# Profiteering at the Nation's Bedside: A Corrupt System Legalized

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Where once patients paid doctors for services, third-party payers now pay doctors not to order services: a system of corporate or government agency profiteering, i.e., taking advantage of a situation to make a self-serving profit by corrupting the provision of care.

The Centers for Medicare and Medicaid Services (CMS) is set to enforce physician profiteering at the bedside, in the guise of "value pay" or "value purchasing."[1] The hope is that profiteering (or "bonus opportunities")[2] for restricting patient "resource use"[3] will "incentivize" doctors at the bedside to play a gatekeeper-like role, as government or corporate agents for rationing care, or more grandly for "prudent use of shared societal resources."[4]

Masquerading euphemisms aside, the CMS dictate to make physicians rationing agents looks like an example of 21st century state utilitarianism, where the ends (cost control) are presumed to justify the means, and the people become captive human subjects of economic and ethical experimentation.[5]

Advocates of managed care have long believed that cost control necessitated a switch of professional loyalty from patients to corporate populations.[6] The progenitors of the Affordable Care Act (ACA or "ObamaCare") clearly agreed. They recommended legalizing the switch through "innovations" such as overriding anti-corporate practice of medicine laws and "problematic…federal anti-kickback and self-referral prohibitions."[7]

**Aspects of Exploitative Profiteering**

**1. Enabling Profiteering: A Scandal**

The enabling legislation for the CMS dictate is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA—the "doc fix" law).[8] This new law legalizes exclusive franchising of insurance underwriting to Alternative Payment Model (APM) programs. These typically are mini-HMO-like hospital staff insurance corporations called Accountable Care Organizations (ACOs). In essence the self-described mega-"payers,"—government agencies and HMO corporations—can transfer underwriting risk to franchised mini-provider insurance corporations, and can auction populations for servicing only to those so franchised, making a neat closed circle of payer collusion and control.

It is disturbing that CMS had already run a huge ACO experiment that failed. CMS reported that in 2012, 220 ACOs were started, 52 cut costs (with $700 million in savings/profits), 115 had no savings, and 53 dropped out.[9, 10] At best, the CMS experiments had a 76% failure rate and minimal savings. The excuses were that value-pay benefits tied to quality were too small and the learning curve too steep. Instead of shelving a failure, CMS announced its massively increased ACO experiment simultaneously with congressional passage of MACRA in March 2015. Secretary Sylvia Burwell wrote that "our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018."[1]

MACRA legislation (and its Merit-Based Incentive Payment System or MIPS[2,8]) legalized ACO gatekeeper incentive payments, i.e., "bonus opportunities" and "negative payment adjustments,"[2] the code words for bribes, i.e., "…money or favor given or promised in order to influence the judgment or conduct of a person in a position of trust."[11]

Meredith Rosenthal, Professor of Health Economics and Policy and Associate Dean for Diversity at Harvard T.H. Chan School of Public Health, notes that "merit" pay is based on four domains: quality of care, meaningful use of electronic health records, participation in clinical practice improvement activities, and (most crucial of all) resource use.[3] The latter is the only one of the four domains with any possibility of controlling costs—and then only if bribes work to reduce orders for care. She points out that there are many factors outside physicians' control. For instance, without population risk adjustment merit pay "will be unfair."

Merit pay (or "value pay" or "value-based purchasing") creates problems for clinics. Integral to value pay is quality, which, like beauty, depends on what's in the eye of the beholder. Corporations are enamored by population statistics including use of their money. Patients are interested in personalization, continuity, timeliness, and trustworthiness in their care. Further, risk adjustment is expensive, whereas administrative data can easily be used to find and punish those clinics spending too much corporate money regardless of fairness.

What happens to the ethical integrity of a nation and its professionals when leaders create a system where doctors are bribed to restrict care at the bedside for the benefit of third-party payers? The scandal is well hidden by merit or value-pay double-speak euphemisms. As George Orwell wrote in 1946, "Political language…is designed to make lies…truthful and murder respectable."[12]

Thus a corrupt system of third-party bribes is legalized and double-speak blinds our political "sages."

**2. Missing the Patient-Third Party Conflict of Interest Scandal Is Common**

In a recent article, Jonathan Oberlander of the University of North Carolina Chapel Hill and Miriam Laugesen of Columbia

University critiqued the CMS initiative and titled it: "Leap of Faith—Medicare's New Physician Payment System."[13] The authors note that Medicare "is set to pay physicians more to embrace innovations whose effectiveness is highly uncertain …yearning for a magic bullet…."

These value-pay incentives have already been adopted by many in the managed-care industry for two reasons. Value-pay sophistry conveys an image of corporate probity and societal concern. In practical terms sophistry hides the conveyance of enormous contracting power to payers—a power to transfer insurance risk and the black hat of profit-driven rationing of care to providers at the bedside.

The CMS experiment in cost control may be a leap of faith into another experiment of corporate contracting empowerment, but this is of little concern to those with a utilitarian mindset. Even fine academic analysts can miss the utilitarian rationalizations of corrupt means to a good end.

ACO gatekeeper bonus pay contingent on restricting patient access to medical care is simply profiteering wrapped in the noble-cause sophistry of "reform," "stewardship," "accountability," or whatever. It creates a patently corrupt financial conflict of interest between ACO corporate gatekeepers and patients.

**3. Waivers to Create a Public-Corporate Cartel System**

ACOs are mini-insurance corporations, yet they have no state insurance license and no (untaxed) reserves, no sales force, no patients, no money, no actuaries, no lobbyists, and no back-office insurance capabilities. Of necessity, they must have legal arrangements with real insurance corporations for these functions.

Partnership mergers or joint ventures for collusive behavior have been legalized through Federal Trade Commission (FTC) and CMS waivers of patient protection laws.

FTC waivers of anti-trust laws[14] can legalize local mergers of hospital and medical staffs into ACOs, and can legalize colluding joint ventures between ACOs and HMOs. These joint ventures are already commonplace. Calling mergers joint ventures avoids anti-trust violation.[15] They can also legalize massive national corporate mergers.[16]

In addition, CMS waivers of anti-fee splitting and anti-self-referral laws[17] can legalize collusion to profiteer from rationing care and to split capitation fee profits and losses among the corporate partners. Thus, the profits for not ordering tests or referrals to other physicians can be split or shared between ACO corporate physicians and hospital and even with a joint-venture HMO. This is known as "gainsharing," a mutual profiteering mechanism lauded for "ObamaCare" cost control[18] and adamantly opposed by others.[19] Contrast shared profiteering for the benefit of third parties to a wage (fee or salary) paid to doctors for services delivered for the benefit of patients.

FTC and CMS waivers define a public-corporate cartel system, because by conveying government sovereignty, cartels can enjoy otherwise illegal collusive behavior.[20] Which partner will then control the other?[21] There is reason to worry if "ObamaCare" cartel creation results in government enriching those skillful at manipulating government.

The ugly possibility of crony cartel collusion has recently arisen. The Obama Administration has winked at and abetted rotating chairs between the CMS regulator and the regulated HMO industry management. This was summed up nicely in a recent *Wall Street Journal* headline: "The Government-Insurance Complex: Big Insurance hires its regulator as its new ObamaCare lobbyist."[22] The article noted that, when the CMS regulator Marilyn Tavenner became CEO of the industry trade association, President Obama promptly nominated Andrew Slavitt, an HMO (UnitedHealth Group) executive, as the new interim CMS regulator.

When does a public cartel become sinister cartel collusion? Rotating the regulator chair with those regulated is likely a sentinel event.

**4. From Cheerleaders to Gatekeepers**

Will "at risk" ACO (or APM) physician gatekeepers of corporate money actually receive more pay for decreasing use of payer money; or is this a delusion? Some professional associations collectively cheered the MACRA "doc fix," but apparently forgot to even think about the fact that clinic losses are predictable when the insurance game is controlled by others.

The CMS value-payment reform means that franchised cartels of merged or joint-ventured HMO-ACO corporations will control the amount of capitated money available at the end of the line for physician gatekeepers to spend on patient care. Spending corporate money is reflected in a "clinic cost of care index."[23] If the clinic spends too much, its members share the loss through a "negative payment adjustment,"[2] such as a future pay withhold, in lieu of real insurance reserves.

Many professional associations cheered merit pay for performance (P4P) of "value." Instead their members now risk bankruptcy and endless withholds contingent on clinic quality reports and on corporate administrative data depicting clinic "resource use."

Worse, these professional associations ignored the loss of the ethical integrity they profess. Gatekeeper value or merit pay really means "bonus opportunities" for restricting the volume of care for their patients or financial threats for ordering too much care—that's profiteering, a value to third parties, not to patients.

## Political Malpractice—From Good Intentions to Inflation and Cartels

How did we get to ACA[24] and its ironic federal waivers of patient protection laws creating merger mania[14,25] and public-corporate cartels protected by government sovereignty?[20] How did we get to creating bedside physician gatekeepers bribed to ration care?[8,17]

The short answer is political malpractice: futile rationing

of medical supply access, when the problem was politically created demand inflation.

Unrelenting U.S. cost-price inflation began abruptly after 1965 for the first time in nearly 100 years.[26] It followed passage of Medicare and Medicaid laws: a tipping point in time, when 85% of the populace (employed workers since 1942 plus the official old, poor, and disabled) suddenly had inexpensive tax-subsidized insurance—a piecemeal U.S. version of National Health Insurance (NHI).

Politically popular inexpensive (subsidized) insurance meant that buying coverage even for affordable and expected medical care made sense. The illusion of "free" care ("the boss pays for it") led to unrelenting demand inflation—induced demand was understood by economists from the beginning.[27-30] By 1970 there was a 7% cost crisis.[31]

The response to demand inflation was four (futile) decades of managed care: government price-fixing and politically created HMO corporations profit-driven to ration supply.[32,33] What was the fatal error of this managed market?

Paraphrasing the economist John Cassidy, no central authority can accomplish the functions of freely determined prices for the allocation of labor, capital, and human ingenuity, however brilliant [or good-willed] the managers.[34]

In contrast to managed markets, free markets work because prices matter.

## Reality Bites Back as Panaceas Fail and Absurdities Prevail

Per-capita healthcare expenditures have a direct, almost linear relationship to a nation's wealth, regardless of the nation's system of insuring care.[35,36] This suggests that politicians attempt to fund medical care as much as they find it politically possible; they promise the happiness of "free" care and promise to lower taxes—it works in time of elections, but deficits mount.

In practical terms, socialized national health service cartel systems abroad balance budgets by providing inexpensive "well care" for the many healthy voters, and queues for the few expensive ill needing "sick care." This is a form of socialized cartel cost control, which the U.S. HMO-ACO cartel system is poised to mimic.

It is absurd to think that massive documentation of processes or outcomes can create cost control through mining big data population statistics for rewarding quality or its lack. For example, there is no quality magic that could have an effect on population and individual health compared with what happened over the last 100 years. During that time public health departments were formed, public water supply and sewage disposal systems were cleaned up, vaccinations became common, and wondrous technologies including antibiotics became available.[37] Today, population health is mostly a function of socioeconomic and cultural factors.[38-41] These factors are beyond the control of clinics.

The high quality of the oft maligned U.S. traditional system of professional medical care is well documented.[42-45] This means that quality improvements will come from diligent incremental efforts in scientific, medical, and technology development.

There is no value or quality pay reform magic bullet to slay politically induced demand inflation.

In the meantime, the ACA becomes unaffordable,[46] the fantasy of cost control through prevention of disease persists,[47] and the panacea of bedside profiteering is pursued.[1,8,18]

## Profiteering Repercussions –A Summary

Our misfortune is that "ObamaCare" and its enabling laws and regulations create a collusive public-corporate cartel system of profiteering for cost control. The system is an economic and human experiment with serious potential repercussions:

- It is proving toxic to public and family finances;
- It creates a powerful public-corporate cartel system prone to corrupt cronyism;
- It creates financial conflicts of interest, which endanger patient health and the morale of their speciously demonized professionals;
- It endangers the moral integrity of the nation's medical system, when value-pay double-speak rationalizes bribing its doctors for cost control;
- It is absurd to ration care supply, when cost inflation is driven by political tax-subsidized demand.

## Conclusion

The job of doctors is to take care of patients. Doctors cannot solve the political problems of tax-subsidized demand inflation and utilitarian rationing of care supply schemes gone awry.

Too many politicians, pundits, and professional associations have little or no insight into the simple philosophic fact that a good end, cost control, never justifies corrupt means, a scandalous system of legalized profiteering at the bedside.

The nation needs a rendezvous with economic and ethical reality.

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