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What fascinating political times we live in. You've doubtlessly seen the incredible images from Wisconsin--and the disturbing scene of **doctors handing out sick notices** to protesting teachers. The sheer vehemence of the protesters and the signs they employ is disturbing to say the least--if the view that public employees should contribute a few percentage points more to their own benefits packages makes one subject to **Hitlerian comparisons in the streets**, it's truly become a cheap epithet.

Yet what this really indicates is the rise of broader fears within society concerning the direction of the country's entitlement structure and the conflict between **public workers and the public who fund their insurance and retirement benefits**. Even as the number of union employees has decreased steadily, the percentage of unionized workers who are public employees has increased dramatically--passing a tipping point in 2009, when these taxpayer-funded workers became the majority of unionized employees. With everyone at the table working on the taxpayer dime, there's no one mindful of a business's bottom line--a finite amount of resources to deploy toward benefit and health insurance packages. For all practical concerns, the public's budget has no bottom line--it is instead a boundless amount of cash for public workers to access, and the part-time state legislators who must approve their deals have nothing approaching the long-term investment of heads of private industry.

As Rep. Paul Ryan (R-WI) noted in an interview this weekend, the moment demands a response from our political leadership--a response that rejects the political dynamics of the past in the interest of pro-growth policies that will benefit more than just public employees who want to remain immune to budget cutbacks and economic downturns. That is why the current fork in the road is so significant. If leadership is unwilling to engage in the tough political confrontation over broad-based entitlement reform, beyond just the limited fight over public unions, the moment may be missed. At an American Enterprise Institute event titled **"Reforming Medicare at Last: A Practical Guide for Reluctant Policymakers**," I witnessed several pragmatic leaders in health policy all endorse dramatic reforms, well beyond the incremental approaches they favored in the past. This is a sign of the tide's pull, when even the pragmatists are favoring bold steps. Which direction those steps head, of course, will make all the difference.

-- Benjamin Domenech

IN THIS ISSUE:

WSJ: MEDICARE FRAUD CRACKDOWN CORRALS 114

We've written in the past about the efforts of *The Wall Street Journal* and the Center for Public Integrity to gain access to the Medicare payments hidden behind a wall by a 1979 court decision in favor of the American Medical Association. Now the initial WSJ reports have resulted at least in part in a crackdown on numerous doctors accused of engaging in fraud within the Medicare system to the tune of millions of taxpayer dollars.

A health-care crime sweep Thursday netted 114 defendants on charges related to Medicare fraud, in what Attorney General Eric Holder called the largest such takedown in U.S. history. The defendants--charged in nine metropolitan areas including Los Angeles, Brooklyn, Detroit and Miami--were allegedly involved in more than 40 schemes, almost all of which were unrelated to one another, officials said. Altogether, the schemes attempted to defraud the government of more than $240 million, according to law enforcement officials.

Several of the cases appear to involve doctors or other health-care practitioners acting alone or with few alleged co-conspirators. One of these, Brooklyn physical therapist Aleksandr Kharkover, had been featured in a December Wall Street Journal article on possible financial abuse involving physical therapy, a growing area of Medicare fraud.

Mr. Kharkover, accused of being involved in one of at least three separate alleged physical-therapy rings broken up this morning, billed Medicare about $11.9 million from January 2005 through July 2010, according to the indictment. During that time period, Medicare paid out $7.3 million, according to a person familiar with the investigation. He is accused of having billed for physical-therapy services that were never performed and weren't medically necessary.

I am told by those within CPI that they are currently culling through terabytes of information and expect to publish "hundreds" of stories on this front over the next year. Needless to say, while patient privacy comes first, there's a dramatic need for transparency to combat fraud--and if these payments can be detailed without direct patient exposure, that is exactly what needs to happen.

SOURCE: **Wall Street Journal**

BOSTON GLOBE: DEVAL PATRICK UNVEILS HEALTH OVERHAUL

I wonder what the Boston Tea Party's advocates would think of the price controls and mandates of the Bay State today. Deval Patrick's legislative solution for the cost crisis in his state, brought on by Mitt Romney's health plan and exacerbated by terrible policy choices since, goes all the way but to the point of empowering the state government to directly set provider rates.

"We have a big stick on us today," said Andrew Dreyfus, chief executive of Blue Cross Blue Shield of Massachusetts, who Patrick pulled in to stand beside him and help field questions from reporters after the speech. The commissioner's review puts "added pressure on us to force hospitals and physicians to moderate the increases that they ask for from us. It's very clear from the governor that if that doesn't happen, it's likely we'll see even bigger sticks coming our way."

Inspector General Gregory Sullivan said he would push for the insurance commissioner to have strong enforcement powers over making sure fees paid to providers are reasonable, while many providers are expected to lobby for exactly the opposite.

"They're saying this is not price regulation," said Joe Alviani, vice president for government affairs for Partners HealthCare, the parent organization of Massachusetts General and Brigham and Women's hospitals, large influential Harvard teaching hospitals that have been able to demand some of the highest prices in the market. But, he said, the powers of the commissioner will test that premise.

Test is a rather mild word for it. I think there is little question that this is direct price regulation, and it is exactly the same end point that we see ahead for the federal program.

SOURCE: **Boston Globe**

MANHATTAN INSTITUTE: THE ROLE FOR RETAIL HEALTH CLINICS IN NEW YORK

The Manhattan Institute's Paul Howard has released an interesting study on how retail health care clinics could fill the gap in health care access inevitably caused by the influx of newly insured individuals. An excerpt:

Beginning in 2014, the Patient Protection and Affordable Care Act, signed into law in March 2010, is expected to significantly extend health-insurance coverage in New York by increasing Medicaid enrollment and offering federal subsidies for the purchase of private health insurance. However, there is no guarantee that the newly insured will be able to access the health-care system in a timely fashion as new demand for services outstrips physician supply.

> After a similar insurance expansion in 2006, Massachusetts patients had to wait longer for physicians' office visits, and hospitals noted a surge in emergency-room use. This suggests that New York policymakers should look for new ways to expand access to health-care services well in advance of full health-reform implementation.
>
> In this study, we examine whether retail health clinics (also called "convenient care clinics") have a role in alleviating pressure on overcrowded physicians' offices and reducing inappropriate emergency-room use, thereby lowering overall health-care costs. Published research and interviews we conducted suggest that retail clinics have the skills and organization to serve as convenient and cost-effective providers of basic health-care services, provided that certain troublesome and unnecessary regulatory barriers are lowered or removed.

Howard identifies many of those troublesome and unnecessary barriers. State legislators ought to take note of this and consider examining the barriers in their own states.

SOURCE: **Manhattan Institute**

FORMER HHS SECRETARY LEAVITT: HEALTH REFORM'S CENTRAL FLAW

Former HHS Secretary Michael Leavitt writes in the *Washington Post* on the need for his successor, Kathleen Sebelius, to give states the flexibility they need on health and entitlement policy:

> If I may, as a former HHS secretary, offer a suggestion to the current secretary, it would be this: Use these expanded discretionary powers to grant states and the private sector more flexibility and more autonomy. Competition, innovation and new models of providing care and expanding coverage are the only ways we will reverse the dangerous course of future health spending. That simply cannot be done from Washington.
>
> There are numerous places where more state flexibility should be granted, such as providing control in how states design health insurance exchanges. States should have substantially more flexibility than is currently being discussed. Insurance exchanges have significant potential to enliven competition, expand access and create accountability, but the law empowers the secretary to write the rules for how states will create and administer their exchanges. This could be done in a top-down, heavy-handed approach, or the secretary could give the utmost flexibility to states to create exchanges that best meet residents' needs and reflect their values. Let states innovate to create value.
>
> Medicaid is another area ripe for state innovation. The federal government should give states their share of the federal health-care subsidies, outline basic standards and then let states design the best care for their residents. The health-care challenges differ by state, from the prevalence of certain diseases to the availability of care. States, not the federal government, are best positioned to understand their markets and residents and to create the proper public-private nexus to deliver the best coverage and care options.

Fine criticisms all, but they are bittersweet coming from Leavitt, who notoriously sat on several such requests for flexibility from the states until the eleventh hour, as we've noted before. Federalism seems far more attractive when one is out of power.

SOURCE: **Washington Post**

CATO INSTITUTE: BAD MEDICINE UPDATE

One last note--one of the best studies out there on President Barack Obama's law is from the Cato Institute's Michael Tanner. He has now updated his research with additional information gathered over the past several months in a useful revise-and-extend of his prior work. "The revised report reflects more recent and accurate cost calculations and updates to related legal cases." I encourage you to check out this report and refer your friends and colleagues to it.

SOURCE: **Cato Institute**

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