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Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify before you today at this hearing on "Unintended Consequences: Medicaid and the Opioid Epidemic." I am a professor at Georgetown University Law Center, and an adjunct scholar at the American Enterprise Institute and Cato Institute. I am here in my academic capacity; no one paid me to appear, or to prepare or submit these remarks.

Much of my testimony is drawn from a forthcoming book I co-authored with Professor Charles Silver of the University of Texas on the American health care system. The book, which is titled Overcharged: Why Americans Pay Too Much for Health Care (forthcoming, 2018), explains how the ways in which we have decided to pay for health care services has predictable consequences on the cost and quality of the resulting goods and services. To put it bluntly, we pay too much, and get too little (in terms of the quality and value). The book also explores how these same features make our public programs extremely vulnerable to fraud, waste, abuse, and overutilization. The book concludes that if we want to address these problems, we must change the incentives that our current health care system creates -- for both providers and patients.

None of this should come as a surprise. The HHS OIG and GAO have submitted scores of reports on these matters. Criminal prosecutions and civil enforcement actions have become routine, along with record-breaking payments from hospitals and pharmaceutical companies. The GAO has long labeled both Medicare and Medicaid as "high risk" programs.[1]

Today, we are here to focus on the opioid epidemic. I commend the Committee for considering these issues. The opioid epidemic has had a staggering cost – whether framed in terms of lost and destroyed lives, broken families and marriages, medical expenses, or lost productivity. The sources of the epidemic are complex, as are the trade-offs with the various strategies for addressing it.

Today, my goal is to flag four important issues: (1) the seriousness of the opioid epidemic; (2) the complexity of the causes of the epidemic; (3) the ways in which the design of the Medicare and Medicaid system make them vulnerable to abuse and over-use of the sort that has fueled the opioid epidemic; and (4) the role that patients have played in health care fraud and overutilization.

Seriousness of the Opioid Epidemic

I suspect Committee members are well aware of the dismal statistics about the opioid epidemic, but it is useful to review some of the figures. The death toll from opioids has climbed dramatically in recent years.[2] The CDC's latest figures (as of January 7, 2018) indicate that there

[1] GAO, 2017 High Risk Report, https://www.gao.gov/assets/690/682764.pdf. *See also* *https://www.gao.gov/highrisk/medicaid_program/why_did_study*.
[2] Rose A. Rudd, Noah Aleshire, Jon E. Zibbell, R. Matthew Gladden, Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014, Morbidity and Mortality Weekly Report, January 1, 2016 / 64(50);1378-82

were 66,817 drug overdose deaths in the 12-month period ending June, 2017, with roughly three-quarters of that total attributable to opioids, and 40% attributable to prescription opioids.[3]

Certain states have been particularly hard hit. According to the CDC, "in 2016, the five states with the highest rates of death due to drug overdose were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), New Hampshire (39.0 per 100,000), Pennsylvania (37.9 per 100,000) and Kentucky (33.5 per 100,000)."[4] Comparing 2015 and 2016, there were "statistically significant increases in drug overdose death rates [in] Connecticut, Delaware, Florida, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin."[5]

Finally, the consequences of the opioid epidemic go far beyond the death toll. In 2014, according to the National Survey on Drug Abuse and Health, an estimated 92 million Americans used prescription opioids; 11.5 million misused them; and almost 2 million had a use disorder.[6] These figures reflect the substantial degree to which opioids are "widely diverted and improperly used."[7]

Complexity of the Causes of the Opioid Epidemic

If we are looking for the root causes of the opioid epidemic, there is plenty of blame to go around. Prescription opioids are a controlled substance, so one needs a prescription from a physician or licensed health care provider to obtain them. Over-prescribing is an unfortunate reality, with some physicians more overt about this than others. In our book, we describe the behavior of Dr. Alvin Yee, who found practicing in an office setting unduly constraining:

> He'd see a dozen or more patients a night, at eateries like Carl's Jr. and Denny's and at coffee shops like Starbucks. He once met a patient at an auto dealership. Wherever he was, Dr. Yee would take out his stethoscope, listen to patients' hearts and lungs, and evaluate their vital signs. Sometimes, he performed neurological exams.
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> Yee's unusual practice style appealed to Millenials. One-third of his patients were in their 20s. Remarkably, many of these young people needed help with pain. Yee gave them prescriptions for OxyContin, Xanax, Roxicodone, and Vicodin. Some patients had trouble concentrating. He wrote them scripts for Adderall, an

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https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w.

[3] National Center for Health Statistics, Centers for Disease Control and Prevention, Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[4] https://www.cdc.gov/drugoverdose/data/statedeaths.html

[5] Id.

[6] David Blumenthal & Shanoor Seervai, To Combat the Opioid Epidemic, We Must Be Honest About All Its Causes, Harvard Bus. Rev. Oct. 26, 2017, at https://hbr.org/2017/10/to-combat-the-opioid-epidemic-we-must-be-honest-about-all-its-causes.

[7] Nora D. Volkow and A. Thomas McLellan, Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies, N Engl J Med 2016; 374:1253-1263, March 31, 2016, http://www.nejm.org/doi/full/10.1056/NEJMra1507771#t=article.

> amphetamine. Despite his low overhead, Yee wasn't cheap. Initial visits cost $600; follow ups were $300. Convenience came at a price.
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> Yee stopped seeing patients after two of his patients died and the feds arrested him for prescription drug fraud. A few of the folks who visited him before he shuttered his practice were U.S. Drug Enforcement Administration agents. Yee gave them prescriptions for controlled substances too. He wrote prescriptions for one agent after being told that the medicine was for a friend who was unable to keep her appointment. Another undercover agent said he was a former heroin addict who'd been borrowing painkillers from others. Yee gave that agent a prescription too, telling him, "You won't be having to bum off of your friends anymore." Yee was so quick on the draw that he once reportedly pulled out his prescription pad while gambling at a Las Vegas casino.

There are plenty of unscrupulous providers like Dr. Yee out there. In 2011, the New York Times observed that "pill mills" were everywhere in Florida; "so many out-of-staters flocked to Florida to buy drugs at more than 1,000 pain clinics that the state earned the nickname 'Oxy Express.'"[8]

Thankfully, providers like Dr. Yee, are outliers, but more subtle forms of over-prescribing are still too common -- whether it is prescribing an opioid the patient doesn't really need; prescribing a dose that is too large; or prescribing a course of treatment that is too long. These outcomes may be the result of genuine disagreements about optimal treatment strategies, or uncertainty about the appropriate level of pain management, or the humane desire to ensure that one's patients are not in pain.

But other factors may play a role as well. Some pharmaceutical companies appear to have engaged in overly aggressive marketing practices.[9] Insurers are reportedly reluctant to cover more expensive pain medications that are less prone to abuse.[10] Additional incentives to prescribe opioids may have resulted from the Joint Commission's Pain Management Standards, and CMS' inclusion of questions about pain in HCAHPS.[11] Insurance (both public and private) makes obtaining opioids less expensive at the point of purchase – but also funds treatment for substance abuse.

To sum up, like many social problems, the opioid epidemic has multiple inter-locking causes. Attempts to "fix" the problem should start with an accurate diagnosis of its causes – followed by a targeted set of strategies that take account of the associated trade-offs.

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[8] Lizette Alvarez, "Florida Laws Shutting 'Pill Mills,'" New York Times, August 31, 2011, http://www.nytimes.com/2011/09/01/us/01drugs.html.

[9] Alana Semuels, Are Pharmaceutical Companies to Blame for the Opioid Epidemic? The Atlantic, June 2, 2017, at https://www.theatlantic.com/business/archive/2017/06/lawsuit-pharmaceutical-companies-opioids/529020/.

[10] Katie Thomas & Charles Ornstein, Amid Opioid Crisis, Insurers Restrict Pricey, Less Addictive Painkillers, ProPublica Sept. 17, 2017, https://www.propublica.org/article/insurers-limit-coverage-of-pricey-less-addictive-painkillers.

[11] Kristina Fiore, Opioid Crisis: Scrap Pain as 5th Vital Sign? MedPage Today, April 13, 2016, https://www.medpagetoday.com/publichealthpolicy/publichealth/57336.

Design Features of Public Programs That Make Them More Vulnerable to Fraud, Waste, and Abuse

Medicare and Medicaid were both designed to mimic the structure of Blue Cross and Blue Shield health insurance plans circa 1965, when health insurance was structured on an indemnity basis. There were no networks, or pre-approvals, and utilization review was quite limited. If your doctor wanted you to have a treatment, it happened, and the insurer simply paid the bill. The large volume of services and the lack of coordination made it difficult to monitor quality of care.

Over time, the private coverage market has evolved – but public payers have remained largely passive bill-payers. The results are easy to observe. As we observe in our book:

> The government has studied prescription drug fraud in public programs repeatedly, and each time it has concluded that fraud is rampant. A 2009 GAO report on the Medicaid programs in five large states (California, Illinois, New York, North Carolina, and Texas) opened with the observation that investigators "found tens of thousands of Medicaid beneficiaries and providers involved in potential[ly] fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both." Sixty-five thousand beneficiaries had engaged in "doctor shopping," by acquiring prescriptions for the same type of controlled substances from six or more different medical practitioners during fiscal years 2006 and 2007. Four hundred of them got prescriptions for controlled substances from 21 to 112 medical practitioners and visited up to 46 different pharmacies to have them filled.
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> Some of the specific findings were macabre. An Ohio physician who specialized in pain management was convicted of filing $60 million worth of fraudulent Medicaid, Medicare, and insurance claims. The doctor got patients hooked on controlled substances "so that he could profit from their habit[s] and increase the income he received from their medical claims. Two patients who regularly saw him died under his care, one from a multiple-drug overdose in the physician's office and one from an overdose of OxyContin taken on the same day that the prescription was written." . . . No wonder the GAO concluded that the five states it examined "did not have a comprehensive fraud prevention framework" for dealing with controlled substances.

Various steps have been taken these problems, including improved surveillance, prior approval, limitations on the number of pills that can be dispensed, disclosure of information to physicians, and prescription drug monitoring databases.[12] These reforms have the potential to help reduce inappropriate prescribing – but design details and implementation affect their impact. And, the fact they are necessary shows how design features of Medicare and Medicaid make them vulnerable to fraud, waste, and abuse.

[12] *See, e.g.,* Centers for Medicare & Medicaid Services, Opioid Misuse Strategy (2016), https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf; Christine Vestal, States Require Opioid Prescribers to Check for 'Doctor Shopping,' Pew Stateline, May 09, 2016, http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/05/09/states-require-opioid-prescribers-to-check-for-doctor-shopping.

The Role of Patients

In many of the schemes we explore in our book, providers are the bad actors, and patients are the innocent victims. But, we also find evidence of patient complicity in some of these schemes. In the words of Peggy Sposato, a former emergency room nurse who joined the Department of Justice as an investigator, "To look at health care fraud and not [see] that the beneficiaries are somehow involved is to be blind to the problem."[13] Doctor shopping to obtain prescriptions for opioids is one obvious example of the problem. I have already mentioned the 2009 GAO study of Medicaid patients, but the problem also affects Medicare. As we note in our book,

> A 2011 GAO report found that doctor shopping was widespread, with more than 170,000 Medicare beneficiaries receiving prescriptions for controlled substances from five or more medical practitioners in 2008. Six hundred Medicare beneficiaries obtained prescriptions from 21 to 87 medical practitioners in a single year. These examples are part of a much larger phenomenon. In 2014, researchers at Harvard Medical School released the results of a study of more than 1.2 million medical records of Medicare patients who took opioids like hydrocodone, fentanyl, morphine, and oxycodone. Nearly 35 percent had prescriptions from more than one doctor. One-third of this group got their prescriptions from four or more doctors. In 2016, half a million Medicare beneficiaries (excluding those with cancer or in hospice) were prescribed "excessive" amounts of opioids (relative to standards set by the CDC), including 70,000 who received "extreme" amounts of narcotics (i.e., more than 240 mg of morphine every day for the entire year), and 22,000 who appeared to be "doctor shopping" (i.e., going to multiple physicians to obtain multiple prescriptions for opioids).

To sum up, some of the scams we explore in our book – including some of those involving opioids -- would not be possible without the complicity of patients.

[13] Kelli Kennedy, "Professional Patients Aid Massive Medicare Fraud in Fla.," Boston Globe, December 25, 2008, http://www.boston.com/news/nation/articles/2008/12/25/professional_patients_aid_massive_medicare_fraud_in_fla/?page=full. See also Jay Weaver, "Medicare Fraud Rampant in South Florida," Miami Herald, August 3, 2008, http://www.miamiherald.com/news/special-reports/watchdog-report/article1929719.html.