, November 28, 2005; A01

Controversial House legislation designed to gain control of Medicaid growth has split Democrats, with lawmakers in Washington united in their opposition while Democratic governors are quietly supporting the provisions and questioning the party's reflexive denunciations.

The Medicaid provisions have become a flashpoint for the opposition of Democrats -- and some moderate Republicans -- to the $50 billion budget-cutting bill that narrowly passed the House last week. The provisions would reduce Medicaid spending by $12 billion through 2010 and $48 billion over the next decade, in part by making it difficult for more affluent seniors to transfer their assets to relatives, then plead poverty to get Medicaid to pay for them to stay in nursing homes.

But the measures would also save $2.4 billion over five years by allowing state governments to impose higher health insurance deductibles, co-payments and premiums on poor Medicaid recipients, including, for the first time, impoverished children and pregnant women. An additional $3.9 billion would be saved by relaxing mandated preventive health care and screening of children and pregnant women.

The changes would trim just 1.7 percent from a program expected to spend nearly $2.8 trillion though 2015, but the proposals have prompted bitter condemnation from congressional Democrats.

"As the number of people without health insurance has increased for four years in a row, Republicans are charging ahead with $45 billion in cuts to Medicaid -- the health insurance program that provides medical care to America's poorest children and many of the survivors of Hurricane Katrina," House Minority Leader Nancy Pelosi (D-Calif.) thundered Nov. 18, just before the pre-dawn passage of the bill. "Republicans give new meaning to the words 'suffer little children.' "

What she did not say is that those changes were proposed over the summer by a bipartisan task force of governors, led by Virginia's Mark R. Warner, whose popularity in a Republican state has made him a rising star in the Democratic Party.

In fact, the most controversial provisions in the House bill were adapted almost word for word from a document drafted by Govs. Warner, Tom Vilsack (D-Iowa), Haley Barbour (R-Miss.), Janet Napolitano (D-Ariz.), Mike Huckabee (R-Ark.), Jennifer M. Granholm (D-Mich.), Dirk Kempthorne (R-Idaho), Jim Doyle (D-Wis.), Mike Rounds (R-S.D.), and Edward G. Rendell (D-Pa.), said Ray Scheppach, executive director of the National Governors Association.

"The House has worked very closely with us," Scheppach said. "From our standpoint, Republicans and Democrats saw this very similarly at the state level."

The split has underscored the differing interests of Democrats in Washington -- out of power and struggling to capitalize on the declining popularity of their adversaries -- and Democratic governors, who take a more pragmatic approach. For governors, the soaring costs of Medicaid threaten to swamp state financing. Already, tens of thousands of people have been thrown off the Medicaid rolls in states such as Tennessee and Missouri, and governors have warned that those cuts will grow deeper if they do not have the flexibility to trim benefits more rationally.

So where Washington Democrats hope to highlight the partisan divide, their gubernatorial counterparts outside the Beltway have emphasized pragmatism and moderation, not only in the way they have governed but in their political campaigns.

That split -- over policy and style -- could come increasingly into focus as potential presidential contenders outside Washington, such as Warner, clash with congressional contenders, such as Sen. Hillary Rodham Clinton (D-N.Y.), as they jockey for position ahead of the 2008 White House race.

For now, Democratic governors have been willing to voice their opposition to the broader budget-cutting bill, attacking provisions that cut child support enforcement, narrow eligibility for foster care and adoption assistance, and impose stricter work requirements on welfare recipients with only modest increases in child care assistance.

"The president and his friends on Capitol Hill have put together a budget that does not reflect the values of everyday Americans," said New Mexico Gov. Bill Richardson, chairman of the Democratic Governors Association.

But they have conspicuously steered clear of the Medicaid debate that will continue to rage into next month, as House negotiators push their Medicaid provisions in conference with a wary Senate.

Thomas S. Kahn, the Democratic staff director of the House Budget Committee, said Democrats are unified on one point: Savings from changes to the Medicaid system should be used to strengthen health care for the poor, not pay for tax cut extensions that congressional Republicans hope to pass when they return in December.

"All Democrats agree strongly that cuts in Medicaid, especially those that hurt poor beneficiaries, should not be used to pay for tax cuts, especially those geared toward those at the top," Kahn said.

And gubernatorial support for the Medicaid changes may not be universal. In an Aug. 31 letter, Gov. Ted Kulongoski of Oregon implored Sen. Gordon Smith (R-Ore.) to oppose increased cost-sharing, especially for Medicaid recipients below the poverty line.

But Kahn and liberal activists acknowledged the fissure with governors is real.

The division stems in part from long-standing fears that if Washington gives states too much latitude over federal programs, some governors will go too far. Under the House bill, the $3 co-payment for Medicaid recipients below the poverty level would be allowed to rise annually with the medical inflation rate. For the first time, states would be allowed to refuse care for patients who refuse to pay.

States would also be allowed to charge co-payments, premiums or deductibles for visits to hospital emergency rooms for non-emergency care and for expensive prescription drugs not on a list of preferred medications.

What really worries liberal policy groups is a measure allowing states to impose any co-payment they want on Medicaid recipients who are above the poverty line, typically the working poor. Those fees are supposed to remain below 5 percent of beneficiaries' total incomes, but policy experts say that cap will be impossible to enforce. Most working poor will not be able to track their annual medical expenses to that degree of specificity.

The nonpartisan Congressional Budget Office estimated that by 2015, 11 million Medicaid beneficiaries -- half of them children -- will face fees they do not face today. About 80 percent of the cost savings from the bill would come not from the premiums and co-payments but from poor people no longer seeking medical attention.

Scheppach allowed that experiences do indicate higher fees might keep some people from seeking needed health care. But, he said, Congress should trust the governors to use the proposed changes wisely.

"We think governors are going to use these measures in a positive way, steering people away from emergency to non-emergency care or getting them drugs that are more affordable," he said, adding that if nothing is done about Medicaid costs, even more people will be cut from the Medicaid rolls entirely. "These are good policies for the long run." © 2005 The Washington Post Company

[22] http://news.yahoo.com/s/ap/unapproved_drugs/print;_ylt=AvicVTTGpxCs4wkaPwlFLBl2wPIE
AP IMPACT: Govt pays for risky unapproved drugs
By RICARDO ALONSO-ZALDIVAR and FRANK BASS, Associated Press Writers Ricardo Alonso-zaldivar And Frank Bass, Associated Press Writers 1 hr 33 mins ago

WASHINGTON – The government is paying millions for risky medications that have never been reviewed for safety and effectiveness but are still covered under Medicaid, an Associated Press analysis of federal data has found. Taxpayers have shelled out at least $200 million since 2004 for such drugs. Yet the Food and Drug Administration says unapproved prescription drugs are a public health problem, and some unapproved medications have been linked to dozens of deaths.
Millions of private patients are taking them as well, and their availability may create a false sense of security.

The AP analysis found that Medicaid, which serves low-income people, paid nearly $198 million from 2004 to 2007 for more than 100 unapproved drugs. Data for 2008 were not available but unapproved drugs still are being sold. The AP checked the medications against FDA databases, using agency guidelines to determine if they were unapproved. The FDA says there may be thousands of such drugs on the market.

The medications are mainly for common conditions like colds and pain. They date back decades, before the FDA tightened its review of drugs in the early 1960s. The FDA says it is trying to squeeze them from the market, but conflicting federal laws allow the Medicaid health program for low-income people to pay for them.

Medicaid officials acknowledge the problem, but say they need help from Congress to fix it. The FDA and Medicaid are part of the Health and Human Services Department, but the FDA has yet to compile a master list of unapproved drugs, and Medicaid — which may be the biggest purchaser — keeps paying.

"I think this is something we ought to look at very hard, and we ought to fix it," said Medicaid chief Herb Kuhn. "It raises a whole set of questions, not only in terms of safety, but in the efficiency of the program — to make sure we are getting the right set of services for beneficiaries."

At a time when families, businesses and government are struggling with health care costs and 46 million people are uninsured, payments for questionable medications amount to an unplugged leak in the system.

Sen. Charles Grassley, R-Iowa, has asked the HHS inspector general to investigate.

That unapproved prescription drugs can be sold in the United States surprises even doctors and pharmacists. But the FDA estimates they account for 2 percent of all prescriptions filled by U.S. pharmacies, about 72 million scripts a year. Private insurance plans also cover them.

The roots of the problem go back in time, tangled in layers of legalese.

It wasn't until 1962 that Congress ordered the FDA to review all new medications for effectiveness. Thousands of drugs already on the market were also supposed to be evaluated. But some manufacturers claimed their medications were grandfathered under earlier laws, and even under the 1962 bill.

Then, in the early 1980s, a safety scandal erupted over one of those medications. E-Ferol, a high potency vitamin E injection, was linked to serious reactions in some 100 premature babies, 40 of whom died.

In response, the FDA started a program to weed out drugs it had never reviewed scientifically. Yet some medications continued to escape scrutiny.

Sometimes, the medications do not help patients. In other cases, the FDA says, they have made people sicker, maybe even killed them. This year, for example, the FDA banned injectable versions of a gout drug called colchicine after receiving reports of 23 deaths. Investigators found the unapproved drug had a very narrow margin of safety, and patients easily could receive a toxic dose leading to complications such as organ failure.

Critics say the FDA's case-by-case enforcement approach is not working.

"The FDA does not appear to have a systematic mechanism to report these drugs out," said Jon Glaudemans, senior vice president of Avalere Health, a health care industry information company, "and there doesn't seem to be a systematic process by which health insurance programs can validate their status. And everyone is pointing the finger at someone else as to why we can't get there."

In most cases, doctors, pharmacists and patients are not aware the drugs are unapproved.

"Over the years, they have become fully entrenched in the system," said Patti Manolakis, a Charlotte, N.C., pharmacist who has studied the issue. Only a few unapproved drugs are truly essential and should remain on the market, she added.

Tackling the problem is made harder by confusing — and sometimes conflicting — laws, regulations and responsibilities that pertain to different government agencies.

Medicaid officials said their program, which serves the poor and disabled, is allowed to pay for unapproved drugs until the FDA orders a specific medication off the market. But that can take years.

Compare that with **Medicare,** the health care program for older people.

Medicare's prescription program is not supposed to cover unapproved drugs. Medicare has purged hundreds of such medications from its coverage lists, but it continues to find others.

It might be easier to sort things out if the FDA compiled a master list of unapproved drugs, but the agency hasn't done so. FDA officials say that would be difficult because many manufacturers do not list unapproved products with the agency. Yet, the AP found many that were listed — a possible starting point for a list.

Among the drugs the AP's research identified were Carbofed, for colds and flu; Hylira, a dry skin ointment; Andehist, a decongestant, and ICAR Prenatal, a vitamin tablet. Medicaid data show the program paid $7.3 million for Carbofed products from 2004 to 2007; $146,000 for Hylira; $4.8 million for Andehist products, and $900,000 for ICAR.

Grassley said the system is failing taxpayers and consumers.

"The problem I see is **bureaucrats don't want to make a decision**," Grassley said. "There is no reason why this should be such a house of mirrors when so much public money is being spent." Grassley is considering introducing legislation to ensure that consumers are told when a medication is unapproved.

FDA officials say they tell Medicaid and **Medicare** when the agency moves to ban an unapproved drug, so the programs can stop paying.

"The situation is complicated by the fact that Medicaid and **Medicare** have a different regulatory regime than FDA does," said FDA compliance lawyer Michael Levy. "There are products that we may consider to be **illegally marketed that could be legally reimbursed** under their law."

The FDA began its latest crackdown on unapproved drugs two years ago and has taken action against nine types of medications and dozens of companies. Typically, the agency orders manufacturers to stop making and shipping drugs, and it also has seized millions of dollars' worth of medications. But federal law does not call for fines for selling unapproved drugs, and criminal prosecutions are rare.

Some manufacturers of unapproved drugs say their products predate FDA regulation and are "grandfathered in."

"These are drugs that don't require an FDA approval," said Bill Peters, chief financial officer of Hi-Tech Pharmacal in Amityville, N.Y. "These are products with active ingredients that have been on the market for a long time." The company is moving away from older products, Peters said, and its new market offerings are FDA-approved.

Levy said the FDA is skeptical that any drugs now being sold are entitled to "grandfather" status. To qualify, they would have to be identical to medications sold decades ago in formulation and other important aspects.

The agency is targeting drugs linked to fraud, ones that do not work and, above all, those with safety risks. While the crackdown has helped, it does not appear to have solved the problem.

The gout drug banned by the FDA this February is not the only recent case involving safety problems.

Last year, the FDA banned unapproved cough medicines containing hydrocodone, a potent narcotic. Some had directions for medicating children as young as age 2, although no hydrocodone cough products have been shown to be safe and effective for children under 6.

In a 2006 case, the agency received 21 reports of children younger than 2 who died after taking unapproved cold and allergy medications containing carbinoxamine, an allergy drug that also acts as a powerful sedative. Regulators banned all products that contained carbinoxamine in combination with other cold medicines.

"We as Americans have a belief that all the prescription drugs that are available to us have been reviewed and approved by the FDA," said Manolakis, the pharmacist. "I think the presence of these drugs shows we have a false sense of security." On the Net:

FDA's unapproved drugs page: http://tinyurl.com/4tv2sb

[23] **Government benefit programs in trouble**

By MARTIN CRUTSINGER, AP Economics Writer 25/03/2008

Trustees for the government's two biggest benefit programs warned that Social Security and Medicare are facing "enormous challenges" with the threat to Medicare's solvency far more severe.

The trustees, issuing their once-a-year analysis, said the resources in the Social Security trust fund will be depleted by 2041. The reserves in the Medicare trust fund that pays hospital benefits were projected to be wiped out by 2019.

Both those dates were the same as in last year's report. But the trustees warned that financial pressures will begin much sooner when the programs begin paying out more in benefits each year than they collect in payroll taxes. For Medicare, that threshold is projected to be reached this year and for Social Security it is projected to occur in 2017.

Both programs are expected to come under increasing pressure as 78 million baby boomers start retiring and drawing benefits.
"The financial difficulties facing Social Security and Medicare pose enormous challenges," the trustees said in their report. "The sooner these challenges are addressed, the more varied and less disruptive their solutions can be."
Treasury Secretary Henry Paulson, one of the trustees, warned of a fiscal train wreck unless something is done.
"Without change, rising costs will drive government spending to unprecedented levels, consume nearly all projected federal revenues and threaten America's future prosperity," Paulson told a news conference where he and the other trustees released the report.
President Bush, who wanted to make overhauling Social Security a top priority in his second term, tapped Paulson to lead that effort. However, Paulson has been unable to forge a consensus with Democrats, who took control of Congress in 2006. He has complained that he is getting tired of playing "solitaire."
Democrats contend that Bush lost valuable time after his 2004 re-election pushing a plan to allow younger workers to direct their payroll tax contributions into private accounts, an idea that went nowhere in Congress.
Reaction in Congress divided along party lines with Republicans saying the new report was an urgent call for action while Democrats accused Republicans of using the report as an excuse for making Draconian cuts in benefits.
For the second year, the report contained a Medicare funding warning that will require the next president to submit soon after he sends his first budget to Congress next year recommendations for dealing with a shortfall in Medicare taxes and projected benefits.
Bush submitted the first of these required responses in February. He recommended among other things that wealthier Medicare beneficiaries pay higher monthly premiums for prescription drug coverage. Under the 2003 law that provided for drug benefits under Medicare, the president is required to submit cost-saving proposals to Congress if the trustees project Medicare will need to rely on general revenue for more than 45 percent of its funding in any future year.
Administration officials said Tuesday that Bush's recommendations, along with proposals to slow Medicare's growth included in the budget, would make a significant dent in the program's shortfalls. However, Democrats have attacked the proposals, making the prospect for legislation this year unlikely.
House Ways and Means Committee Chairman Charlie Rangel said Congress "will do what we have to in order to restore long-term financial stability to these programs."
But many analysts think the whole debate will be left for the next president to take up with Congress, given the difficulty of making changes in such politically sensitive programs as Social Security and Medicare during an election year.
While the Social Security trust fund will have resources until 2041, the more critical date in terms of government revenues will occur in 2017. In that year, Social Security, which has been providing billions of dollars in surpluses to the government for over two decades, will start having to pay out more in benefits than it will receive that year in payroll taxes.
At that point, the government will have to start replacing the money it has borrowed from the Social Security trust fund. It can do that only by increasing borrowing from the public, raising taxes or cutting other government programs. The elimination of the Social Security surplus is a key reason that experts are projecting sizable budget deficits in future years.
In 2041 when the Social Security trust fund is exhausted, the program will be collecting enough in payroll taxes to pay 78 percent of current benefits. That is up from an estimate of 75 percent last year. The improvement came in part from an increase the report made in the number and type of immigrants, both legal and illegal, who will be arriving in the country in future years. The higher number boosts the number of people paying into Social Security

[24] A claim for 2 weeks stay was submitted by a facility for a patient who was not even in the facility. When asked whether the patient was on site, the response wsa "Medicare always pays for 2 weeks, whether the patient is there or not."

[25] August 26, 2005 **California Accuses Drug Companies of Fraud** By JOHN M. BRODER

LOS ANGELES, Aug. 25 - The attorney general of California sued 39 drug companies on Thursday, accusing them of bilking the state of hundreds of millions of dollars by overcharging for medicines.

Attorney General Bill Lockyer charged that the drug makers, including some of the world's leading pharmaceutical concerns, defrauded the state's Medi-Cal system for at least the past decade. Mr. Lockyer said the drug manufacturers charged Medi-Cal as much as 10 times the price for some drugs as they charged others, like private pharmacies and hospitals.

Medi-Cal is the state's version of the federal Medicaid program for the poor, which is jointly financed by the states and the federal government. Drug costs account for about $4 billion of Medi-Cal's $34 billion annual budget.

"We're dragging these drug companies into the court of law because they're gouging the public on basic life necessities," Mr. Lockyer said at a news conference here. "This scheme has cost California taxpayers potentially hundreds of millions of dollars and is jeopardizing the public health by diverting money away from patient care."

Mr. Lockyer said that each of the companies made as much as $40 million a year in illegal profits. He said he hoped to recover that amount plus the triple damages allowed under the state's false claims act.

Thursday's legal filing amends a 2003 suit against two drug companies, Abbott Laboratories and Wyeth Pharmaceuticals, to add about three dozen new defendants, including Amgen, Baxter Healthcare, Bristol-Myers Squibb, GlaxoSmithKline, Mylan Laboratories, Novartis and Schering-Plough. It was immediately consolidated in federal court in Boston with similar litigation filed by more than 10 other states and localities, including New York, Texas, Florida and Illinois.

Officials at several drug companies declined to comment.

Mary Anne Rhyne, a spokeswoman for the American subsidiary of GlaxoSmithKline, Europe's largest pharmaceutical company, said that the prices Medi-Cal and other state Medicaid operations pay were standardized and approved by the government. Ms. Rhyne did not deny that different end-users pay widely varying prices for medicines, but said the prices were negotiated with the government and other buyers.

"We follow the law, and we follow government guidelines," she said. "They are fully aware that the government bases payment on the average wholesale price, which represents one of several starting points for negotiation of a reimbursement."

The suit originally arose from a whistle-blower lawsuit filed in 1998 by a Florida pharmacist, who noticed wide discrepancies in prices charged by drug manufacturers. California joined that suit in 2003 and expanded it on Thursday after more investigation. The pharmacist, John Lockwood of Ven-A-Care, a home health care company in Key West, Fla., appeared at the news conference with Mr. Lockyer. "These drugs are far too important to everyone in this country to allow this kind of fraud scheme to continue," Mr. Lockwood said.

California officials cited as an example a pint bag of saline solution used as an intravenous drip manufactured by Abbott Laboratories. The lowest

price available to health care providers was 95 cents, the officials said. Medi-Cal was charged $9.78 for the same item.

"We have an ocean of it," Mr. Lockyer said. "It's called saltwater."

Mr. Lockyer held up a bottle of 50-milligram tablets of Atenolol, a generic high blood pressure treatment manufactured by Mylan Laboratories, for which the state paid $804.70. A pharmacy chain pays $33.85 for the same bottle, he said.

Mr. Lockyer acknowledged that the Medi-Cal system might not always be the most prudent buyer of pharmaceuticals and other medical services. But he said that did not let the drug companies off the hook for what he called an elaborate scheme of fixing prices.

"I wish there had been more aggressive negotiations along the way," Mr. Lockyer said. "Now we have to clean up after the elephant."

[26] Individual Market Deductibles May Be "Substantial."

CQ HealthBeat (4/15,/11 Norman) reports, "The deductibles for the minimum health insurance coverage that some people will be required to buy under the healthcare law could be 'substantial,'" according to a study released by the Kaiser Family Foundation. The study predicts that people "earning below 400 percent of the federal poverty level will be eligible for subsidies, though the highest earners in that group could still face some pretty substantial cost-sharing." Deductibles are estimated in the analysis -- which is "pegged to 2014, the first year of the individual mandate -- to be at least $2,750 for the least comprehensive single plan in the individual and small group market." Meanwhile, the Department of Health and Human Services "has not yet determined what benefits must be included in the plans."

[27] http://en.wikipedia.org/wiki/Stark_Law

Physician self-referral is the practice of a physician referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement. Critics of the practice allege an inherent conflict of interest, given the physician's position to benefit from the referral. They suggest that such arrangements may encourage over-utilization of services, in turn driving up health care costs. In addition, they believe that it would create a captive referral system, which limits competition by other providers. (see physician self-referral)

Congress included a provision in the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) which barred self-referrals for clinical laboratory services under the Medicare program, effective January 1, 1992. This provision is known as "Stark I". The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. A number of observers recommended extending the ban to other services and programs. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid; this legislation, known as "Stark II," also contained clarifications and modifications to the exceptions in the original law. Minor technical corrections to these provisions were included in the Social Security Amendments of 1994.

Passage of Stark II raised a series of concerns on the part of many provider groups. While Stark I and II were intended to remove potential conflicts of interest from physician decision making, a number of persons have argued that the legislation, particularly parts of Stark II, represents an unwarranted intrusion into the practice of medicine. They have stated that the legislation, particularly the provisions relating to compensation arrangements, is too complex and may, in fact, impede physicians' ability to participate in managed care networks.

On November 20, 1995, Congress gave final approval to the conference report on the Balanced Budget Act (BBA) of 1995. President Clinton vetoed the measure on December 6, 1995. BBA included several amendments to the physician self-referral provisions. The two major changes were the repeal of the prohibitions based on compensation arrangements and the reduction in the list of services subject to the ban.

The Federal Register announced that publication of Stark III has been extended until March 26, 2008, and Phase II will remain in effect through that date.
The Phase III final rule was published on September 5, 2007, at 72 FR 51012, and became effective December 4, 2007.
The Stark Law is related to, but not the same as, the federal anti-kickback law.
Lawyers and laypersons can find Stark at [42 U.S.C.S. §1395nn] which is §1877 of the Social Security Act. Additionally, the regulations are at [42 C.F.R. §411.350 through §411.389].
[28] http://www2.census.gov/prod2/decennial/documents/10107945v1pAch02.pdf
Population for the 1960 census.

[29] http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls
Projections by age from 2010 to 2050.
[30] An elderly patient was released from a hospital, to go home. The chart included a comment that the daughter did not pick up the patient. So the hospital moved the patient to assisted living at thousands a day.
[31] **June 8, 2008** Concerned About Costs, Congress Pushes Curbs on Doctor-Owned Hospitals
By ROBERT PEAR

WASHINGTON — For years, Democrats have been trying to stop the proliferation of doctor-owned hospitals, in the belief that they drive up costs by encouraging doctors to order more procedures.

Now Democrats in Congress are moving to impose new restrictions on these for-profit hospitals, but they have carved out exemptions for a few institutions represented by influential senators and well-connected lobbyists.

Senator Patty Murray of Washington, a member of the Appropriations Committee and the Senate Democratic leadership, secured a special dispensation to help Wenatchee Valley Medical Center, in rural Wenatchee, Wash. The provision was included in a bill that was passed recently by the Senate and is coming up soon in the House.

Without Mrs. Murray's help, the hospital says, it might have been forced to close its doors or sell 60 percent of its stock, all of which is now owned by doctors. Mrs. Murray said the hospital deserved an exemption because it was "a bedrock of health care in the local community."

Senator Herb Kohl, Democrat of Wisconsin, persuaded the Appropriations Committee and the full Senate to accept legislative language benefiting Aurora BayCare Medical Center in Green Bay.

The hospital's lobbyists include Theodore H. Bornstein, a former chief of staff for Mr. Kohl, and Bill Broydrick, whose Web site quotes a description of him as "the state's No. 1 super lobbyist."

The Kohl provision would allow the Green Bay hospital to expand by building a new cardiac catheterization laboratory.

The issue often puts lawmakers in the awkward position of having to choose between doctors and hospitals.

Critics say that when doctors have a financial stake in a hospital, they have an incentive to send patients there because they not only receive professional fees for their services, but also can share in hospital profits and see the value of their investment increase. Such arrangements can lead to greater use of hospital services and higher costs for Medicare and other insurers, say the critics, including many in Congress.

On three occasions in the last 10 months, either the House or the Senate has approved legislation that would bar doctors from referring Medicare and Medicaid patients to hospitals in which the doctors have an ownership interest. None of the proposals have gotten all the way through the legislative process.

The House approved the restrictions twice, as part of a child health bill in August and a mental health bill in March. The Senate approved the restrictions last month, in a bill providing money for the Iraq war and various domestic programs.

With the House poised to take up the war spending bill in the next few days, the issue is heating up again.

The special treatment for a handful of hospitals has drawn criticism from conservative Republicans, who support unfettered growth of doctor-owned hospitals, and liberal Democrats, who favor stringent rules with no exceptions.

"If the members of the Senate really believe that specialty hospitals are harmful, then there should not be earmarks protecting the specialty hospitals in home states of certain members of the Appropriations Committee," said Senator Tom Coburn, Republican of Oklahoma.

Representative Pete Stark, the California Democrat who is chairman of the Ways and Means Subcommittee on Health, said he would prefer not to exempt any doctor-owned hospitals.

“Once you start making exceptions,” Mr. Stark said, “everybody lines up and says ‘me too.’ Then you go hospital by hospital, and that’s a political nightmare.”

The White House opposes the limits on doctor-owned hospitals, saying they “could restrict patient choice without decreasing Medicare costs” — a view shared by the American Medical Association.

But Representative Frank Pallone Jr., the New Jersey Democrat who is chairman of the Energy and Commerce Subcommittee on Health, defended the restrictions.

“Physician-owned hospitals are a problem because they are being overutilized,” Mr. Pallone said recently on the House floor. “Physicians are referring patients to these hospitals in many cases for unnecessary procedures.”

The American Hospital Association, which represents 5,000 hospitals of all types, supports the proposal.

Doctor-owned hospitals “create a potential conflict of interest between a patient’s health care needs and the physician’s financial interests,” said Richard J. Pollack, executive vice president of the hospital association. Moreover, he said, doctor-owned specialty hospitals tend to skim off the more profitable cases, “siphoning resources away from full-service community hospitals.”

Many of the newer doctor-owned hospitals have been established by orthopedists, cardiologists and surgeons, who say they are tired of wrangling with hospital bureaucrats and want more control over the quality of care. Doctors say specialty hospitals can be more efficient than general hospitals because they focus on a limited set of procedures.

But the inspector general of the Department of Health and Human Services has found that some doctor-owned hospitals are not equipped to handle complications requiring emergency care.

The government considers a hospital to be doctor-owned if doctors hold any financial stake in it. Many are built through joint ventures, with the doctors’ share in the range of 45 percent to 50 percent.

Dr. David L. Weber, chief executive of the Wenatchee Valley Medical Center, said the proposed restrictions “would be devastating to our hospital” without the exemption obtained by Mrs. Murray.

The 20-bed Wenatchee hospital is the hub of a rural health care network serving a region of 12,000 square miles, Dr. Weber said. While the hospital does not have an emergency department, he said, it is "in the process of building one, so we will be more of a full-service hospital."

The Senate bill, like the House version, generally prohibits doctor-owned hospitals from expanding their capacity by adding beds or operating rooms. But it makes an exception for hospitals that meet five criteria dealing with factors like local population growth and the ratio of hospital beds to population in the state.

Industry experts estimate that only eight or nine hospitals, including the one in Green Bay, could meet these criteria.

Rohit Mahajan, a spokesman for Mr. Kohl, said the senator generally supported efforts to limit doctor-owned specialty hospitals. But in imposing such limits, he said, Congress must not cripple full-service hospitals like Aurora BayCare.

Mr. Stark said that if doctors did not like the proposed restrictions, they could sell their interest in a hospital to other investors, nonprofit groups or foundations.

But Representative Michael C. Burgess, a Texas Republican and an obstetrician-gynecologist, said Congress should "keep its hands off" doctor-owned hospitals.

"This is a free country," Mr. Burgess said. "If you want to invest in a hospital, if you are willing to put personal capital at risk, you should not be forbidden to do so just because you are a doctor."

32

July 7, 2008
Doctors Press Senate to Undo Medicare Cuts
By ROBERT PEAR
WASHINGTON — Congress returns to work this week with Medicare high on the agenda and Senate Republicans under pressure after a barrage of radio and television advertisements blamed them for a 10.6 percent cut in payments to doctors who care for millions of older Americans.
The advertisements, by the American Medical Association, urge Senate Republicans to reverse themselves and help pass legislation to fend off the cut.
How to pay doctors through the federal health insurance program is an issue that lawmakers are forced to confront every year because of what is widely agreed to be an outdated reimbursement formula. But the dispute, which showcases the continued potency of health care issues, has reached a

new level of urgency this year. Some doctors are reassessing their participation in the program and powerful interests on all sides are in a lobbying frenzy.

Just before the Fourth of July recess, the House passed a bill to prevent the Medicare pay cut by a vote of 355 to 59. In the Senate, Republicans blocked efforts to take up the bill, so the cut took effect on July 1, as required by the formula. But the Bush administration has delayed processing of new claims to give Congress time to come up with a compromise.

Senator Harry Reid of Nevada, the majority leader, said he planned to force another vote this week, and Democrats pressed their case over the weekend in their national radio address.

Democrats need just one more vote to pass the bill, and they hope to win over Republicans who were hit by advertisements over the recess. The advertisements assert that Republicans have been protecting "powerful insurance companies at the expense of Medicare patients' access to doctors." The commercials were aimed at 10 Republican senators, including seven up for election this fall.

But President Bush has vowed to veto the bill, so the fight — and the uncertainty — could continue for weeks.

Mr. Bush and many Republicans oppose the bill because it would finance an increase in doctors' fees by reducing federal payments to insurance companies that offer private Medicare Advantage plans as an alternative to the traditional government-run Medicare program.

Insurance companies and the White House argue that the bill would hurt beneficiaries who rely on private Medicare plans. America's Health Insurance Plans, a trade group, ran television advertisements last week, urging Congress to "stop cuts to Medicare Advantage."

Medicare is just one issue on which Congress is stalled. The Senate has yet to finish work on a bipartisan bill to help homeowners facing foreclosure. Lawmakers are also struggling with legislation to regulate electronic surveillance and deal with soaring gasoline prices.

But the Medicare issue has been a sticking point for years. The question is how to rein in the rapidly rising cost of the federal health program. Members of both parties say they want to change the formula, which defines a "sustainable growth rate" for spending on doctors. But Congress is nowhere near agreement.

The pending bill offers a short-term fix. It would reverse the 10.6 percent cut and increase Medicare payments to doctors by 1.1 percent in January. Under the current formula, doctors would still face cuts of more than 5 percent a year from 2010 to 2012.

Despite the president's veto threat, many House Republicans bolted and voted for the bill, putting added pressure on their colleagues in the Senate.

As the maneuvering goes on in Washington, doctors around the country have begun to reassess their participation in Medicare.

Dr. David D. Richardson, 40, an ophthalmologist in Los Angeles County, closed his practice last week to all but emergency patients and those needing surgery.

"I love practicing medicine," Dr. Richardson said, "but I would lose more money by keeping my office open than by pulling it back to a skeleton crew. Just like a physician in the emergency room, I try to reduce the hemorrhaging."

In Topeka, Kan., Dr. Kent E. Palmberg, senior vice president and chief medical officer of the Stormont-Vail HealthCare system, said its 70 primary care doctors were "no longer accepting new Medicare patients as of July 1 because of the draconian cut in Medicare reimbursement."

Dr. Gerald E. Harmon, a family doctor in Pawleys Island, S.C., said he decided last week that he would not take new Medicare patients "until further notice."

"This is not what we enjoy doing," says a notice in his waiting room. "It is what we must do to maintain financial viability."

Dr. Harmon said that Democrats had been more helpful on Medicare legislation, but that the two parties shared responsibility for the impasse.

"Rome is burning, and Nero is fiddling away, trying to get re-elected," Dr. Harmon said.

Doctors have also entered the political arena. One made a direct appeal to Mr. Bush at a fund-raiser last week in Jackson, Miss. Dr. J. Patrick Barrett, a spine surgeon and president of the Mississippi State Medical Association, said he had told Mr. Bush that the Medicare pay cut would be "extremely detrimental to the health and welfare of the elderly population."

In an interview, Dr. Barrett said: "I lose money whenever I operate on a Medicare patient. In the last week, a number of doctors have told me they will quit seeing new Medicare patients or will cut back on the amount of Medicare work they do."

The A.M.A.'s advertisements focus on Senators John Cornyn of Texas, John E. Sununu of New Hampshire and Roger Wicker of Mississippi, among others.

Republicans defend their position in various ways. Mr. Cornyn said the bill provided only "a patchwork fix." Senator Charles E. Grassley of Iowa said Democrats were playing "partisan games."

Senator Jon Kyl of Arizona, the Republican whip, said, "Nobody wants to cut physicians' pay." But lawmakers disagree over how to cover the cost of remedial legislation.

More than 10 million of the 44 million Medicare beneficiaries are in private Medicare Advantage plans offered by companies like Humana, UnitedHealth and Coventry Health Care. Many of these plans offer extra benefits like vision and dental care. But independent studies have repeatedly found that the private plans cost the government more per person than traditional Medicare.

Expecting the battle to resume this week, Coventry Health Care, in an e-mail message dated July 3, asked insurance agents across the country to call Congress and oppose the pending Medicare bill, saying that it would be "harmful to beneficiaries."

On the other side of the issue, military families have joined doctors and AARP, the advocacy group for older Americans, in lobbying for the bill. Relatives of active-duty military personnel, military retirees and their dependents receive care under a federal program known as Tricare, which uses the Medicare fee schedule to pay doctors.

When Medicare reduces payments to doctors, fees under the military program are also reduced, and it becomes more difficult for military families to find doctors.

Congress is "playing chicken with your health care," the Military Officers Association of America told its members in a bulletin last week.

Medicare receives 15 million claims a week for services paid under the physician fee schedule, so any change in payment rates has big implications. Michael O. Leavitt, the secretary of health and human services, said he would try to "minimize the impact" of the cut by instructing Medicare contractors to hold claims for 10 business days.

Kerry N. Weems, the acting administrator of the Centers for Medicare and Medicaid Services, said doctors would not be paid at the lower rates "before July 15 at the earliest."

However, Medicare officials said, that is simply what the law requires. Under existing law, claims cannot be paid sooner than 14 days after they are received. And if claims are filed on paper, rather than electronically, they cannot be paid sooner than 29 days after they are received.

[33] April 28, 2008 Congress Near Deal on Genetic Test Bias Bill New York Times.

By ANDREW POLLACK Congress reached an agreement clearing the way for a bill to prohibit discrimination by employers and health insurers on the basis of genetic tests.

Senator Tom Coburn, an Oklahoma Republican who had been almost single-handedly holding up action on the bill, said in an interview Tuesday that most of his concerns had been resolved and predicted that the bill would pass soon.

Senator Edward M. Kennedy, who is chairman of the Senate Health Committee, said a bipartisan agreement had been reached to move the bill to the Senate floor.

Proponents say the new law, more than a dozen years in the making, would help usher in an age of genetic medicine, in which DNA tests might help predict if a person is at risk of a disease, allowing action to be taken to prevent it.

Some of the tests already exist, like one for breast cancer risk, and new ones are being introduced almost every month. But backers of the legislation say many people are afraid of taking such tests because they fear the results would be used to deny them employment or health insurance.

“This bill removes a significant obstacle to the advancement of personalized medicine,” said Edward Abrahams, the executive director of the Personalized Medicine Coalition. His group is an organization of drug and diagnostic companies, academic institutions and patient groups that advocate using genetic information to choose the most appropriate treatment for each patient.

The agreement would end a 13-year odyssey for the bill, first proposed in 1995 by Louise Slaughter, a House Democrat from western New York, who has been promoting it ever since.

The bill, called the Genetic Information Nondiscrimination Act, or GINA, has had broad support in Congress but has never managed to pass both houses in the same session.

It passed the Senate by votes of 95 to 0 in 2003 and 98 to 0 in 2005 but was kept from a vote in the House by Republican leadership. Last year, with Democrats newly in control, the House approved the bill 420 to 3. But this year Senator Coburn had placed a hold on the bill, preventing the Senate from voting on it.

One of Senator Coburn’s main concerns was that the bill might subject employers to civil rights lawsuits stemming from disputes over medical coverage. And employers that also finance their own health insurance, he said, might be sued twice. “We would have created a trial lawyers’ bonanza,” he said.

Senator Coburn, a medical doctor, had called for a "firewall" between the employer and insurance sections of the bill. "We withstood all the criticism we got from lots of people, and now we got it fixed," he said.

Proponents of the bill say the negotiated changes do not affect the substance of the legislation.

Harry Reid, the Nevada Democrat who is the Senate majority leader, sent an e-mail message to his colleagues Tuesday asking for unanimous consent to bring the bill forward to the Senate floor. Debate would be limited to two hours, with only one amendment being offered to reflect the agreed-upon changes.

Olympia J. Snowe, Republican of Maine, who has been a leading sponsor of the legislation in the Senate, called on her colleagues Tuesday to pass it. "More than a decade after we began the effort to protect Americans from genetic discrimination, the Senate is finally poised to see the fruition of those efforts," she said in a press release that quoted another senator describing GINA as "the first civil rights act of the 21st century."

President Bush has indicated that he supports the bill, although the White House has expressed concerns, citing among other things the need for a firewall. Those concerns have also been dealt with in recent negotiations, Congressional staff members said.

GINA would make it illegal for health insurers to raise premiums or deny coverage based on genetic information, and would prohibit employers from using such information for decisions on hiring, firing, promotions or job assignments.

Genetic information, for the law's purposes, would include not only tests that determine variations in a person's DNA, but also a family history of a particular disease.

But GINA does not prohibit discrimination once someone already has a disease, and some experts said such protection would have to be the next step.

"You don't want to be denied health insurance when you are at risk for breast cancer," said Sonia M. Suter, an associate professor at George Washington University Law School. "But it seems to me you really don't want to be denied health insurance when you have breast cancer."

The bill is expected to help mainly those applying for individual health insurance policies. That is because existing federal law already prohibits group insurance plans from discriminating against an individual based on genetic information.

Some 35 states have laws against genetic discrimination in employment and 47 have them against discrimination in health insurance, according to an article in The New England Journal of Medicine last year by Kathy Hudson, director of the Johns Hopkins Genetics and Public Policy Center in Washington. But the laws vary widely. It is not clear whether the new federal law would take precedence.

Some groups representing businesses opposed GINA, saying it was an unnecessary and costly burden on employers. They said that such discrimination was not a problem and that there had been no cases brought under any of the state laws.

“We do certainly think that this legislation is a solution in search of a problem,” said Michael J. Eastman, executive director for labor policy at the U.S. Chamber of Commerce, a business lobbying group.

But backers of the bill say such cases have occurred, although the people involved often do not come forward.

Moreover, they say, genetic testing is in its infancy. Just in the last several months, companies like Navigenics, 23andMe and Decode Genetics have started to offer scans of a person’s entire genome, looking for signposts that might signify risks of various diseases. In less than a decade it could become affordable to determine one’s entire DNA blueprint.

Supporters of the bill say that fear about misuse of genetic information has also discouraged people from participating in studies aimed at finding new genes that carry disease risk. Francis S. Collins, the director of the federal government’s National Human Genome Research Institute, told Congress last year that about a third of people with family history of a disease declined to participate in such research at the National Institutes of Health.

Health insurers have generally expressed support for the bill, with some reservations. They say the bill might interfere with their ability to request certain genetic tests — like ones that would help determine the best treatment for a patient.

“There are appropriate uses of information, there are appropriate questions to ask, as long as there is no discrimination,” said Mohit Ghose, spokesman for America’s Health Insurance Plans, a lobbying group for the health insurance industry.

Some experts, while welcoming the bill, said it did not go far enough.

Mark A. Rothstein, director of the bioethics institute at the University of Louisville School of Medicine, said GINA did not cover life insurance and long-term care insurance and that there already were legal ways for prospective employers to gain a job candidate’s health information.

"GINA promises more than it delivers," he said.

[34] Dow Jones Newswire (5/20/2011, Brin, Subscription Publication) quotes AHIP President Karen Ignagni as saying, "'Focusing on health insurance premiums while ignoring underlying medical cost drivers will not make healthcare coverage more affordable for families and employers. The public policy discussion needs to be enlarged to focus on the soaring cost of medical care that threatens our economic competitiveness, our public safety net, and the affordability of healthcare coverage."

[35] OMHA has an annual budget of about $65 million (2005-2011_, and conducts about 13,000 hearings from about 30,000 appeals.

[36] Atlanta Hospital Worker Exposed Nearly 700 Patients, 100 Employees To TB.
CNN (5/27/2011) reported that nearly "700 patients at Emory University Hospital in Atlanta have been exposed to tuberculosis after coming in contact with a hospital employee carrying the disease," hospital spokesperson Lance Skelly said Thursday. He said the Georgia Department of Community Health and the hospital have "identified 680 patients who were exposed to tuberculosis between November and February."

The Atlanta Journal-Constitution (5/28, Williams) noted that an "additional 100" hospital employees were also "exposed by a respiratory technician who unknowingly carried the disease." The worker, who had a "persistent cough for weeks, was diagnosed April 17," according to Skelly. The Los Angeles Times (5/27, Cevallos) "Shots" blog also covered the story.

[37] https://townhall.com/columnists/kurtschlichter/2017/03/02/president-trump-needs-to-keep-his-promises-no-matter-how-hard-the-haters-squeal-n2292429

This much is clear – if President Trump (Oh, how I love the sweet agony just uttering those syllables causes annoying people) fails to keep his word, he's toast. And he should be – we've spent decades being lied to, bamboozled, and swindled by both fork-tongued liberals and fake "conservatives." There's no more slack to give; we're done with leeway and wiggle room. The president has two choices: Keep his promises, or fail disastrously. And it looks like he's going with the former and winning.
Your joint address killed, Mr. President. By coming in there cool, collected, and competent, you reset the chessboard. Pelosi looked like she was going to plotz; the GOP now has tons of footage of white-clad Dems – sans the distinctive hoods of their party forefathers – refusing to applaud for jobs, for cops, for putting Americans ahead of foreigners, and for our troops and Gold Star families. See ya in 2018, suckers.
The Democrats and the GOP squishboyz desperately wanted to oppose a buffoon. Tuesday night, they found that instead they are opposing a president.
America is behind your plan. Even your opposition knows it; the Dem pain was compounded when they let their response be delivered by that guy from Heaven's Gate. Can you imagine the Crown Royal-fueled tirade in Chateau Hillary? Can't you just see Bill Kristol the next morning, unshaven and in his bathrobe, wandering through his mansion muttering about how he still prefers rule by the Deep State?
Their pain is fun, but now America expects you to perform. Get it done. And in the process, win yourself another term and go down in history loved by the real people, and unloved by all the right people.
Here's the thing, Mr. President: Everybody is going to be telling you why you can't do what you promised to do up there on the dais, and failing that,

why you shouldn't even try. They'll smoothly offer you reasonable, rational explanations about why you absolutely must break your promises. And they'll sound good, because lying is what they do. That's all they do.
Don't let them do you.
There are a thousand plausible-sounding excuses for not repealing Obamacare. There is one reason why you must – because you said you would, over and over again. The media is going to tell you that you can't – it'll wheel out a nonstop conga line of whiny deadbeats afflicted with the sadz because people who actually work for a living are going to stop having to subsidize their effort-free lifestyle. When it does, ask the first question the rest of us would ask: "Well, does Freddie Freeloader have a cell phone? How about a big screen? Is there an Xbox in his apartment? Because if so, then what Freddie really wants is not for us to pay for his health insurance. He could pay for that if he wanted. He wants us to pay for his toys, and the normals are sick of sweating so that some shiftless couch-tater doesn't have to."

The media will spaz out. We'll cheer.
The liberals will go more insane than usual when you dismember the walking corpse that is Obamacare. Just ignore them. You could stop on your way to cure cancer and rescue the kids' puppies from a burning orphanage and they'd still shriek that you're the same as Hitler because he liked dogs too.
A bunch of pseudocons in Congress will try and talk you out of it, and if you were weak and stupid, you would listen. But I don't think you're either. They'll whisper, "Oh, we can't repeal Obamacare because we have to replace it with something that we didn't bother coming up with in the seven years we spent campaigning on repealing it. Also, some people might show up at our town halls and be mean to us and make us wet our collective panties."
Reject the cowardly counsel of these gutless femboys – the GOP caucus is the Atlanta Falcons of American politics, perpetually shouting "Hold my Zima!" and then proving that yes, they are, in fact, that dumb. If they are so stupid as to think dinguses who show up in a Louisiana town hall and boo Jesus are anything but leftist plants – because hating on the Lord is totally a Bible Belt thing – then you shouldn't bother trying to reason with them. Grab a whip and a chair, get on Air Force One, and fly to the district of the wimpiest Obamacare-appeaser you can find, then hold a rally for his primary opponent. If they won't back you out of principle, make them back you out of sheer political terror. But make them back you. Break them. And get Obamacare repealed.

The same with the wall. Build it. And the military. Rebuild it. You know what our main ground combat systems were when I entered basic training on 1 December 1987? The M1 Abrams tank and the M2 Bradley infantry fighting vehicle. Guess what they are today? The M1 Abrams tank and the M2 Bradley infantry fighting vehicle. And when you get the production lines for planes and ships going again, show up, shake those American workers' hands and take credit for another thing you promised – jobs.
Don't expect help from the media making your accomplishments known. [**], don't even expect the media to merely not do its job. Expect the media to actively behave as the collection of partisan Democratic hacks it is and try to distract the people from what you achieve when it's not outright lying about you. Breaking News: "Oh my gosh, Steve Bannon placed his salad fork on the wrong side of the plate! And don't pay attention to the Ford or Monsanto jobs President Trump saved."
On family leave, well, I'd prefer you had not made that promise, but you did. On infrastructure, well, not necessarily my cup of tea. But you promised it, and those workingmen Obama and Co. dissed and dismissed want to get out there doing their hard, vital jobs again. You gotta do it – and when you do, you can show them how a pro builds. Obama's stimulus was giving free money to his progressive parasite pals. Mr. President, fix our roads and you'll fix the liberals for a generation – in the way a boy dog gets fixed by a veterinarian.

On immigration, keep deporting. Ignore the media and the Fredocons' wishcasting that you're on the verge of betraying us whenever you mention you would like to find a solution to the problem. You know, and we know, that amnesty would gut your support. You'd lose us overnight. That's why your refusal to betray us will fill your opponents with sadness – call their sorrow a fringe benefit.
The days of equivocation and deceit are done. Mr. President, you can either fail to keep your word and go down as history's biggest loser as our country literally splits apart, or keep your word and be remembered – by the people, if not by the displaced and furious elites you've beaten – as the greatest winner since Ronald Reagan.
Come on Mr. President, keep your promises. Make us tired of all the winning.

[38] **The Anatomy of Health Care in the United States from JAMA by Hailton Moses (et al)**
http://jama.jamanetwork.com/article.aspx?articleid=1769890
[39] **By Harold Brubaker, Inquirer Staff Writer**
POSTED: JULY 28, 2014
In a bid to cut Medicare spending and help pay for health-care changes, the Obama administration has significantly expanded audits designed to recover improper payments from health-care providers.
"We are taking, I would say, a brutal spanking, those that are fully compliant and within regulation," said Tim Fox, founder and chief executive of Fox Rehabilitation, a Cherry Hill company that provides physical therapy and other services to the elderly.
"It's dead easy to commit fraud under Medicare, and that's why there's so much fraud and abuse out there," Fox said. He said the government was "cracking down" to help pay for the expansion of health coverage under the Affordable Care Act.
The government has to "recoup those dollars from somewhere, so what they're going to do is fight and recoup dollars in fraud and abuse," said Fox, whose firm employs 905, including 709 clinicians who visit patients in their homes in eight states.
The experience at Fox Rehab, founded in 1998, is just one example of how the Affordable Care Act is roiling the industry, forcing providers to find new ways to do things with less.
At a significant cost, Fox said, his company is fighting back against payment denials and winning 85 percent of its cases at the third level of appeal, but the increase in audits in 2012 was followed last year by a 15 percent cut in Medicare reimbursements for outpatient physical therapy.
The combination resulted in tight cash flow at Fox Rehab, where 62 office workers were laid off and therapists took a 5 percent pay cut. The company expects to have about $90 million in revenue this year.
Fox said he considered bringing in private equity to shore up the company, but rejected what he called low-ball offers. Instead he got additional financing from TD Bank.
"TD Bank continued to support us, and worked very well with us," he said.
The bulk of Fox Rehab's patients are heavy utilizers of medical services, which puts the company in the crosshairs of officials bent on eliminating wasteful spending.
The Centers for Medicare and Medicaid Services, the division of the U.S. Department of Health and Human Services that administers Medicare, employs an alphabet soup of auditors to make sure that hospitals and other health-care providers don't overcharge Medicare.
$604 billion

The stakes are high. Medicare covered 51 million seniors and disabled Americans in 2013 at a cost of $604 billion. In fee-for-service Medicare, which allows health-care providers to bill for individual services and is the program under which outpatient therapy is provided, improper payments were estimated at $36 billion, or 10.1 percent of total expenditures in that category.
One group of auditors, known as recovery audit contractors, have the authority to issue payment denials for bills that are up to three years old. Those contractors get to keep a cut - typically 12.5 percent - of what they recover for Medicare.
A recent report by the staff of the Senate Special Committee on Aging criticized the incentives for recovery audit contractors, which are known as RACs. The committee would like to see more emphasis on improving billing practices.
"The RAC incentive structure is not based on reducing future improper payments, but on recovering past improper payments. This could be viewed as providing an incentive to keep improper payment rates high," the report said, rather than eliminating improper billing in the first place.
At a July 9 Senate Special Committee on Aging hearing, an official from one of the RACs defended the program, which started in 2009.
$8 billion recovered
"Mirrored after successes realized in the private sector, recovery auditors have together returned more than $8 billion in overpayments to the Medicare Trust Fund," said Chad Janak, a vice president at Connolly L.L.C., based in Wilton, Conn.
Medicare officials have proposed changing the recovery audit contractor program to delay auditor payments to as long as 400 days. Under current contracts, the auditors are paid no longer than 120 days from when they uncover what they consider an improper payment.
In a twist, Medicare started in April 2013 to require RACs to conduct prepayment audits on bills filed by outpatient-therapy companies, a move away from the traditional "pay-and-chase" mentality. That means auditors constantly ask for additional documentation, prior to issuing payments to therapists.
"The requests come in daily in a large volume," said Kim Baker, practice compliance officer and director of program integrity at Fox Rehabilitation.
That puts further financial pressure on providers - because they now must wait longer for payment. That delay means the company has to have more money on hand to pay for day-to-day operations, one of many difficult changes for Fox Rehab.
"We are not the same organization that we were three years ago," Fox said.

Audited Claims
The number of Fox Rehab payment claims being audited has jumped because of new efforts to recoup improper payments.

Year	**Audited Claims**
2011	503
2012	4,709
2013	19,736

SOURCE: Fox Rehab hbrubaker@phillynews.com 215-854-4651

[40] April 23, 2012
Insurers Alter Cost Formula, and Patients Pay More
By NINA BERNSTEIN
Despite a landmark settlement that was expected to increase coverage for out-of-network care, the nation’s largest health insurers have been switching to a new payment method that in most cases significantly increases the cost to the patient.

The settlement, reached in 2009, followed New York State's accusation that the companies manipulated data they used to price such care, shortchanging the nation's patients by hundreds of millions of dollars.

The agreement required the companies to finance an objective database of doctors' fees that patients and insurers nationally could rely on. Gov. Andrew M. Cuomo, then the attorney general, said it would increase reimbursements by as much as 28 percent.

It has not turned out that way. Though the settlement required the companies to underwrite the new database with $95 million, it did not obligate them to use it. So by the time the database was finally up and running last year, the same companies, across the country, were rapidly shifting to another calculation method, based on Medicare rates, that usually reduces reimbursement substantially.

"It's deplorable," said Chad Glaser, a sales manager for a seafood company near Buffalo, who learned that he was facing hundreds of dollars more in out-of-pocket costs for his son's checkups with a specialist who had performed a lifesaving liver transplant. "I could get balance-billed hundreds of thousands of dollars, and I have no protection."

Insurance companies defend the shift toward Medicare-based rates under the settlement, which allowed any clear, objective method of calculating reimbursement. They say that premiums would be even costlier if reimbursements were more generous, and that exorbitant doctors' fees are largely to blame.

But few dispute that as the nation debates an overhaul aimed at insuring everybody, the new realpolitik of reimbursement is leaving millions of insured families more vulnerable to catastrophic medical bills, even though they are paying higher premiums, co-payments and deductibles.

"They're not getting what they think they're paying for," said Benjamin M. Lawsky, the superintendent of the New York State Department of Financial Services, whose investigators recently found that under the switch, 4.7 million New York State residents — 76 percent of those with out-of-network coverage — are facing reimbursement reductions of 50 percent or more.

The switch "certainly creates the appearance that insurers are trying to end-run the settlement and keep out-of-network payments low," Mr. Lawsky said.

Mr. Lawsky, who worked for Mr. Cuomo when he was attorney general, is seeking legislation in New York State to require that minimum reimbursements be linked to the new database, known as Fair Health.

In the 2009 settlement, the insurers did not admit wrongdoing. But they paid to set up Fair Health as a replacement for Ingenix, a database owned by the insurance giant United Healthcare. Mr. Cuomo said Ingenix had consistently understated local "usual and customary" rates — so-called U.C.R.'s — that were used nationally to determine how much of a bill was paid when a patient used an out-of-network doctor.

Fair Health collects billions of bills from insurers to calculate a usual fee for each medical procedure in a given locality. But increasingly, reimbursement is not based on such prevailing rates.

"This shift is mirrored across the country, and the implications in terms of declines in reimbursement are similar," said Rob Parke, a benefits expert at Milliman, an international actuarial and consulting firm.

The level of reimbursement varies by plan, pegged to benchmarks unknown or misunderstood by many consumers. The traditional benchmark was 80 percent of the U.C.R., while newer ones mostly range from 140 percent to 250 percent of Medicare rates. That sounds like more, but typically amounts to less, and is drastically below charges in large, emergency out-of-network bills.

Depending on the plan, insurers may cover 60 percent to 80 percent of the benchmark sum; the patient is not only responsible for the rest but also for any outstanding balance, to which out-of-pocket maximums do not apply. The average emergency bill that insurers reported to state investigators, for example, totaled $7,006, or 1,421 percent of the Medicare rate, and left patients owing an average of $3,778.

Fair Health's Web site allows consumers to compare likely out-of-pocket costs. Mr. Glaser, who joined Fair Health's consumer advisory board last month after seeing his reimbursement drop, gained his knowledge of health insurance the hard way.

When his son, Ethan, was a baby, doctors said he had a rare liver disease. The family, which was in a health maintenance organization, had to appeal three times to get approval for the out-of-network surgery that saved the boy, now 10. So Mr. Glaser was overjoyed two years ago when his employer switched to a preferred provider organization that promised out-of-network coverage. Including premiums and deductibles, he and his employer pay about $14,600 a year for family coverage.

But he discovered that at 150 percent of Medicare rates, it fell far short. In the case of a $275 liver checkup, for example, the balance due was $175, almost three times the patient share under Fair Health's customary rate, and three and a half times what it was five years ago under Ingenix.

If Ethan had to repeat the $200,000 transplant, which used some of his father's liver in 2003, the plan would pay little of the cost under the Medicare formula. Laws protecting consumers from extra out-of-pocket costs apply only to H.M.O.'s, which require prior approval to go out of network.

"I wish I could tell you that's a unique case," said Sandy Praeger, who is chairwoman of the health insurance committee of the National Association of Insurance Commissioners and is Kansas' insurance commissioner. She said consumers were caught in the middle of a battle between insurers demanding discounts and doctors who resist by billing more than they expect to get paid — a conflict intensified because Medicare tilts its payments toward primary care, while most people go out of network for specialists.

"For some things, Medicare is really a poor payer," she said. "So if that's the benchmark, that just magnifies the problem."

United Healthcare referred questions about the switch to the New York Health Plan Association, an insurance trade group, whose president, Paul F. Macielak, said the Fair Health database was inflated by a subset of physicians. "In an ideal world, everyone would be in network, subject to a contracted rate," Mr. Macielak added.

Doctors, however, complain that insurers are pressuring physicians to join networks by slashing outside reimbursement.

"They want to get them trapped, and then limit care," said D. Brian Hufford, a lawyer who represented physicians in major class action lawsuits against Ingenix. "They're simply trying to shift all the risks to the doctors while they take all the profits."

Mark Wagar, the president and chief executive of Empire Blue Cross, which is rapidly switching to Medicare benchmarks, said the concerns were exaggerated, since all but 5 percent of medical care takes place in network.

"It's the tail wagging the dog," he said of Mr. Lawsky's proposed legislation to set minimum reimbursement.

Jennifer C. Jaff, founding director of Advocacy for Patients with Chronic Illness, uses her own case as an example of the fallout.

Ms. Jaff, 54, said she maintained out-of-network coverage with $14,000 in annual premiums because she has Crohn's disease and is at high risk of colon cancer, which killed three of her grandparents. Last year, after a terrible experience with an in-network doctor in 2010, she said, she returned to a top specialist at NewYork-Presbyterian Hospital who had performed her colonoscopy and upper endoscopy in 2008, coping with scar tissue from her eight abdominal surgeries.

Even with 250 percent of Medicare rates as the benchmark, Ms. Jaff owed four times more than she had paid when Ingenix rates were in effect, or $3,137 of a $4,200 doctor's bill that had increased by only 13 percent.

Separately, her insurer, Anthem Blue Cross of Connecticut, paid a $7,806 "facilities fee" to the hospital, about double what the hospital had billed, under a flat rate negotiated by Empire, Anthem's affiliate in New York.

"Is that not nuts?" Ms. Jaff asked.

Mr. Wagar, of Empire, defended the practice, saying it kept down premiums over all. An Empire spokeswoman noted that Ms. Jaff's specialist had charged double the median price of a colonoscopy in New York City, which the Medicare formula almost covers.

As for the upper endoscopy, the Medicare formula covered only half the median price; it was halved again, Empire said, to $220 of the $1,860 bill, under new rules that restrict payment when two procedures are done at the same time, to prevent overbilling for patients prepared and sedated only once.

"There's not a doctor in Manhattan that would have done that endoscopy for $220," Ms. Jaff protested. "They're not using anything that's tied to reality

[41] http://www.fixodent.com/

[42] www.**poligrip.com**/faqs.aspx

[43] Judge Orders Fresenius To Pay $82.6 Million To Resolve Medicare Overbilling Lawsuit.
The AP (5/27/2011) reports, "A federal judge in Nashville awarded the US government $82.6 million on Thursday from three companies in a Medicare fraud case initiated by whistleblowers." US District Judge William J. Haynes Jr. ruled that Fresenius, and two companies it now owns, "'exhibited reckless disregard of legal mandates' in billing the Medicare program for home dialysis supplies."

Bloomberg News (5/26, Voreacos, Fisk) reported that Germany-based Fresenius, the "world's biggest provider of kidney dialysis," was ordered to pay "trebled damages of $38.9 million under the False Claims Act and statutory penalties of $43.7 million." The lawsuit claimed that Fresenius and "Renal Care Group and Renal Care Group Supply Co., overbilled Medicare between 1999 and 2005 for home support dialysis supplies." Fresenius spokesperson Terry Morris "said the company just received the decision and would issue a statement."

[44] Sleep Therapy Company Will Pay $650K To Settle Medicare False Claims Case.
The AP (5/27) reports that Department of Justice officials said Thursday that Areté Sleep LLC, Areté Sleep Therapy LLC and Areté Holdings LLC will "pay $650,000 to settle allegations that its sleep medicine and durable medical equipment facilities in Arizona and Texas submitted false claims" to Medicare from "Nov. 1, 2002 through Dec. 31, 2009." Prosecutors say the claims were for "diagnostic sleep tests performed by technicians lacking the licenses or certifications required by Medicare rules and regulations." Federal authorities say Areté, which "filed for Chapter 11 bankruptcy" protection in January, has "agreed to pay the settlement from the proceeds of the sale of its assets."

[45] http://www.dcexaminer.com/local/011309-529_medical_errors_reported_during_12-month_period_in_DC.html
529 medical errors reported during 12-month period in D.C. By Bill Myers Examiner Staff Writer 1/13/09
D.C. doctors sliced open the wrong breast on a cancer patient, operated on the wrong part of a patient's spine, sewed up patients with needles and sponges still inside and tried to revive a stricken patient with a broken ventilator, a new city report has found. There were at least 529 "adverse events" in District hospitals and clinics in the 12 months between July 2007 and June 2008, the city Department of Health's annual report has found. At least 14 of these errors cost a patient his or her life, the report found. More than **1 million people are killed or injured by medical errors in the United States every year**. In 2006, D.C.'s council required the department of health to gather data on medical mistakes from hospitals and clinics in the hopes that local doctors and staff could learn from others' errors. Nearly three-fourths of the mistakes occurred in city hospitals, the recently released report concluded. Many of the "events" were the result of paperwork errors. The report provides a brief snapshot of a woman who was scheduled for a right breast biopsy but someone wrote down the left breast.
An attendant in the operating room told the surgeon about the error, but the surgeon didn't hear. Faulty equipment also took its toll. One patient went into respiratory distress while recovering from surgery. Staff hooked the patient up to a ventilator, but the machine was broken. The patient died. At least seven people died because they were given the wrong medicine, or the wrong dose of medicine, the annual report found. A mother died in childbirth — during an otherwise low-risk Caesarean section — because the hospital "did not identify risk reduction strategies," the annual report

found. The annual report may be just the tip of the iceberg: The Department of Health reported that only 10 of 15 hospitals participated in the report; only two of 21 nursing homes participated.

[46] Hospitals Under Increased Pressure To Reduce Preventable Infection Rates.

On its "Weekend Edition Saturday" program, NPR (5/28/2011, Varney) reported that although it has been "more than a decade since a panel of top scientists declared hospital safety" as a national priority, about "90,000 patients still die each year from preventable infections resulting from routine surgeries and hospital care," according to the Centers for Disease Control and Prevention. However, under legislation in more than "two dozen states and new Medicare rules that went into effect earlier this year," hospitals are now required to report infections "or pay a penalty. That's left hospital administrators weighing the cost of 'fessing up against the cost of fines."

[47] HHS Issues Final Rules On Health Insurance Rate Reviews.

The Los Angeles Times (5/20/2011 , Helfand) reports that under new rules (pdf) issued Thursday by the Obama Administration, health insurers will be "required to justify annual premium increases of 10% or more to state regulators." Federal officials, "pointing out that the average cost of health insurance has more than doubled over the last decade, said the effort would help states curb unreasonable rate proposals for millions of individual insurance buyers and small businesses."

According to The Hill (5/20, Baker) "Healthwatch" blog, HHS will "review all rate increases of 10 percent or more. If the department finds an increase to be excessive, the insurer will have to disclose its justification for the hike." The regulation implements a provision of the healthcare reform law that "allows HHS to review insurers' proposed rates, but the new law does not give HHS any power to block increases from taking effect."

The New York Times (5/20, A16, Pear, Subscription Publication) reports, "Starting in September 2012, the federal government will set a separate threshold for each state, reflecting trends in insurance and healthcare costs." Federal officials "acknowledged that they did not have the authority to block rates that were found to be unjustified," but they noted that many states already have that authority. Moreover, the federal government is "providing $250 million to states to strengthen their capacity," although a few states opposed to the federal healthcare law "have turned down the money."

Bloomberg News (5/20, Armstrong) reports that the rules were "prompted partly by a proposal from the California subsidiary of Indianapolis-based WellPoint to raise rates as much as 39 percent in 2010." After an investigation by California's insurance commissioner, the "underlying calculations were found to be incorrect and WellPoint cut the increase in half. ... 'Effective rate review works...by protecting consumers from unreasonable rate increases and bringing needed transparency to the marketplace,'" said HHS Secretary Kathleen Sebelius in a statement announcing the rules. The announcement will be a disappointment to health insurance industry. America's Health Insurance Plans had been lobbying for the "government to do away with the 10 percent rate review threshold, calling it flawed."

Dow Jones Newswire (5/20, Brin, Subscription Publication) quotes AHIP President Karen Ignagni as saying, "'Focusing on health insurance premiums while ignoring underlying medical cost drivers will not make healthcare coverage more affordable for families and employers. The public policy discussion needs to be enlarged to focus on the soaring cost of medical care that threatens our economic competitiveness, our public safety net, and the affordability of healthcare coverage."

Kaiser Health News (5/19, Appleby) said consumer groups "were generally supportive" of the announcement. Health Care for America Now Director Ethan Rome said the regulation "puts insurers on notice that 'unjustified, double-digit premium rate increases will not be tolerated.'" Still, some consumer groups "took issue with the 10 percent standard, saying the rule needed a secondary 'trigger' -- such as increases that go beyond

medical cost inflation." Without a secondary review option, the "regulation could 'lock in a 9.9 percent increase as the de facto 'reasonable' rate,'" warned the advocacy group Consumer Watchdog "in a letter to HHS."

Meanwhile, the Hartford Courant (5/19, Sturdevant) "Insurance Capital" blog noted that yesterday's announcement was the "final part of proposed rules issued in December 2010."

Also covering the release of the new rules were the Wall Street Journal (5/20, Adamy, Subscription Publication), the AP (5/20), CQ HealthBeat (5/20, Norman, Subscription Publication), PBS (5/20, Clune, Bowers), Modern Healthcare (5/19, Zigmond, Blesch, Subscription Publication), and MedPage Today (5/19, Walker).

[48] California's medical schools graduate about 1,000 new doctors a year. California has openings for 3,000 new intern training slots a year. Thus California, having saved on the med school costs for the extra 2,000 new interns annually, has resources to lure interns from the other 49 sates, territories and District. If states know other states will poach their students by the thousands, the poachee (states losing interns) is discouraged from committing extra resources and expenses for expanding medical education, only to lose them to the poacher (states gaining interns with surplus seats).

[49] About 2006, CMS attempted to try a procurement bidding model for some DME http://www.cms.hhs.gov/DMEPOSCompetitiveBid/.
The Durable Medical Equipment Competitive Bidding Program, which affects only Medicare beneficiaries in traditional fee-for-service in 10 competitive bidding areas, has been delayed. Medicare beneficiaries may use **any** Medicare-approved supplier for Durable Medical Equipment. If a beneficiary changed suppliers when this new program started (July 1, 2008), they can either continue to use the new supplier or choose another supplier. The original DME payment rates in effect prior to July 1 are reinstated retroactively. All Medicare households in the 10 competitive bidding areas will be notified of this change directly in a letter from CMS within two weeks.

***** Announces It Will Not Participate in Round One of CMS Competitive Bidding Program**

SAN ANTONIO--(BUSINESS WIRE)--May 15, 2008--*** [Provider], Inc. (NYSE: [PROVIDER]), a global medical technology company with leadership positions in advanced wound care and therapeutic support systems, today announced that it will not be a *** supplier in phase one of the competitive bidding program administered by the Centers for Medicare and Medicaid Services (CMS). The program covers Medicare home placements in 10 designated metropolitan areas and is scheduled to take effect in July 2008.

"We continue to believe that [PRODUCT] has been improperly included in competitive bidding due to a demonstrable lack of comparable or effective alternatives to [PROVIDER]'s [PRODUCT](R) Therapy system," said [] President and Chief Executive Officer of [PROVIDER]. "We believe that the CMS bidding and contracting process does not ensure access to effective [PRODUCT] in the home, and Medicare beneficiaries are likely to be harmed as a result."

The Medicare Modernization Act of 2003 established the competitive bidding program with the express condition that patients should retain access to quality medical devices in the home. Notwithstanding this mandate, CMS has proceeded with [PRODUCT] competitive bidding which will result in the loss of access to [PROVIDER]'s life and limb-saving technologies for those Medicare patients.

To date, approximately 3 million patients have been treated with this technology and there is currently no clinically-proven equivalent to the proprietary foam-based [PRODUCT] Therapy system. Multiple studies have shown the superior clinical and economic benefits of [PRODUCT] Therapy, with results of 15 randomized controlled clinical trials published in peer-reviewed scientific journals. Moreover, [PRODUCT] Therapy is the only [PRODUCT] product that has received unique FDA clearances for mechanisms of action, the treatment of specific wound types, and use in

the homecare setting. The Company estimates the revenue impact of the first phase of [PRODUCT] competitive bidding in the 10 designated metropolitan areas to be less than 0.5% of [PROVIDER]'s total estimated revenue for 2008.
About [PROVIDER]
[Provider], Inc. is a global medical technology company with leadership positions in advanced wound care and therapeutic support systems. We design, manufacture, market and service a wide range of proprietary products that can improve clinical outcomes while helping to reduce the overall cost of patient care. Our advanced wound care systems incorporate our proprietary [PRODUCT](R) Therapy technology, which has been clinically demonstrated to help promote wound healing and can help reduce the cost of treating patients with serious wounds. Our therapeutic surfaces, including specialty hospital beds, mattress replacement systems and overlays, are designed to address pulmonary complications associated with immobility and to prevent skin breakdown. We have an infrastructure designed to meet the specific needs of medical professionals and patients across all health care settings including acute care hospitals, extended care facilities and patients' homes both in the United States and abroad. Forward-Looking Statements
This press release contains forward-looking statements, including management's expectations for the impact of the CMS competitive bidding on [PROVIDER]'s business. The forward-looking statements contained herein are based on our current expectations and are subject to a number of uncertainties. All information set forth in this release is as of May 15, 2008. We undertake no duty to update this information. More information about the company is described in our Annual Report on Form 10-K for the fiscal year ended December 31, 2007 and in our Quarterly Report on Form 10-Q for the quarter ended March 31, 2008, which are on file with the SEC and available at the SEC's Web site at www.sec.gov.
CONTACT: [Provider], Inc., San Antonio Media Relations: ***
SOURCE: [Provider], Inc..

[50] "*Marcus Welby, M.D.*, aired on ABC from late September, 1969 through mid-May 1976, was one of the most popular doctor shows in U.S. television history. During the 1970 television year, it even ranked number one among all TV series according to the Nielsen Television Index. As such, it was the first ABC program to take the top program slot for an entire season." It was set in "the suburban office of a general practitioner." http://www.museum.tv/archives/etv/M/htmlM/marcuswelby/marcuswelby.htm

[51] , 1939 film with Stewart and Lombard.
[52] http://www.cbo.gov/doc.cfm?index=17&type=0&sequence=3

Economic Factors That Affect the Characteristics of the Physician Workforce

The pattern of behavior observed during the late 1960s and the 1970s after the introduction of Medicare, Medicaid, and their precursor programs illustrates the response of the supply of physicians to economic incentives.[(14)] The historical evidence is consistent with the view that the introduction of those government insurance programs brought about a surge in demand for physicians' services. That surge led to an increase in physicians' income and in the rate of return on medical education from the mid-1960s to the early to mid-1970s.

[53] Quest Diagnostics Will Pay $241 Million To Settle Suit Alleging Medi-Cal Overcharges.

The AP (5/20/2011, Mohajer) reports that Quest Diagnostics has agreed to repay California "$241 million for more than 15 years of overcharges to Medi-Cal," the state attorney general's office announced Thursday. The settlement is the "result of a 2005 lawsuit brought by a whistleblower who alleged the labs systematically overcharged" Medi-Cal patients "up to six times more than other customers." The settlement is the "largest ever

recovered under California's False Claims Act," according to the state Attorney General's office. In a statement, Quest officials "acknowledged the settlement but denied all allegations of wrongdoing."

[54] http://www.dcexaminer.com/opinion/Universal_coverage_First_look_at_the_disaster_in_Massachusetts_011109.html
Universal coverage? First, look at the disaster in Massachusetts By Examiner Editorial **- 1/11/09**
. . .in 2006, Massachusetts became the first state in the nation to require all residents to buy health insurance. A new state health insurance clearinghouse was created, with taxpayers subsidizing those who couldn't afford to buy coverage. . . ..
Just a year after the universal coverage law passed, **The New York Times** reported, state insurers were already jacking up **rates to twice the national average.** According to Dr. Paul Hsieh, a physician and founding member of Freedom and Individual Rights in Medicine, 43 mandatory benefits — including those that many people did not want or need, such as invitro fertilization — raised the costs of coverage for Massachusetts residents by as much as 56 percent, depending upon an individual's income status. . . .
Small businesses with more than 10 employees were required to provide health insurance or pay an extra fee to subsidize uninsured low-income residents, yet the overall costs of the program increased more than $400 million — 85 percent higher than original projections. To make up the difference, payments to health care providers were slashed, so many doctors and dentists in Massachusetts began refusing to take on new patients. In the **state with the highest physician/patient ratio in the nation**, some people now have to wait more than a year for a simple physical exam.
The irony is that Massachusetts officials reluctantly admitted that, despite increased enrollment, the state is still far from universal coverage — the original goal of the landmark law. To make matters worse, Massachusetts is grappling with a multibillion-dollar deficit while Democratic Gov. Deval Patrick desperately tries to slow down those still-spiraling health care costs, which he said last week were "not sustainable." If this sounds just like Canadian-style socialized medicine, that's because it is. **Massachusetts residents now pay more for less access to health care,** yet their state still has an uninsured problem! . . .

[55] http://online.wsj.com/article/SB10001424052748704457604576011382824069032.html
- DECEMBER 22, 2010

Confidentiality Cloaks Medicare Abuse
By MARK SCHOOFS And MAURICE TAMMAN
Christopher G. Wayne doesn't look like a typical family-practice doctor. Known to admirers as the "Rock Doc," he wears his hair spiked, punk style, and festoons himself with chains, bangles and leather bracelets.
He uses his upscale Miami Beach home as a production studio for Playboy photo spreads, and his MySpace page shows him posing with celebrities such as Paris Hilton and Aerosmith's Steven Tyler.
View Full Image

Alexia Fodere

Dr. Christopher Wayne, Florida's 'Rock Doc,' once earned a big part of his income from Medicare physical-therapy payments.

There's something else about Dr. Wayne that doesn't resemble a normal family-practice doctor: his earnings from Medicare, the government insurance program for the elderly and disabled. Dr. Wayne took in more than $1.2 million from Medicare in 2008, according to a person familiar with the matter, a large portion of it from physical therapy. That's more than 24 times the Medicare income of the average family doctor, according to a Wall Street Journal analysis of Medicare-claims data.

The regimen of physical therapy Dr. Wayne said he usually provided—30 minutes each of heat packs, massage, electrical stimulation and ultrasound—is also unusual.

Editors' Deep Dive: Physical Therapists Face Hurdles to Care

- **PHYSICAL THERAPY**
  Physical Therapists Encounter Unique Ethical Issues
- **GP (General Practitioner)**
  GPs Should Have Thorough Understanding of Physiotherapy Services
- **Physical Therapy**
  Study Targets Effective Acute Care Practice

Stephen Levine, a former board member of the American Physical Therapy Association, said those services are usually used in conjunction with more sophisticated forms of therapy, such as neuromuscular reeducation. Used on their own, with rare exceptions, "it's a form of abuse," said Mr. Levine. "Wouldn't we all love to…have someone rub our backs and have the government pay for it—but it's just not appropriate," he added.

Secrets of the System

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

Dr. Wayne, a 50-year-old osteopath, denies abusing the system and hasn't been accused of wrongdoing by authorities. He says his regimen "does wonders" if used correctly. He adds that he gave physical therapy to "patients who needed it, with appropriate diagnoses, and I should get paid for it."

Medicare administrators apparently felt otherwise. In 2009 he says he was placed on heightened scrutiny and eventually sold his business. But not until he had received more than $2.6 million from Medicare between 2007 and 2009, according to the person familiar with the matter.

Physical therapy, which cost Medicare almost $3.5 billion in 2008, offers a case study in how Medicare polices its payments. Even when Medicare identified providers whose physical-therapy billing raised red flags, it kept paying thousands or even millions of dollars, sometimes for years, The Wall Street Journal found. Among the cases:

•A physical therapist in Brooklyn who billed for so much therapy—more than $2.5 million in 2008 alone—that it would have been virtually impossible for him to have performed it all within state and Medicare guidelines, fraud experts say. Medicare has continued to pay him, shelling out nearly a million dollars through July of this year.

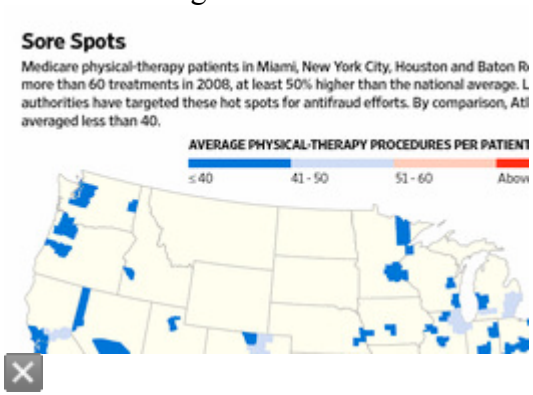
•A second doctor in Florida who pocketed more than $1.8 million from Medicare in 2007, much of it from physical therapy on patients with an extremely rare condition. Even after a Medicare antifraud contractor flagged this doctor, the agency paid him at least $6.7 million over more than two years.

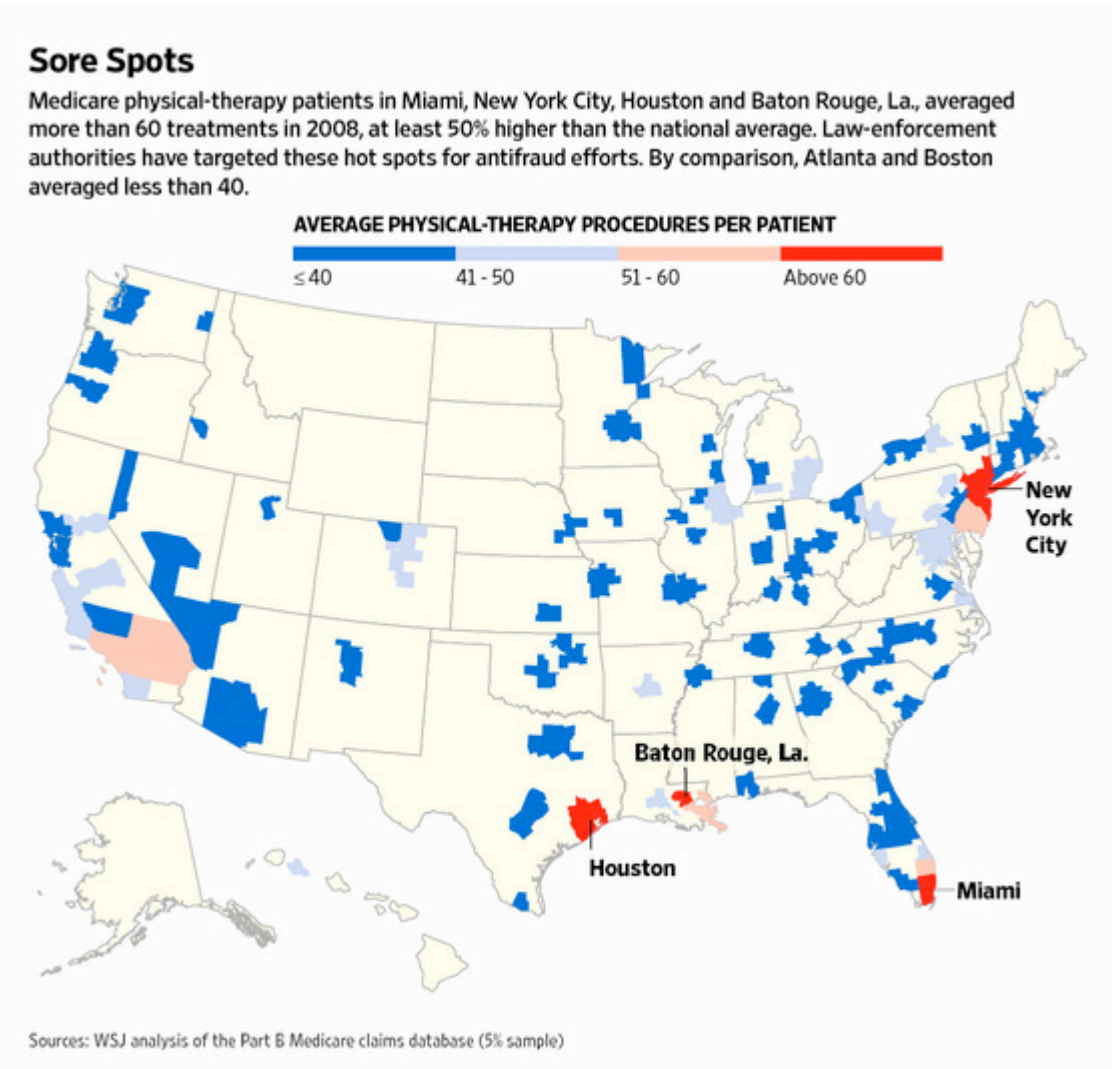
•A Houston doctor whose Medicare billing under her provider number spiked from zero to more than $11.6 million in less than a year. At the time, this doctor was being investigated for misconduct in a company owned by a Nigerian with an alleged history of fraud.

Sore Spots

Medicare physical-therapy patients in Miami, New York City, Houston and Baton Rouge, La., averaged more than 60 treatments in 2008, at least 50% higher than the national average. Law-enforcement authorities have targeted these hot spots for antifraud efforts. By comparison, Atlanta and Boston averaged less than 40.

View Full Image





There are plenty of reasons why Medicare often fails to stop questionable payments up front. To protect law-abiding doctors and hospitals—the vast majority—Medicare is required to pay nearly everybody within 30 days. Medicare says it is reluctant to suspend payments to providers who may have made honest mistakes, out of concern that beneficiaries might go without needed treatment. Law-enforcement agencies and Medicare contractors, overwhelmed by the sheer volume of Medicare fraud cases, can't investigate and prosecute them all. Sometimes, prosecutors and investigators ask Medicare to keep paying so as not to tip off targets of an investigation.

But a central problem is that Medicare hasn't fully exploited its most valuable resource: its claims database, a computerized record of every claim submitted and every dollar paid out.

"That's really the crux of the issue," said Kimberly Brandt, who led Medicare's antifraud efforts from 2004 through June of this year. She said the program is "definitely on the right path" to making better use of its database, "but it's not going to be a flip of the switch or an easy transition."

The Wall Street Journal originally identified Dr. Wayne and the other medical providers discussed in this article through a Medicare database that is much more limited than the one available to fraud investigators. The database, obtained in conjunction with the nonprofit Center for Public Integrity, contains records only through 2008, and includes the claims of just 5% of randomly selected Medicare beneficiaries.

Under a three-decade-old court decision protecting physician privacy, Medicare is prohibited from releasing to the public details of doctors' billings. The Journal agreed not to publish individual physician billing information obtained solely through the database as part of its arrangement with the Centers for Medicare and Medicaid Services, or CMS. Billing figures for doctors named in this article were obtained from the providers themselves or from others familiar with their businesses.

CHRISTOPHER WAYNE, MIAMI BEACH

View Full Image

MySpace

Dr. Wayne, pictured on his MySpace page, collects vintage automobiles and modern art. He says he trained his 'office girls' to provide physical therapy. In 2008 he received about $1.2 million from Medicare. The agency later moved to restrict its payments to him.

Some law-enforcement veterans argue that the government should release billing data to the public as a deterrent to fraud and abuse, so long as patient confidentiality isn't compromised. Kirk Ogrosky, a former assistant U.S. attorney specializing in health-care fraud and now a partner at the law firm Arnold & Porter LLP, says law enforcement can't do all the work on its own. He adds that when doctors "understand their billing information is public and people can examine it, that deters them from overbilling."

Peter Budetti, the head of CMS's new antifraud arm, says Medicare is moving away from its traditional "pay-and-chase" approach, in which it tries to recover improper payments already out the door. He says he'd like to emulate the credit-card industry, which has developed software to flag suspicious charges before paying them. "Fraud prevention is our new emphasis," he said.

The main responsibility for flagging fraudsters lies with a network of private contractors that are tasked with mining the data.

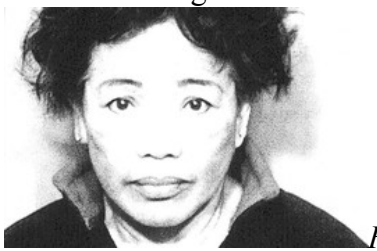
There are occasional false alarms. About two years ago, a claim for a prostate exam performed on a woman raised suspicions, according to executives at one Medicare contractor. It turned out to be a legitimate case because the patient had undergone a sex-change operation.

The final line of defense is law enforcement. The Bush and Obama administrations have expanded multiagency strike forces—called HEAT, for Health Care Fraud Prevention and Enforcement Action Teams—into new cities beyond their original base in southern Florida. In contrast to most previous efforts, these teams mine claims data to decide which cities, types of fraud, and providers to target. Since March 2007, federal health-fraud

prosecutors with these strike forces have charged more than 850 defendants for alleged frauds exceeding $2 billion in billings, according to the government.

THERESA RICE, HOUSTON

View Full Image



Humble Police Dept. Dr. Rice, shown in a 2004 police photo when she was accused of shoplifting, got caught up in an alleged Nigerian fraud ring. Medicare was billed around $11.6 million in less than a year under her name.

Overall, the highest-dollar schemes have involved pharmaceutical and drug-company fraud, followed by hospital scams, according to data from the Health and Human Services inspector general. Recently, physical-therapy abuse has cropped up on the federal radar screen. Law-enforcement authorities were so alarmed by the physical-therapy billing patterns in Brooklyn that they deployed a special strike force there. In Florida's Miami-Dade County, a known Medicare-fraud hot spot, 2009 per-patient expenditures on outpatient therapy were triple the national average, according to CMS.

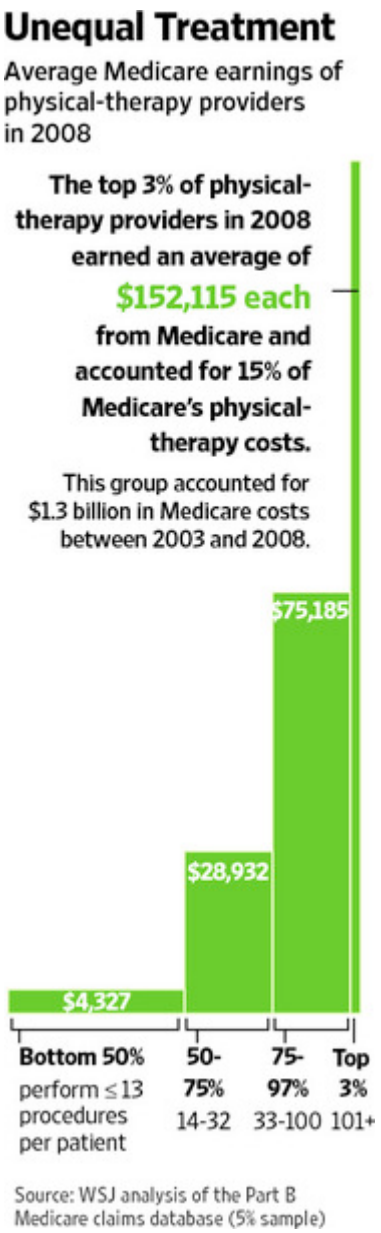
A Journal analysis of the 5% database focused on the physicians and physical therapists in private practice who performed the most physical-therapy treatments per patient. Only 3% of providers administered 90 or more treatments per patient; the national average was about 40. That top 3% accounted for more than 14% of all Medicare physical-therapy expenditures from 2003-2008, or an estimated total of nearly $1.3 billion. While some of that billing would be legitimate, said Mr. Levine, much of it would likely be abusive or fraudulent.

One Florida physician—not Dr. Wayne—made almost all his money from physical therapy, according to the Journal's analysis of the 5% database. According to separate billing totals reviewed by The Wall Street Journal, this internal-medicine doctor took home more than $8.1 million from Medicare from 2007 through 2009.

The Journal cannot name this doctor because the paper was able to learn a crucial piece of information about his practice—the type of disorder he billed for—only from the database, not from any other source.

From 2006 through 2008, more than 40% of this doctor's patients in the database were described as suffering from brachial neuritis. That's a rare nerve-and-muscle condition estimated to occur in about three out of every 100,000 Americans. In 2008, the Florida doctor earned at least 25% more from brachial neuritis patients than any other provider, according to the Journal's database analysis.

A contractor in charge of ferreting out fraud in Florida—SafeGuard Services LLC, owned by Hewlett-Packard Co.—flagged this doctor for heightened scrutiny at least as early as June 2007. But it wasn't until September 2009 when Medicare stopped paying nearly all of his claims, according to a government official with knowledge of the matter. During that time, Medicare paid out more than $6.7 million to this doctor, according to the billing totals reviewed by the Journal.



Officials from SafeGuard and CMS declined to comment, citing the policy against discussing any particular provider.

In the 1990s, this doctor filed for bankruptcy. On a recent morning a Porsche and a late-model Mustang sat in the driveway of his spacious middle-class home. Asked about his medical practice, the doctor said, "I don't have anything to say to you," and shut his door.

The Journal's analysis suggests one center of intensive physical-therapy billing is Houston. That's where Dr. Theresa Rice works. Dr. Rice, who is in her late 70s and received her medical degree in the Philippines, has been licensed to practice medicine in Texas since 1981, public records show.
In 2004, she was convicted of shoplifting $748 in jewelry from a Foley's department store. In an interview, Dr. Rice at first denied the conviction, saying there must have been a computer error. After being told that the Journal had her booking photo, she admitted that she had shoplifted. "I lied to you," she said.
In 2007, the Texas Medical Board began probing Dr. Rice for her involvement in a business owned by a Nigerian businessman "who has a history of fraudulent activity, and is sought by authorities under several known aliases," according to a Medical Board document. Dr. Rice approved home health services based on patient assessments made by an unqualified physician assistant, and she could provide no medical records for those patients, the Board found.
Dr. Rice said she was duped in that case, an explanation the Medical Board accepted. She was fined $1,500 and required to take a course in medical ethics, according to the Medical Board document.
Dr. Rice billed Medicare nothing in 2007 for services she performed or supervised, according to a person familiar with her business. But starting in October 2008, billing under her provider number skyrocketed. In less than a year, Medicare received claims totaling over $11.6 million and paid out more than $7.1 million.
Medicare stopped paying in mid-2009, when federal investigators shut down the clinic where she worked, City Nursing. That clinic was owned by a different Nigerian businessman, Umawa Imo. At least seven people have been indicted on health-fraud charges connected to the clinic, in what a senior law-enforcement official called the largest physical-therapy fraud in Houston history. The alleged scheme involved several people of Nigerian descent as well as at least two American doctors, according to the federal indictment and law-enforcement officials. Medicare paid out about $27 million over 28 months, according to the indictment.
Dr. Rice wasn't indicted and maintains she was duped again. Mr. Imo has pleaded not guilty to health-care fraud and conspiracy charges. His lawyers said he is innocent and trusted the people running the clinic.
Short of an audit or investigation, there is often no way to tell who actually performs physical therapy. That's because doctors who "directly" supervise physical therapists—meaning the doctor is in the same office suite at the same time the therapy is being performed—don't need to state on the claim form who administered the therapy. It's billed as if the doctor performed it.
In the case of City Nursing, the clinic where Dr. Rice worked, an affidavit for a search warrant alleges there was only one physical therapist. The indictment charges that patients were paid to sign documents saying they had received physical therapy that never happened.
Dr. Rice is now working at a storefront operation called Clinica de la Familia. A CMS spokesman said she's no longer eligible to get paid by Medicare and declined to provide further details. Of her current clinic, Dr. Rice said, "We are not doing any fraudulent thing."
Federal authorities say that in Brooklyn, physical-therapy abuse appears to be especially rife among Russian immigrants. A Journal analysis of the 5% database shows that eight of Medicare's 30 top-earning physical therapists work in Brooklyn. Seven of them have names that seem Russian or from neighboring nations.
Brooklyn physical therapist Aleksandr Kharkover billed Medicare for more than $2.5 million in 2008, according to a person familiar with his business, and received more than $1.8 million.
On an autumn weekday at about 9:00 in the morning, two Journal reporters arrived at Mr. Kharkover's home, a brick bungalow. He appeared in a white T-shirt emblazoned with the slogan, "Freedom isn't free." Asked if billing $2.5 million to Medicare fit with his records, he replied, "I'd say that fits."

Mr. Kharkover and two people familiar with his practice said he sees patients only in their homes. Fraud experts say this makes it virtually impossible for him to have legitimately billed such high amounts.

New York State allows a physical therapist to supervise only two assistants on home visits, and the therapist must be in the same home at the same time as his assistants, according to New York State and Medicare officials. Unless Mr. Kharkover held therapy sessions in which several patients congregated in one home, he would effectively be limited to billing little more than what he himself could perform.

Under generous assumptions, a single therapist could earn $1 million from Medicare in a year by working 12.5 hours a day, seven days a week, with no time off. Medicare paid Mr. Kharkover more than $960,000 in the first seven months of this year, according to the person familiar with his business.

CMS and its main New York antifraud contractor, SafeGuard Services, declined to comment on Mr. Kharkover.

Mr. Kharkover declined a second interview. His attorney, Montell Figgins, said his client is a "successful businessman," adding that "there is no reason to believe my client was doing anything illegal."

As for Dr. Wayne, he said he expanded physical therapy at his clinic near Miami's design district because his patients needed it. Medicare regulations require that physical therapists billing under a physician must have completed an accredited physical-therapy education program. But Dr. Wayne said he trained his "office girls" to do the work in part because hiring full-fledged physical therapists was too expensive.

Referring to Medicare's therapist-education requirement, he said, "I interpret that as, 'If I train them in physical therapy, that should be good enough.'"

Dr. Wayne acknowledged grossing $1.1 million or $1.2 million from Medicare in 2008, and estimated his take-home that year from his clinic was roughly $400,000. He said his Medicare reimbursements plummeted after March 2009, when he says Medicare tightened scrutiny of his billing. According to the person familiar with the matter, Medicare paid only about 12.5% of his claims in the second half of 2009.

Dr. Wayne said he is appealing many of the denied claims, but that the drop in Medicare reimbursements and other business issues led him to sell his practice and caused him financial distress. On a recent evening, he opened envelopes from a bank, and said they were notices of bounced checks.

Still, full-scale replicas of medieval knights' armor greet guests at his home, and hanging on the walls are what he said are two original Picassos, several Dalis and photographs by Helmut Newton. Also present recently was Eliza Carson, a Playboy model who said she's 20 years old. She barely glanced up from texting on her phone as she asked Dr. Wayne how he managed to keep his hair spiky when he sleeps. He explained that he uses an airplane pillow.

Dr. Wayne now works in a pain-management clinic in Fort Lauderdale. He said he doesn't have a board certification in pain management, and said the clinic accepts only cash. Of his patients at the clinic, Dr. Wayne said, "I write their pain prescriptions, and they're gone."

—James Oberman, Anton Troianovski and Gina Chon contributed to this article.

Write to Mark Schoofs at mark.schoofs@wsj.com and Maurice Tamman at maurice.tamman@wsj.com

[56] Sebelius Says Ryan's Budget Plan Would Hurt Seniors.

Politico (5/20, Haberkorn) reports, "Health and Human Services Secretary Kathleen Sebelius went to Capitol Hill Thursday to help Democrats refine their message on the House Republican budget: It's going to cut seniors benefits today." This "counters the message Budget Committee Chairman Paul Ryan has tried to convey about his plan," that it "would preserve Medicare for those over age 55." Sebelius said, "Instead of improving Medicare, they would end Medicare as we know it by turning it into a private insurance company voucher program." She added that Ryan's "plan would wipe out the new benefits that many seniors are seeing by repealing the Affordable Care Act."

The Washington Post (5/20, Sonmez) "2chambers" blog reports that Sebelius, Sen. Sheldon Whitehouse (D-RI) "and the other Senate Democrats argued that the House Republican budget blueprint drafted by Rep. Paul Ryan (R-Wis.) would reopen the 'donut hole,' the prescription drug coverage

gap for seniors on Medicare." Whitehouse stated, "What the Republicans are saying -- that this won't affect seniors now, that the cuts are all off in future years -- is flat-out false."

MSNBC's The Ed Show (5/19, 10:00 p.m. EST) reported, "Senate Republicans will have to side with Ryan's right wing social engineering plan or they'll have to side with 80% of the American people who want Washington to leave Medicare and Medicaid absolutely alone. Senate Democrats and health and Human Services Secretary Kathleen Sebelius held a press conference earlier today along with Senator Brown of Ohio, who read a letter from a constituent that clearly laid out what is at stake." The Hill (5/20, Baker) "Healthwatch" blog and Talk Radio News (5/20, Bunnell) also cover the story.

Sebelius, Senators Release Report Showing Negative Impact Republican Budget Could Have On Medicare Benefits. The Charleston (WV) Gazette (5/20, Nyden) reports that Sen. Jay Rockefeller (D-WV) was "one of four senators who released a report on Thursday showing the increased costs the proposed House Republican budget would impose on senior citizens by cutting Medicare benefits." The Republican budget would "reopen the prescription drug 'donut hole,' costing each of four million seniors who fall into the coverage gap up to $9,300 by 2020," the senators said. During the next 13 years, the report predicts the proposed Republican budget would "cost seniors across the country an additional $44 billion in prescription drug costs." Sen. Rockefeller released the report at a press conference yesterday in conjunction with Sens. Sherrod Brown (D-OH), Barbara Mikulski (D-MD) and Sheldon Whitehouse (D-RI), as well as HHS Secretary Sebelius.

[57] US Alleges New York City Overbilled Medicaid.

In a front-page story, the New York Times (1/12, A1, Hartocollis) reports, "The federal government has accused New York City of overbilling Medicaid by "at least tens of millions of dollars" by improperly approving 24-hour home care for thousands of patients." The Times continues, "In a lawsuit filed Tuesday, the United States attorney's office in Manhattan also insinuated that the city had cheated the federal government after a 2006 change in Medicaid rules relieved the city of having to contribute to the cost of the round-the-clock care." The suit, "which followed a whistle-blower's complaint, also said the city ignored rules requiring recommendations from doctors, nurses and social workers before patients could be enrolled in the home care program, or sometimes rejected doctors' findings that the services were not needed."

The AP (1/12) reports, "The government in a lawsuit in US District Court in Manhattan sought civil penalties and damages against the city, saying administrators over the last 10 years routinely reauthorized 24-hour continuous personal care services for applicants without obtaining the required local medical evaluation. The lawsuit said city administrators sometimes overruled the local medical director when the director decided continued care was inappropriate. In a release, US Attorney Preet Bharara said the allegations 'unfortunately reflect a systemic failure to responsibly administer the Medicaid program.'" The Wall Street Journal /Dow Jones Newswires (1/12, Kell) also reports this story.

[58] FDA Approves Clostridium Difficile Treatment.

On the front-page of its business section, the New York Times (5/28, B1, Pollack, Subscription Publication) reported that the Food and Drug Administration approved Optimer Pharmaceuticals' Dificid (fidaxomicin). Dificid is the "first new medicine in 25 years approved to treat diarrhea caused by Clostridium difficile, a nasty and persistent bacterium that one study suggests may have surpassed the better known MRSA as the leading hospital-acquired infection."

Bloomberg News (5/28/2011, Peterson, Waters) reported that 548-patient study funded by Optimer found that infections subsided in 88 percent of those "treated with fidaxomicin and 86 percent of those taking vancomycin," which until now, was the only drug approved by the FDA for C. difficile infections.

Meanwhile, the San Diego Union Tribune (5/28, Darcé) suggested that some "investors might have been disappointed in some of the wording in the drug's FDA-approved label that could play a role in encouraging physicians to prescribe Optimer's pill over vancomycin. The label says the 'sustained clinical response' of Dificid is superior to vancomycin." But Optimer "officials originally pushed for the drug to be described as a 'global cure' for the disease. That wording didn't make it into the final version." Also covering the story were the AP (5/29, Perrone), Dow Jones Newswire (5/28, Dooren, Subscription Publication) and MedPage Today (5/27, Frieden) and Medscape (5/27, Hitt).

59 Report: Health system wastes $750B each year Institute says that's 30% of spending. By Ricardo Alonso-Zaldivar.
Associated Press: Report: Health system wastes $750B each year - Washington Times http://www.washingtontimes.com/news/2012/sep/6/report-health-system-wastes-750b-each-year/print/#ixzz25nrSbpah The U.S. health care system squanders $750 billion a year — roughly 30 cents of every medical dollar — through unneeded care, Byzantine paperwork, fraud and other waste, the influential Institute of Medicine said Thursday in a report that ties directly into the presidential campaign.
President Obama and Republican Mitt Romney are accusing each other of trying to slash Medicare and put seniors at risk. But the counter-intuitive finding from the report is that deep cuts are possible without rationing, and a leaner system may even produce better quality.
"Health care in America presents a fundamental paradox," says the report from an 18-member panel of prominent specialists, including doctors, business people and public officials. "The past 50 years have seen an explosion in biomedical knowledge, dramatic innovation in therapies and surgical procedures, and management of conditions that previously were fatal. … Yet, American health care is falling short on basic dimensions of quality, outcomes, costs and equity."
If banking worked like health care, ATM transactions would take days, the report says. If home building were like health care, carpenters, electricians and plumbers would work from different blueprints and hardly talk to each other. If shopping were like health care, prices would not be posted and could vary widely within the same store, depending on who was paying.
If airline travel were like health care, pilots would be free to design their own preflight safety checks — or not perform one at all.
How much is $750 billion? The one-year estimate of health care waste is equal to more than 10 years of Medicare cuts in Mr. Obama's health care law. It's more than the Pentagon budget. It's more than enough to care for the uninsured.
Getting health care costs better controlled is one of the keys to reducing the deficit, the biggest domestic challenge facing the next president. The report does not lay out a policy prescription for Medicare and Medicaid, but it suggests there is plenty of room for lawmakers to find a path.
Both Mr. Obama and Mr. Romney agree that there has to be a limit to Medicare spending, but they differ on how to get that done. Mr. Obama would rely on a powerful board to cut payments to service providers, while gradually changing how hospitals and doctors are paid to reward results instead of volume. Mr. Romney would limit the amount of money future retirees can get from the government for medical insurance, relying on the private market to find an efficient solution. Each accuses of the other of jeopardizing the well-being of seniors.
But panel members urge a frank discussion with the public about the value Americans are getting for their health care dollars. As a model, they cited "Choosing Wisely," a campaign launched earlier this year by nine medical societies to challenge the widespread perception that more care is better.
"Rationing to me is when we are denying medical care that is helpful to patients, on the basis of costs," said Dr. Rita Redberg, a cardiologist and medical school professor at the University of California, San Francisco. "We have a lot of medical care that is not helpful to patients, and some of it is harmful. The problem is when you talk about getting rid of any type of health care, someone yells, 'Rationing.'"
More than 18 months in the making, the report identifies six major areas of waste: unnecessary services ($210 billion annually), inefficient delivery of care ($130 billion), excess administrative costs ($190 billion), inflated prices ($105 billion), prevention failures ($55 billion) and fraud ($75 billion). Adjusting for some overlap among the categories, the panel settled on an estimate of $750 billion.

Read more: Report: Health system wastes $750B each year - Washington Times http://www.washingtontimes.com/news/2012/sep/6/report-health-system-wastes-750b-each-year/print/#ixzz25nrugqAU
Follow us: @washtimes on Twitter

[60] US Health Care System 'Wasted' $750 Billion in 2009. *Reported by Julielynn Wong, M.D., ABC News Medical Unit:* The U.S. health care system wasted $750 billion on unnecessary and overpriced medical tests and treatments, administrative fees, medical fraud and missed prevention opportunities in 2009, a new report found.
The report, released today by the Institute of Medicine, suggested the money squandered on services that failed to improve Americans' health could have provided health insurance for more than 150 million workers or covered the salaries of all of the nation's first responders for more than 12 years.
"I was surprised at how much waste there seems to be," said report author Dr. Mark Smith, a former expert adviser to President Clinton's Task Force on National Health Care Reform and president of the Oakland-based California HealthCare Foundation. "We're spending money in ways that don't seem to improve people's health."
The wasted money could provide health insurance coverage for more than 150 million workers, according to the report. And 75,000 deaths might have been prevented if states delivered higher-quality care.
"Much of what's in this report is beyond partisan politics," said Smith. "There may be disagreement on how to get there but there's pretty broad agreement on where we need to go."
Dr. Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore said the report is a reminder that the current health care system is failing and needs to be reformed.
"We have been talking about improving quality and value for over a decade," said Pronovost, who was not involved in the report. "Yes we need to do this. … The question is how." The U.S. spends more than twice as much per person on health care as all other industrialized countries despite being the only developed country that doesn't provide basic health insurance for all its citizens, according to Dr. Timothy Johnson, ABC News senior medical contributor and author of "The Truth About Getting Sick in America."
The U.S. also has the lowest life expectancy among the top five spenders on health care, Johnson wrote in his book. Roughly $190 billion was wasted on administrative costs in 2009, according to the report. And medical service and product prices above competitive benchmarks cost $105 billion.
Smith said the Affordable Care Act's medical loss ratio provision limits the amount of each premium dollar insurers can use to pay indirect health care costs, which include administrative costs and profits. The provision is designed to curb administrative costs and high prices in health care, he said.
Unnecessary and inefficiently delivered health care services cost $340 billion in 2009, according to the report. And missed prevention opportunities cost the health care system $55 billion. Medical fraud perpetrated by payers, clinicians and patients cost about $75 billion in 2009. "I hope our policy makers read this report closely. It should serve as the foundation going forward for how to fix our health care system," said Dr. Kenneth E. Thorpe, former deputy assistant secretary for health policy under President Clinton and current professor of health policy at Emory University in Atlanta. "These fixes would reduce the cost of health care and improve outcomes."
Smith said Americans should expect better value from their health care."It's not about spending more or less money. Are you getting better value?" he said. "It's possible and necessary."

[61] Waste in U.S. health care systemVictoria Colliver

Read more: http://www.sfgate.com/health/article/Waste-in-U-S-health-care-system-3845880.php#ixzz25nt3TGnl

The U.S. health system wastes more than $750 billion a year - or 30 percent of medical expenses - in unnecessary, inefficient services, and each year tens of thousands of deaths could be averted through better care, according to a report released Thursday by the Institute of Medicine.

Despite those sobering figures, the 18-member committee behind the national report, which includes several Bay Area health experts, concluded that improving quality and lowering cost or not only possible but could be done with tools and technologies that exist.

"In some ways, the American medical system is the best the world has ever seen. We do things every day that are exceptional, almost miraculous," said the committee's chairman, Dr. Mark Smith, president and chief executive officer of the California HealthCare Foundation, a health care philanthropic group in Oakland.

Smith also described a "maddening paradox" in which patients get either too little treatment or too much and a system that "rushes some things into widespread practice before there have even been enough studies and there are other things we have known for 100 years and still can't get people to do."

The report outlines a series of recommendations to improve the system, including rewarding health care providers for quality rather than for the volume of procedures or services they provide, using technology to better coordinate care and reduce waste, and recognizing that patients should be considered partners in their health decisions.

Optimistic for change Though many of those ideas have been discussed for years, the committee contends that recent improvements in computing tools, political acknowledgement from both Democrats and Republicans about the broken heath care system and an increasingly savvy patient population make the nation poised to change.

With the federal government moving forward on the Obama administration's health law and both sides clashing over the costs of Medicare and Medicaid, the report's release is clearly timely.

"Certainly having the release two months before the presidential election does remind one it's really important as a bipartisan goal to have a better system with lower costs," said committee member Dr. Rita Redberg, a cardiologist and professor of medicine at UCSF.

Redberg said the strategies to improve health care should be embraced by both parties. "I don't think people consciously want to be spending billions of dollars on health care that is not helping people and is actually making people worse," she said.

Other Bay Area members of the committee included George Halvorson, the chief executive officer of Kaiser Permanente, which is headquartered in Oakland, and Dr. Paul Tang, chief innovation and technology officer for the Palo Alto Medical Foundation.

The nearly 400-paged tome is part of a series of reports issued by the Institute of Medicine, an arm of the National Academies of Sciences, over the past 13 years covering such topics as medical errors, quality of care and nursing.

A slow learner Health care has been slow to learn from other industries, such as banking, airlines and retailers, when it comes to convenience, safety and satisfaction, the report concluded.

The report highlights that despite the fact the U.S. spends about 18 percent of its economy on health care, patients aren't necessarily healthier than countries that spend less. Additionally, the authors estimate that 75,000 deaths in 2005 could have been prevented if care for any particular condition had been delivered at the highest level of the best performing state in that category. It also notes health costs have increased at a greater rate than the economy for 31 of the past 40 years. The report was sponsored by the Blue Shield of California Foundation, the Charina Endowment Fund and the Robert Wood Johnson Foundation.

-- Read the report: The Institute of Medicine's "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America" can be found here: bit.ly/OZvRet

Source: Institute of Medicine
Health care waste Here are some of the major areas of waste in the U.S. health care system identified by the Institute of Medicine report released Thursday. The estimates are in dollars per year from 2009:
-- Unnecessary services: $210 billion Excessive administrative costs: $190 billion -- Inefficient delivery of care: $130 billion -- Inflated prices: $105 billion -- Fraud: $75 billion -- Missed prevention opportunities: $55 billion
Victoria Colliver is a San Francisco Chronicle staff writer. E-mail: vcolliver@sfchronicle.com
Read more: http://www.sfgate.com/health/article/Waste-in-U-S-health-care-system-3845880.php#ixzz25ntNdok9
Read more: http://www.sfgate.com/health/article/Waste-in-U-S-health-care-system-3845880.php#ixzz25ntIKYAK

[62] If banking worked like health care, ATM transactions would take days, the report said. If home building were like health care, carpenters, electricians and plumbers would work from different blueprints and hardly talk to each other. If shopping were like health care, prices would not be posted and could vary widely within the same store, depending on who was paying. If airline travel were like health care, individual pilots would be free to design their own preflight safety checks - or not perform one at all. President Obama has said he would rely on a powerful board to cut payments to service providers, while gradually changing how hospitals and doctors are paid to reward results instead of volume. Republican presidential candidate Mitt Romney has said he would limit the amount of money future retirees can get from the government for medical insurance, relying on the private market to find an efficient solution. As a model, they cited 'Choosing Wisely,' a campaign launched earlier this year by nine medical societies to challenge the widespread perception that more care is better. 'Rationing to me is when we are denying medical care that is helpful to patients, on the basis of costs,' said cardiologist Dr. Rita Redberg, a medical school professor at the University of California, San Francisco. 'We have a lot of medical care that is not helpful to patients, and some of it is harmful. The problem is when you talk about getting rid of any type of health care, someone yells, "Rationing".' More than 18 months in the making, the report identified six major areas of waste (see box) and adjusting for some overlap among the categories, the panel settled on an estimate of $750 billion. Examples of wasteful care include most repeat colonoscopies within ten years of a first such test, early imaging for most back pain, and brain scans for patients who fainted but didn't have seizures. The report makes ten recommendations, including payment reforms to reward quality results instead of reimbursing for each procedure, improving coordination among different kinds of service providers, leveraging technology to reinforce sound clinical decisions and educating patients to become more savvy consumers. The report's main message for government is to accelerate payment reforms, said panel chair Dr. Mark Smith, president of the California HealthCare Foundation, a research group. For employers, it's to move beyond cost shifts to workers and start demanding accountability from hospitals and major medical groups. For doctors, it means getting beyond the bubble of solo practice and collaborating with peers and other clinicians. 'It's a huge hill to climb, and we're not going to get out of this overnight,' said Smith. 'The good news is that the very common notion that quality will suffer if less money is spent is simply not true. That should reassure people that the conversation about controlling costs is not necessarily about reducing quality.' The Institute of Medicine is an arm of the National Academy of Sciences.

[63] Arkansas Officials Will Not Pursue Medicaid Reforms That Would Hinder Physician Recruitment.
The Arkansas News (5/19/2011, Lyon) reported that Arkansas "state officials will not pursue any Medicaid reforms that would harm the state's ability to recruit and retain doctors, state Department of Human Services Director John Selig assured legislators" on Thursday in an update detailing plans on overhauling the state's Medicaid program. "Earlier this month, the US Department of Health and Human Services gave Arkansas conditional approval to move forward in putting together a reform proposal." Speaking at a joint meeting of the House and Senate committees on public health, welfare

and labor, Selig stated, "We won't pursue [reform] if we don't think it will provide some savings compared to what we would have spent and keep our providers." He added, "We're not going to do it if it does harm to our system."

[64] Fazio Introduces Bill To Subject Health Insurers To Federal Antitrust Laws.
The Oregonian (6/3/2011, Pope) reports that Rep. Peter DeFazio (D-OR) is now "arguing that health insurance companies are driving premiums to artificial heights because federal law exempts them from anti-trust law." On Tuesday, the congressman renewed "his effort to change what he says is a misguided federal law," saying, "Right now, it is legal under federal law for insurance companies to collude to drive up prices, limit competition, conspire to underpay doctors and hospitals, and price gouge consumers." For that reason, Fazio has introduced a measure with Rep. Louise Slaughter (D-NY), which is similar to one passed overwhelmingly last year in the House, to subject health insurers to federal antitrust laws.

[65] Massachusetts AG Seeks Authority To Prohibit Nonprofit Insurers' Payments To Board Members.
The Boston Globe (4/15, Weisman, Bierman) reports, "The battle over payments to board members at nonprofit health insurers escalated yesterday, as state Attorney General Martha Coakley pressed for legislation that would give her authority to prohibit the fees, while two large Massachusetts health insurance companies again said the money they pay directors is well spent." Coakley's office released a report that "said the insurers' longtime practice of paying directors can't be justified." However, both Harvard Pilgrim Health Care and Tufts Health Plan "yesterday defended their fee-paying practices against Coakley's criticism." The Boston Herald (4/15, Dwinell, McConville) also covers the story.

[66] Washington Post. A Medicare scam that just kept rolling
The government has paid billions to buy power wheelchairs. It has no idea how many of the claims are bogus.
Written byDavid A. Fahrenthold
Published on August 16, 2014
LOS ANGELES — In the little office where they ran the scam, a cellphone would ring on Sonia Bonilla's desk. That was the sound of good news: Somebody had found them a patient.
When Bonilla answered the phone, one of the scam's professional "patient recruiters" would read off the personal data of a senior citizen. Name. DOB. Medicare ID number. Bonilla would hang up and call Medicare, the enormous federal health-insurance program for those over 65.
BREAKING POINTS:
WHERE GOVERNMENT FALLS APART
Fourth in a series examining the failures at the heart of troubled federal systems.
She asked a single question: Had the government ever bought this patient a power wheelchair?
No? Then the scam was off and running.
"If they did not have one, they would be taken to the doctor, so the doctor could prescribe a chair for them," Bonilla recalled. On a log sheet, Bonilla would make a note that the recruiter was owed an $800 finder's fee. "They were paid for each chair."
This summer, in a Los Angeles courtroom, Bonilla described the workings of a peculiar fraud scheme that — starting in the mid-1990s — became one of the great success stories in American crime.
The sucker in this scheme was the U.S. government. That wasn't the peculiar part.

The tool of the crime was the motorized wheelchair.

The wheelchair scam was designed to exploit blind spots in Medicare, which often pays insurance claims without checking them first. Criminals disguised themselves as medical-supply companies. They ginned up bogus bills, saying they'd provided expensive wheelchairs to Medicare patients — who, in reality, didn't need wheelchairs at all. Then the scammers asked Medicare to pay them back, so they could pocket the huge markup that the government paid on each chair.

A lot of the time, Medicare was fooled. The government paid.

Since 1999, Medicare has spent $8.2 billion to procure power wheelchairs and "scooters" for 2.7 million people. Today, the government cannot even guess at how much of that money was paid out to scammers.

Now, the golden age of the wheelchair scam is probably over.

But, while it lasted, the scam illuminated a critical failure point in the federal bureaucracy: Medicare's weak defenses against fraud. The government knew how the wheelchair scheme worked in 1998. But it wasn't until 15 years later that officials finally did enough to significantly curb the practice.

"If you play it right, you can make a lot of money quickly, stealing from Medicare," said James Quiggle, of the nonprofit Coalition Against Insurance Fraud, recounting the lesson of the past decade and a half. "You can walk into the United States, with limited English skills, no knowledge of medicine, and — if you hook up with the right people, that know how to play the system like a Stradivarius — you can become an overnight millionaire."

Video: How to scam Medicare in 4 easy steps

Con artists have defrauded the American taxpayer for millions. Sadly, it's not that hard. Here's what they did. (David Fahrenthold, Osman Malik, and Gabe Silverman)

'I said I didn't need it'

In the courtroom in Los Angeles, 42-year-old Olufunke Fadojutimi was on trial. Prosecutors alleged she'd run a wheelchair-scam operation out of an office-park suite in suburban Carson, Calif.

As these scams go, this one was medium-sized. It billed Medicare for about 1,000 power wheelchairs.

"I said I didn't need it," witness Heriberto Cortez, 73, testified on the stand. Cortez was recalling the day when a stranger — allegedly one of Fadojutimi's patient recruiters — came to his house and offered him a wheelchair. He said no. She didn't listen.

"She insisted," Cortez said. "She said that they were giving the chairs away."

Later in the trial, 71-year-old Rodolfo Fernandez testified that a woman showed up at his house in Los Angeles. The woman asked if he was on Medicare. He was.

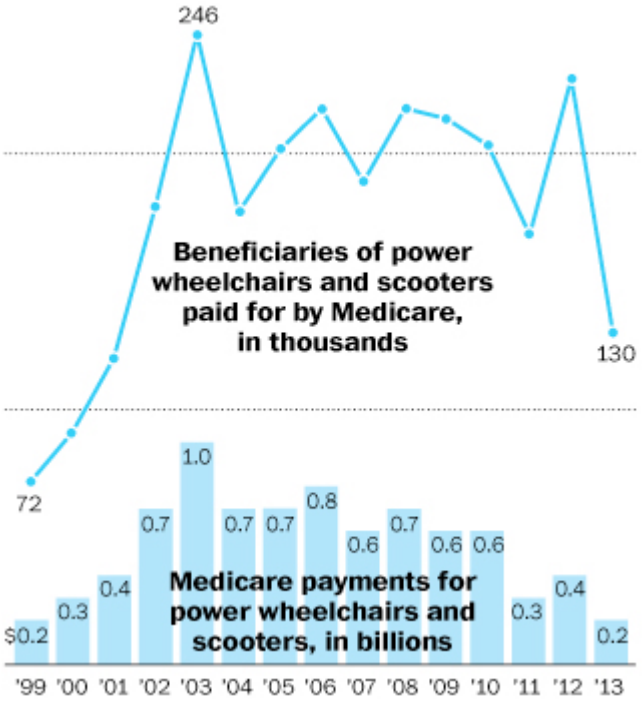
The next day, she came back with a van. Other seniors were already inside.

"They took us to a clinic. They did an exam on us," Fernandez recalled, translated speaking through a Spanish interpreter.

Authorities said the doctor at this clinic was in on the scam, too. He was paid to find the same problems, every time. The patient was too weak to use a cane. Or a walker. Or even a non-motorized wheelchair. Only a motorized wheelchair would do. Instead of making lame men walk, the doctor's job was to make walking men lame — at least on paper.

A surge in power wheelchairs and scooters paid for by Medicare

Since 1999, Medicare has spent $8.2 billion to procure power wheelchairs and scooters for 2.7 million people. Today, the federal government does not know how much of that money was actually paid to scammers.



Source: U.S. Centers for Medicare and Medicaid Services

In his testimony, Fernandez noted that the clinic was in a second-floor walk-up.

"I had to climb the stairs," Fernandez said, in order for the doctor to proclaim him unfit to climb stairs.

After seeing the doctor, prosecutors said, both Cortez and Fernandez got power wheelchairs from Fadojutimi's company. The company then sent Medicare the bills. Medicare paid.

Today, Cortez's wheelchair sits in his garage, still wrapped in plastic from the factory. Fernandez's wheelchair is occupied by an enormous stuffed animal wearing a Los Angeles Lakers hat.

"I put my little teddy bear on top of it," Fernandez said, as jurors smiled at a photo of the bear in the chair.

An overwhelmed system

Fraud in Medicare has been a top concern in Washington for decades, in part because the program's mistakes are so expensive. In fiscal 2013, for instance, Medicare paid out almost $50 billion in "improper payments." These were bills that, upon further reflection, contained mistakes and should not have been paid.

No one knows how much of that money was actually lost to fraud, and how much of it was caused by innocent errors.

The power-wheelchair scam provided a painful and expensive example of why Medicare fraud works so often. The fault lay partly with Congress, which designed this system to be fast and generous. And it lay partly with Medicare bureaucrats — who were slow to recognize the threat and use the powers they had to stop it. As a result, scammers took advantage of a system that was overwhelmed by its own claims and lacked the manpower and money to check most of those claims before it paid.

The scheme first appeared in the mid-1990s in Miami — a city whose mix of elderly people and professional scammers has always made it the DARPA of Medicare fraud, where bad ideas begin.

"The patients would be walking," said one former Justice Department official, recalling investigations from that time. "And they'd have the wheelchair, a $2,500 wheelchair, sitting in the corner with stacks of [stuff] on it. And [investigators] would say, 'Why do you have this?' And they would say, 'They told me I could have this, so I took it.' "

Fraudsters, they were learning, had invented a new twist on an old trick: the Medicare equipment scam.

The original equipment scam had sprung up in the 1970s, at a time when Medicare was young and criminals were still learning how to steal its money. Doctors, for example, could bill Medicare for exams they didn't do. Hospitals could bill for tests that patients didn't need.

The equipment scam was the poor man's way in, an entry-level fraud that didn't require a medical degree or a hospital.

Instead, the crooks only had to set up a "medical equipment" company and get access to the Medicare system. Then, they needed to learn a simple scheme, in which the fraudster would run the normal order of medical decision-making in reverse.

A legitimate medical-supply company, of course, must wait for a patient to see a doctor, then come looking for somebody to fill a prescription. But a fraudster starts with a prescription he wants to fill.

Then he goes looking for a patient and a doctor to foist it on.

By the 1990s, fraudsters had already perfected parts of this equipment scam. To find the patients, for instance, they had learned to use professional recruiters, called "marketers" or "cappers."

These recruiters induced seniors to hand over their Medicare ID numbers. Sometimes, they just paid the patients a bribe. Other times, they talked them into giving the number up free. *The government is offering free wheelchairs, but only for a limited time. If you don't act now . . .*

Most fraudsters had also learned to buy off a doctor or two, paying a set price for each bogus prescription. But some had also perfected a cheaper method.

They corrupted dead doctors instead.

"The Russian mob up in Brooklyn has been doing this for years. . . . They scour the obits. They find out when Doctor Morris has died. They immediately write to Medicare and they say, 'Hi, I'm Doctor Morris, and I'm changing my address,' " said Lewis Morris, a former top official at the Department of Health and Human Services' office of the inspector general.

If it works, the dead doctor's mail is delivered to the live crook. Including paperwork with the doctor's Medicare ID number. "So the new Doctor Morris, Sammy Scumbag, starts writing scrip in the name of Doctor Morris," Morris said. Recent reforms have lessened this problem.

The payoff of this whole scheme came when a scammer sent Medicare a bill. The bill would say that the bought-off doctor had prescribed some piece of equipment to the bought-off (or hoodwinked) patient.

The fraudster would say that he had supplied that thing. Now, he wanted Medicare to pay its share — usually, 80 percent of the price tag.

But what was the best kind of equipment to use?

Heriberto Cortez testified in the trial of Olufunke Fadojutimi that he told one of Fadojutimi's patient recruiters he didn't need a motorized wheelchair. "She insisted," Cortez said. (J. Emilio Flores for The Washington Post)

This was the piece of the scam that wasn't perfect yet. Through the '80s and '90s, scammers had tried orthopedic braces. Oxygen tanks. Electric nerve-stimulation kits. Prosthetic limbs. Everything had a downside. The items that didn't arouse suspicions (like diabetes test strips) were often too cheap to make much money from. And the real big-ticket items (like limbs) attracted too much attention if you billed them by the hundreds.

Then they discovered the power wheelchair.

And it was perfect.

“Let me put it to you this way: An $840 power wheelchair, Medicare pays close to $5,000 for. So there’s a huge profit margin there. Huge,” said one California man who participated in a recent fraud scheme involving wheelchairs.

Medicare used to set its payments for most power wheelchairs based on manufacturers’ suggested retail prices. It did not lower those prices significantly for years, even when it was obvious that wholesale prices were far, far lower. So for scammers, each wheelchair brought a hefty profit.

And the chairs were also good for evading authorities’ attention. A wheelchair was supposed to treat a condition — trouble with mobility — that was a heck of a lot easier to fake than a missing arm.

“You don’t have to do [expletive], and make a [expletive]-load of money,” the California fraudster said, summing up the scam’s appeal in a single profane sentence. He asked not to be identified, spoke on the condition of anonymity because his court case is still pending. “I would say there’s almost no hassle at all.”

Photographic evidence

In the courtroom in Los Angeles, another member of Fadojutimi’s operation — office manager Maritza Velasquez — was testifying. She said her husband drove the delivery truck, delivering real wheelchairs to the scam’s bogus patients.

She said he would actually take pictures at each stop — the chair and the person together — to keep in their files as proof of receipt. Legally, this was not a great idea. Mainly because many of the photos showed recipients standing up. Right next to the chair that Medicare had bought them because they couldn’t stand up.

“There was a guy who was actually in work clothes, like construction clothes, with cement kneepads,” Velasquez said, recalling one photo. He been out doing hard manual labor.

“So that was . . .” — Velasquez paused on the stand, looking for the right word — “different.”

$20,000 in one day

In the early 2000s, the wheelchair scam spread from Miami to Houston. There, it exploded. In 2001, for example, Medicare had paid for only 3,000 power wheelchairs in the county that includes Houston.

In 2002, it paid for 31,000.

“I was told that I could make a quick 200 bucks. And basically I went up there and I made like $800” on the first day, said Lorine Hawthorne, of Houston. She had been recruited as a marketer for a Houston scam in those go-go days, finding elderly people and delivering them to a handpicked clinic.

“The most I ever made in one day, probably, was like $20,000,” she said. “That’s a lot of money for one day.” Hawthorne pleaded guilty to one count of fraud in 2005.

From Houston, the scam spread out: to Louisiana, to Arkansas, to California. Nationwide, Medicare saw a sharp spike in wheelchair claims. Before the fraud had taken off, the chairs were rare: One study estimated that in 1994, only 1 in 9,000 beneficiaries got a new wheelchair.

By 2000, it was 1 in 479.

By 2001, it was 1 in 362.

By 2002, it was 1 in 242.

And beyond the simple increase in wheelchair claims, there were other signs that these claims might be bogus. Before the scam took off, for example, power-wheelchair prescriptions were usually written for patients with serious and advanced illnesses such as multiple sclerosis or Parkinson’s disease. But as the scam grew, that changed.

“Many more of the diagnoses were things where you sort of go, ‘What?’ ” said James Goodwin, a University of Texas medical school professor. Looking in Medicare’s own data, he saw a rise in power wheelchairs prescribed for more common conditions such as arthritis and back pain. “It becomes a very, very strong picture, strongly suggesting there’s a lot of abuse going on there.”

As early as 1998, Medicare had recognized the existence of the wheelchair scam with a national “fraud alert.” But, to front-line fraud investigators, it was obvious that the crooks were still getting their claims paid.

The power wheelchair scam

A federal government crackdown on Medicare fraud has weakened medical supply companies' ability to receive large profits from filling power wheelchair prescriptions. The lucrative scam overbilled the federal spending program for more than a decade and it is unknown how much money was actually paid out. Here's how the crime worked:

- 1
- 2
- 3
- 4

Next

Patient recruiter found a patient

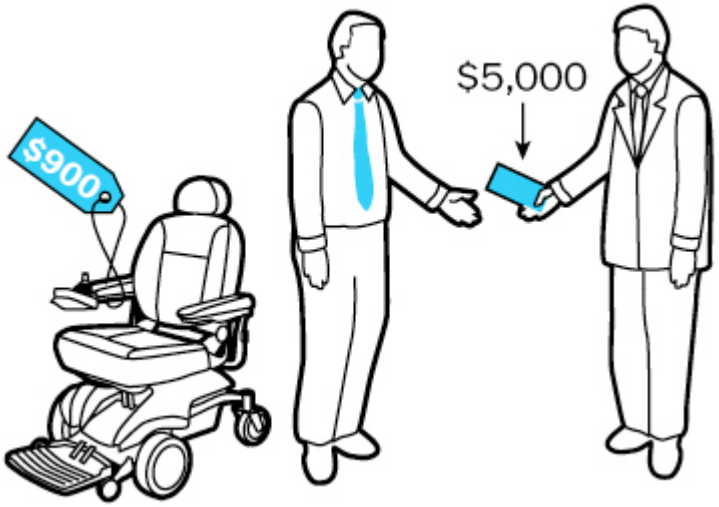
A patient recruiter called a "capper" found a potential power-wheelchair patient by visiting individual homes, nursing facilities or community centers for seniors. The capper gave a senior's name and Medicare number to a medical supply company involved in the scam. The medical supplier confirmed with Medicare that a power wheelchair had not been previously paid for and provided to the patient.

Patient recruiter found a patient

A patient recruiter called a "capper" found a potential power-wheelchair patient by visiting individual homes, nursing facilities or community centers for seniors. The capper gave a senior's name and Medicare number to a medical supply company involved in the scam. The medical supplier confirmed with Medicare that a power wheelchair had not been previously paid for and provided to the patient.
Doctor wrote a wheelchair prescription

The capper or medical supply company then made an appointment for the patient with a doctor involved in the scam. The doctor wrote a prescription for the senior to have a power wheelchair or scooter.
Wheelchair was delivered to the patient

Some scams skipped this step and delivered nothing to patients. But in many cases, scammers actually delivered a power wheelchair — or a cheaper three-wheeled "scooter." Delivering the chairs kept patients from feeling ripped off, and made it less likely they would tip off authorities about fraud.
Medical supply company billed Medicare



The medical supplier billed Medicare for the filled prescription. For years, Medicare did not ask for a copy of the prescription or any record of the patient's health examination to confirm need of a wheelchair. Medicare also paid much more than the chair's wholesale cost.

Sources: U.S. Department of Health and Human Services, HHS Office of Inspector General

"An agent in Little Rock witnessed a scooter race in one of the neighborhoods. Old people. One of them had attached an ice chest to it," said Mike Fields, a fraud investigator at the Department of Health and Human Services (A "scooter" is a less expensive kind of powered chair, also heavily used in frauds.) "It just gets your blood up, you know. Knowing how much we'd paid for them."

But for Medicare officials at headquarters, seeing the problem and stopping it were two different things.

That's because Medicare is an enormous system, doing one of the most difficult jobs in the federal government. It receives about 4.9 million claims per day, each of them reflecting the nuances of a particular patient's condition and particular doctor's treatment decisions.

By law, Medicare must pay most of those claims within 30 days. In that short window, it is supposed to filter out the frauds, finding bills where the diagnosis or the prescription seem bogus.

The way the system copes is with a procedure called "pay and chase." Only a small fraction of claims — 3 percent or less — are reviewed by a live person before they are paid. The rest are reviewed only after the money is spent. If at all.

The whole thing is set up as a kind of honor system, built at the heart of a system so rich that it made it easy for people to be dishonorable.

"The thing had been set up to pay the claims of Dr. Marcus Welby, M.D., and it was very good at doing that," said Ted Doolittle, a former top Medicare fraud-control expert. Marcus Welby, a kindly and honest doctor, was the protagonist of a 1970s TV show.

The wheelchair scam, Doolittle said, hit the system in "a big, undefended underbelly."

Starting in 2003, Medicare officials started trying to stop the wheelchair scams by changing their rules. That was the beginning of a long — and one-sided — game of cat and mouse.

The officials always thought they'd done enough. The scammers were always a step ahead.

In 2004, for instance, Medicare started to require that any doctor who prescribed a power wheelchair actually had to see the patient, in person. For the scammers, that was a new obstacle. But not a big one. They just had their corrupt doctors see patients in person.

Then, in 2007, the government began a legal crackdown. It began a "strike force" of prosecutors, who targeted equipment fraud in problem cities. They nailed some of the most egregious wheelchair scammers. But the courts could only handle a relatively small number of scammers, so prosecutors tended to choose the most obvious fraud operations. The smarter, steadier operations didn't stand out, and survived.

"Not only greedy, but stupid. Those are the ones we catch," said Malcolm Sparrow, a professor at Harvard's John F. Kennedy School of Government who has studied Medicare fraud. "We're mostly getting people who didn't finish high school, who've stolen more than $10 million in three months. Those are the ones we get. And you know the clever people are just invisible."

So despite these efforts, the scam churned on. In 2012, about 219,000 people got a wheelchair from Medicare. That was 1 in 235 beneficiaries: After a decade in which Medicare tried to make these chairs harder to get, people were getting them at about the same rate as in 2002.

So why didn't Medicare do even more to stop the wheelchair scam?

The answer seems to be that — in the huge universe of Medicare's money — this big scam was still not that big. Last year, for instance, power wheelchairs accounted for just 2 percent of Medicare's equipment spending. Which accounted for just 3 percent of Medicare's $248 billion outpatient spending (called "part B").

"Even though power wheelchairs was sort of the big gorilla in the room of [equipment fraud], it was still a tiny little gorilla, in comparison to the rest of Medicare," said John Warren, who worked in Medicare's anti-fraud office between 2005 and 2007.

Also, he said, Medicare was always reluctant to clamp down too much on wheelchairs, for fear that it would backlog the system and keep legitimate wheelchair patients from getting their chairs. "Looking back, I think we did pretty good," Warren said.

'This is not about stealing. This is fraud.'

In the Los Angeles trial, prosecutors said that Fadojutimi's operation ran for six years. It adapted to the requirement that doctors see patients in person. It stayed below the radar well enough to avoid the strike-force crackdown.

In fact, it shut down on its own after Medicare started giving its claims special scrutiny. By the time the scam wrapped up in 2010, prosecutors said, it had taken in about $4.3 million from Medicare.

Later, however, fraud investigators stumbled upon the operation. And when they started looking, the scam unraveled quickly.

For one thing, Velasquez had saved pages from the "marketer log," which the scam used to track which recruiters had brought in which patients. That was, in effect, a running diary of a criminal conspiracy. Government's Exhibit 25.

"When the government is presenting its case, you might be inclined to say, 'Wow! She's guilty,' " Fadojutimi's defense attorney, Femi Banjo, told the jury during his opening statement. His only play was to make the best of a bad situation, urging them to keep an open mind.

Prosecutors in a fraud case in Los Angeles submitted as evidence photos of motorized wheelchairs that were delivered to Rodolfo Fernandez and Joyce Journagin as part of an alleged Medicare scam. Neither recipient needs a wheelchair. Fernandez testified that the clinic where he was examined and prescribed the wheelchair was located in a second-floor walk-up. "I had to climb the stairs," he said.

Banjo also told the jury that he objected to something a prosecutor had said: that Fadojutimi's wheelchair operation had "stolen" money from the government.

"This is not about stealing," Banjo said, trying to draw a moral distinction. "This is fraud."

After a five-day trial, jurors found Fadojutimi guilty on all seven counts of health-care fraud, plus one count of conspiracy and one count of money laundering. She is awaiting her sentence.

A scam's slow death

In the past few years, at last, the government says it has outsmarted the wheelchair scammers.

For one thing, Medicare began using competitive-bidding processes to lower what it paid for wheelchairs. The total spending on wheelchairs and scooters — which had reached as high as $964 million in 2003 — fell to $190 million last year.

It also required wheelchairs to be given out on a rent-to-own basis, instead of paid for all upfront. That gave more time to check if the claim was bogus. And in 2012, Medicare also made a crucial change in the way it handled wheelchair claims. Now, in 19 states, the government reviews all wheelchair bills before it pays them.

Finally, last year the feds went after the Scooter Store.

That company had become famous for its commercials telling seniors: "Your power chair will be paid in full." In 2007, the store had already been fined for fraudulent practices, which included billing Medicare for power wheelchairs that patients did not want or need.

Last year, as part of a new investigation, federal agents with a search warrant raided the Scooter Store headquarters in New Braunfels, Texas. No new criminal charges have been brought. But Medicare was still concerned enough to cut off funding to the Scooter Store.

It was a death sentence. The business, heavily dependent on federal payments, shut down last fall.

Last year, about 124,000 people got power wheelchairs from Medicare. That was the lowest total since 2001, equivalent to one for every 400 beneficiaries.

That's the good news. The bad news is that, when officials go back to try to figure out what the scammers stole, they get mired in an unholy bureaucratic mess.

When officials review old wheelchair bills, they discover that at least 80 percent of them were "improper": They contain major errors and shouldn't have been paid as is. Perhaps the patient's diagnosis didn't actually qualify for a power wheelchair. Perhaps the paperwork was incomplete.

How many of those bills were sent in by fraudsters, trying to squeeze through the system's blind spots?

Medicare can't say.

"You'd have to talk to the patient. You'd have to talk to the providers" and ask if the wheelchair was really needed, said Shantanu Agarwal, a doctor who is Medicare's top fraud fighter. "And then, at the end of it, you could make a reasonable, fact-based, experienced-based determination about whether this is probably fraud," Agarwal said. Medicare doesn't have the time or money to do that for power wheelchairs now.

Today, even while the wheelchair scam is in decline, that same "pay and chase" system is allowing other variants of the Medicare equipment scam to thrive.

They aren't perfect. But they work. In Brooklyn, for instance, the next big thing is shoe inserts. Scammers bill Medicare for a $500 custom-made orthotic, according to investigators. They give the patient a $30 Dr. Scholl's.

In Puerto Rico, the next big thing seems to be arms and legs.

In one case there, two dozen companies billed Medicare for $5.3 million in prosthetic legs inside of a year. In many cases, their "patients" had no record of amputations in their medical history. Many of them didn't even live in Puerto Rico. But Medicare paid for the legs.

Alice Crites in Washington contributed to this report.

[67] Group Spotlights Health Insurance Trade Associations' Political Contributions.

The Hill (4/14,/2011 Pecquet) "Healthwatch Blog" reported that health insurance agents and brokers, "who are lobbying to be excluded" from the medical-loss ratio provision in the healthcare reform law "gave lawmakers more than $3.18 million in the 2010 election cycle, Consumer Watchdog said Thursday." The $3.18 million represents the "contributions from the top three" trade associations for agents and brokers: the "National Association of Insurance and Financial Advisors, the Independent Insurance Agents and Brokers of America and the National Association of Health Underwriters," according to data from the Center for Responsive Politics. Republicans received "two-thirds" of the contributions. The bill's "main sponsors, Rep. Mike Rogers (R-Mich.) and John Barrow (D-Ga.), received $16,000 and $12,500 respectively," according to Consumer Watchdog.

[68] GOP Lawmakers Complain About Proposed Bonuses For MA Plans.

CQ (4/15/2011, Adams, Subscription Publication) reports that Sen. Orrin G. Hatch (R-UT) and House Ways and Means Committee Chairman Dave Camp (R-MI) "complained Thursday that the Department of Health and Human Services is bypassing Congress by giving private Medicare Advantage plans extra money through a bonus program." The healthcare law included "a 3.5 percent reduction in payments to the Medicare Advantage health plans run by private insurers. But HHS officials have announced that they would be giving performance bonuses to some plans through a demonstration program," which in effect provides them with an increase rather than the decrease mandated by the law. Hatch and Camp wrote in a letter to HHS Secretary Kathleen Sebelius, "While we appreciate the administration's newfound support for the MA program, we are concerned about CMS' use of this payment demonstration authority and the lack of transparency in accounting for taxpayer dollars."

The Hill (4/15, Pecquet) reports in its "Healthwatch" blog that Hatch and Camp also wrote in the letter to Sebelius, "Given the fact that without this demonstration, the new healthcare law would have taken current plans and choices away from many seniors in October of 2012 -- right before the 2012 presidential elections -- we believe that the (demonstration) may represent a thinly veiled use of taxpayer dollars for political purposes."

[69] Axxent FlexiShield Mini Recall Elevated To Class I.

The New York Times (4/15/2011, A17, reports that "the recall of a medical device" known as the Axxent FlexiShield Mini, "that left particles of tungsten in women's breasts has been classified as the most serious type of recall, one involving 'situations in which there is a reasonable probability

that use of these products will cause serious adverse health consequences or death,' the Food and Drug Administration said on Wednesday." The device, used during a particular type of radiation treatment, "left the breast tissue and chest muscles riddled with hundreds of tungsten particles." The Times adds, "That the tungsten shows up on mammograms is what made the recall Class I, the most serious type, said Karen Riley, a spokeswoman for the Food and Drug Administration."

[70] **AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com]**
Sent: **Wednesday, November 17, 2010 7:36 AM**
Administration Announces New Quality Initiatives Under Healthcare Law.
The Los Angeles Times (11/17, Levey) reports, "The Obama administration on Tuesday announced new initiatives to boost the quality of medical care that Americans receive, laying the foundation for what many experts think could be one of the most far-reaching benefits of the new healthcare law." This "10-year, $10-billion effort -- which proponents hope can reduce hospital-acquired infections, help ensure seniors take their medications, and more -- has garnered far less attention than the politically charged debate about repealing the law," yet "the quality-improvement campaign is quietly winning the support of corporate leaders, consumer groups, doctors and healthcare experts across the political spectrum." Commenting on the announcement, CMS Administrator Dr. Donald Berwick said, "The American healthcare system is not currently performing the way it needs to**. It's broken."**

The AP (11/17) reports, "Medicare's new chief called for more steps to improve patient safety Tuesday, in the wake of a government report that said one in seven hospitalized Medicare patients is harmed during their stay." Approximately "1.5 percent of those patients, or 15,000 people a month, suffered a complication that contributed to their death, the inspector general for the Department of Health and Human Services said." In response to the findings, Berwick, who is "a well-known quality-care specialist," said, "We have to do better." CMS "unveiled a new Medicare 'innovation center' Tuesday designed to develop and test ways to improve quality of care and lower health care costs for everyone, not just Medicare recipients."

The Hill (11/17, Pecquet) also notes the launching of the new innovation center in its Healthwatch blog, and quotes Berwick as saying, "For too long, health care in the United States has been fragmented -- failing to meet patients' basic needs, and leaving both patients and providers frustrated. ... The Innovation Center will help change this trend by identifying, supporting, and evaluating models of care that both improve the quality of care patients receive and lower costs." Richard Gilfillan, the center's acting director, "added that the center aims to improve the care of Medicare and Medicaid patients alike by working to 'identify, validate, and scale models that have been effective in achieving better outcomes and improving the quality of care." Reuters (11/17, Stephenson) and PBS's NewsHour (11/17, Winerman) also cover the story.

[71] **From:** AHLA Member Services [mailto:HealthLawDaily@ahla.custombriefings.com]
Sent: Thursday, December 09, 2010 7:13 AM
As Oversight Committee Chair, Issa To Focus Attention On Medical Device Costs.
The Wall Street Journal (12/9, Mundy) reports that Rep. Darrell Issa (R-CA) has announced in an interview given this week that among his top priorities is reducing medical costs. In particular, the congressman, who was named on Dec. 8 to be the next chairman of the House Committee on Oversight and Government Reform, will focus on costs relating to medical devices and device-related procedures. Data released this week by the Senate Finance Committee revealed that Medicare paid $100 billion from 2003 to 2009 for medical device-related procedures. For that reason, among others, Issa believes it might be worth looking into the cost-effectiveness as well as the efficacy of medical devices. However, he prefers that physicians make these decisions, not the government bureaucracy

[71] http://www.fda.gov/cder/about/history/Histext.htm
Drug regulation farther down in the distribution system came under scrutiny in 1955, when FDA undertook a pilot study of adverse drug reaction reporting. In cooperation with the American Society of Hospital Pharmacists, the American Medical Association, and others, the study focused on reactions reported by hospitals and pharmacists. Adverse reaction reporting at this time was voluntary and reports normally were scarce. This study blossomed into a more ambitious effort in 1957 to test a large-scale system for voluntary reporting to assist with post-marketing evaluation of new drugs. By 1963 the study had evolved into a voluntary reporting system with almost 200 hospitals participating.
[71] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.
[71] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.

[71] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.
[71] "Personalized Medicine: Panacea or Pipedream?" by Jeffrey Gibbs (attorney, Washington DC). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 6.

[71] Figure cite by United States Senate Committe on Finance, sent to A ccreditation Council for Continuing Medical Education, FDLA Advertising and Promotion Conference September 2008, Washington D.C.
[71] http://www.cahi.org/cahi_contents/resources/pdf/n145HighCostofHealthCare.pdf
Council for Affordable Health Insurance's Issues and Answers, No. 145, July 2007. Solutions for Today's Health Policy Challenges.
[71] http://www.cahi.org/cahi_contents/resources/pdf/n145HighCostofHealthCare.pdf
Council for Affordable Health Insurance's Issues and Answers, No. 145, July 2007. Solutions for Today's Health Policy Challenges.
[71] Riegel v. Medtronic Inc. No. 06-179 - 510k-premarket approval deference medical device U.S. Supreme Court 2008
[72] Pitts, Pallone Fight Proposals To Curb Medical Imaging.
The Hill (5/31/2011, Pecquet) "Healthwatch" blog reported that Reps. Joe Pitts (R-PA) and Frank Pallone (D-NJ) "the top Republican and Democrat on the Energy and Commerce Health panel are pushing back against proposals to curb medical imaging tests paid by Medicare, arguing that they could restrict access to 'life-saving medical tools.'" In a letter to Glenn M. Hackbarth, the chairman of the Medicare Payment Advisory Commission, Reps. Pitts and Pallone "request that scheduled imaging payment cuts be allowed to go into effect before new restrictions are considered. In April MedPAC voted to submit clinicians who order large numbers of such tests to prior authorization, a recommendation that's expected to be included in the commission's June report to Congress."

[73] http://www.fda.gov/cder/about/history/Histext.htm
Drug regulation farther down in the distribution system came under scrutiny in 1955, when FDA undertook a pilot study of adverse drug reaction reporting. In cooperation with the American Society of Hospital Pharmacists, the American Medical Association, and others, the study focused on reactions reported by hospitals and pharmacists. Adverse reaction reporting at this time was voluntary and reports normally were scarce. This study blossomed into a more ambitious effort in 1957 to test a large-scale system for voluntary reporting to assist with post-marketing evaluation of new drugs. By 1963 the study had evolved into a voluntary reporting system with almost 200 hospitals participating.

[74] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.

[75] HHS Announces Lower Premiums For PCIP Program.

The AP (6/1/2011) reports, "The government is cutting premiums by up to 40 percent in 17 states and implementing other changes to make it easier for people with pre-existing medical conditions to get health insurance." This announcement "comes as enrollment in the Pre-Existing Condition Insurance Plan continues to lag far behind expectations, often because people can't afford the premiums or find it too hard to meet enrollment requirements." The program is part of the healthcare law, which President Obama signed last year, and it "offers health insurance to people with medical problems at prices the average healthy person would pay, although that's not necessarily cheap."

USA Today (6/1, Kennedy) reports that the lower premiums will lead to "savings for people across the country," according to Sebelius. For instance, "in Florida, the average monthly payment for a person older than 55 is $390. After July 1, it will drop to $234 a month." In addition, "people who would like to enroll in the program...no longer need to provide a letter from an insurance company denying them coverage." They simply "need a letter from a doctor saying they have a medical condition." But, the "rule that a person may not have had health insurance for the past six months still applies."

The Los Angeles Times (6/1, Levey) reports, "The administration is directly slashing premiums in the District of Columbia and most of the 23 states that have elected to have the federal government run their health plans. The remaining 27 states, which each run their own plans, will be able to reduce premiums as well."

The Wall Street Journal (6/1, Adamy, Subscription Publication) says that many consumers had shied away from the program largely due to costs. The Administration hopes that the new changes will make the program more attractive to people with pre-existing conditions.

The Hill (6/1, Baker) explains in its "Healthwatch" blog that the "high-risk pools were designed to provide a temporary option for people who haven't been able to get insurance because of a pre-existing condition. Insurance companies will be required to sell insurance to everyone beginning in 2014, regardless of their health status." To date, however, enrollment rates have been lower than anticipated.

The Huffington Post (6/1, Delaney) reports that in fact, "only 18,000 Americans have signed up for the PCIP. Officials initially said it would reach hundreds of thousands by the time the program is phased out in 2014, when it will become illegal for insurance companies to discriminate against the sick."

The National Journal (6/1, McCarthy, Subscription Publication) reports, "Starting July 1, 2011, people applying for coverage can simply provide a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability, or illness," HHS stated.

CQ (6/1, Norman, Subscription Publication) reports that Richard Popper, the CMS official who oversees the program, "told reporters Tuesday that the people are being enrolled 'at an increasing rate, but we know we have the capacity to cover even more people so we're making these

adjustments today.'" Popper added that "HHS officials cannot waive other eligibility requirements that are spelled out in the statute, such as a rule that people must be without insurance for six months before qualifying for the risk pool."

Also covering the story are Reuters (6/1), McClatchy /Kaiser Health News (6/1, Galewitz), the Arizona Republic (6/1, Alltucker), Fort Worth Star Telegram (6/1, Fuquay), Miami Herald (6/1, Singer), Palm Beach Post (FL) (6/1, Singer) "On Call" blog, and the Las Vegas Review-Journal (6/1, Milliard).

[76] The $2 Million Patients New York Faces Review for Medicaid Rates Charged in Care of Mentally Disabled BY JACOB GERSHMAN

New York's state-run institutions for the mentally disabled are billing the Medicaid program nearly $2 million per patient a year—a rate that goes far beyond the cost of caring for the patients and is attracting the scrutiny of federal regulators. The state spends $700 million a year to house about 1,400 disabled people in the facilities. But it bills Medicaid more than three times that amount. By taking advantage of federal matching funds, the state pockets approximately $1 billion extra every year—and uses it to subsidize other areas of the budget. A senior health-care adviser to Gov. Andrew Cuomo said ..

[77] Figure cite by United States Senate Committe on Finance, sent to A ccreditation Council for Continuing Medical Education, FDLA Advertising and Promotion Conference September 2008, Washington D.C.

[78] "Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48

[79] Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48

[80] "IP Considerations in Early Biomarker Development in the Personalized Medicine Age." By Peter Keeling CEO of Diaceutics, and Mollie Roth, Corporate Counsel, V-P Diaceutics. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 28

[81] Riegel v. Medtronic Inc. No. 06-179 - 510k-premarket approval deference medical device U.S. Supreme Court 2008.

[82] Cooper, FDLI 2008. p. 5

[83] Cooper, FDLI 2008. p. 5

[84] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18

[85] http://www.cahi.org/cahi_contents/resources/pdf/n145HighCostofHealthCare.pdf
Council for Affordable Health Insurance's Issues and Answers, No. 145, July 2007. Solutions for Today's Health Policy Challenges.

[86] http://www.cahi.org/cahi_contents/resources/pdf/n145HighCostofHealthCare.pdf
Council for Affordable Health Insurance's Issues and Answers, No. 145, July 2007. Solutions for Today's Health Policy Challenges.

[87] "IP Considerations in Early Biomarker Development in the Personalized Medicine Age." By Peter Keeling CEO of Diaceutics, and Mollie Roth, Corporate Counsel, V-P Diaceutics. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 28

[88] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.

[89] "Personalized Medicine: The Role of Laboratories." By Pratt (Cief Director, Quest Diagnostics), Dunn (Assoc Professor, University of Oklahoma Health Sciences Center), and Weck (Assoc Professor Univ. Of North Carolina). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 18.

[90] "Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48

[91] See Dark Remedy **The Impact Of Thalidomide And Its Revival As A Vital Medicine** .
http://www.perseusbooksgroup.com/basic/search.do?searchText=dark+remedy&imprintCid=BA&x=6&y=8

Discovered in Germany in the 1950s, it was marketed and targeted at pregnant women, causing many thousands of birth defects. It was not approved in the U.S. It is approved for treatment of leprosy.
http://www.fda.gov/cder/news/thalinfo/default.htm

[92] "Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48.

[93] http://www.fda.gov/cder/about/history/Histext.htm In May 1972, FDA applied the principle of a retrospective review to over-the-counter (OTC) drugs. The OTC review focused on active ingredients, around 1,000 different items, and panels of experts were convened to evaluate these drugs. The review is ongoing.

[94] "Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48

[95] "Ensuring the Safety of Parenteral Pharmaceuticals: How Manufacturers Can Benefit from New Pyrogenicity Testing Methods" by Nancy Beck, Scientfic and Policy Advisor at The Physicians Committee for Responsible Medicine, Washington DC. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 40

[96] "Personalized Medicine: Panacea or Pipedream?" by Jeffrey Gibbs (attorney, Washington DC). Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 6.

[97] http://www.fda.gov/cder/about/history/Histext.htm As a result of the narrowly avoided tragedy from thalidomide, Senator Estes Kefauver re-introduced his bill to amend the Food and Drug Act. On October 10 President Kennedy signed the Drug Amendments of 1962, also known as the

Kefauver-Harris Amendments. These Amendments required drug manufacturers to prove to the FDA that their products were both safe and effective prior to marketing. … To further comply with the drug amendments of 1962 the FDA contracted in 1966 with the National Academy of Sciences/National Research Council to study drugs approved between 1938 and 1962 from the standpoint of efficacy. The Drug Efficacy Study Implementation (DESI) evaluated over 3000 separate products and over 16,000 therapeutic claims. The last NAS/NRC report was submitted in 1969, but the contract was extended through 1973 to cover ongoing issues. The initial agency review of the NAS/NRC reports by the task force was completed in November 1970. One of the early effects of the DESI study was the development of the Abbreviated New Drug Application (ANDA). ANDAs were accepted for reviewed products that required changes in existing labeling to be in compliance. In September 1981 final regulatory action had been taken on 90% of all DESI products. By 1984, final action had been completed on 3,443 products; of these, 2,225 were found to be effective, 1,051 were found not effective, and 167 were pending.

[98] "Pharmaceutical Safety is not Served by Federal Supremacy" by Thomas N. Tiedt, Director Med-Tox Group Sarasota, Fl. Reported in Sept Oct 2008 Update, Food and Drug Law, Regulation, and Education, Issue 5 (2008) Washington D.C. www.fdli.org pg. 48