

TRANSCRIPT:
MEDICARE AUCTION UPDATE
PETER CRAMTON
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PETER CRAMTON

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Peter Cramton: Good morning everyone. Welcome. I'm very glad that you could participate in this event today, it's a very important event... we're talking about the Medicare Auctions, the Competitive Bidding Program -- I use the word "auction" and "competitive bidding" to mean the exact same thing, just the way we use the word "car" and "automobile" to mean the same thing. I like auction because it's shorter.

There's some very wise words here, which I hope you had a chance to read.

Let me give you the two-minute summary, which you are going to hear again and again throughout the event. The first is the bad news. CMS is doing an atrocious job with the DME competitive bidding program.

I want to use strong language; for the first three months I used much more friendly language, and I've tried very hard to work in a collaborative way with CMS and I'm still eager to work in a collaborative way with CMS, however, that has proven to be very challenging.

It's been nine months exactly since Nancy Johnson, 24-year Congresswoman from the great state of Connecticut, gave me a call on August 24th and asked me if I would look at the Medicare Auction rules. She knew that that I was an expert in auctions, and that I might have something interesting to say.

I took a look at the rules; within ten minutes I could see easily that they were fatally flawed, and they had to be fixed. I then spent a week looking at them quite carefully, studying them, looking

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at the reference materials, and called her back and we spoke; and then I came to the Hill under Nancy's suggestion, and spoke to a number of committees, including the Ways and Means Committee.

I was actually very impressed by the knowledgeable staff on the Ways and Means Committee; I told them about the glaring flaws that I had identified; and at the end of it they said: This all makes sense to us, it sounds good, but... you're one expert. We have experts come in all the time, and usually when we have a second expert come in, they say something else. A third expert, something again. And so why should we put any weight on what you're saying.

And I said: No. In fact, every expert will say the exact same thing. And they said: Well, show us that.

And so I sent, within a week, an email to my colleagues -- 250 auction experts from around the world at all the universities, including Nobel laureates and so on -- and I sent them a letter that I asked them to sign, which spoke firmly about the very serious flaws in the CMS auction program.

Within 48 hours, I had 167 signatures from these experts, leading experts in auction design, and I sent that back to the chair of the Ways and Means Committee. And that led, in fact, to several letters from Congressmen -- both Representatives and Senators -- to CMS and Health and Human Services demanding that this be looked into and addressed.

It's now nine months later, and nothing has happened. Through this entire time I have tried to engage CMS, I have been successful in having two meetings with CMS in that nine-month period; I have spoken with Jonathan Blum on two occasions on this, in addition to email exchanges; and I've spoken with Assistant Secretary Sherry Glied a number of times on this

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matter as well. And the progress has been extremely slow. So I'm afraid with respect to CMS actions, I can only offer bad news. And that's too bad.

And in fact, governments are perfectly capable of doing well-designed and structured auctions. In fact, the U.S. government is capable of doing it. And there's very good examples of this.

One of them is the FCC Spectrum Auctions, which have been initiated in 1993; they have been... they've worked extremely well, there's been a few bumps in the road but they've fixed those bumps, and they continue to have a very effective process.

Another example would be the electricity markets. Which also have had a few bumps in the road -- most notably California in 2000/2001 -- but they, too, have addressed those problems... in fact in some ways that I'll talk about in just a moment.

So government can do auctions well, and in fact that's been my experience, and that's why I am so upset about what's happening here, is because I know how well auctions work when they're done right.

And so that's the second point, which is the good news. The good news is that competitive bidding can bring substantial savings to the taxpayers. Can bring quality goods and services to the Medicare beneficiaries. And that's a wonderful thing. But we've got to do this right. And we actually know how to do it right.

And that's what I'm going to talk about very briefly, and then we're going to see a couple of video clips from an event that was held at the University of Maryland on April 1st, and then we're going to open it up to the panel, and have them have a chance to speak briefly, and then we'll throw it up to questions.

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Motivation. I don't think that you need much motivation here... many of you are very young, and you should be concerned about this. You might not be old right now, but there is a lot of unfunded Medicare expenses. It's estimated around \$70 trillion... I'm not sure if it's exactly 70, it might be 60, it might be 120... it's a very big number.

Medicare is unsustainable in its current form. It must be addressed, or you will not have Medicare as we know it when you grow old enough to enjoy the benefits.

Just looking at diabetes. What we're talking about today is one piece of the puzzle. But it's a very important piece. Durable medical equipment sits at the bottom of this upside-down pyramid -- and this is just diabetes and the date is a few years old, it's actually... the amounts are growing quite a bit since 2007 -- but what this illustrates is that in fact, if you mess up badly down here, then what's going to happen is, you will ultimately have much larger expenses as beneficiaries end up going to the hospital room, the ER for emergency treatment, rather than the home care.

So if you do home care right, if you do prevention right, then you can save a dramatic amount of money, and actually greatly improve wellbeing at the same time.

Fact. The CMS auction design is fatally flawed. I say fact, because it is a fact. When all the experts in the world agree that something is fatally flawed, it is fatally flawed. Just like when all the doctors say you have lung cancer, you have lung cancer. It's a fact. It's not open for debate.

That's what we're talking about here. All economists will agree with this. I've been saying this for nine months. I have never once been challenged, in nine months.

We know how to do efficient auctions; they're done with very simple price discovery processes where we collect bids from the bidders expressing their costs of providing service; and so this is an experiment that Charlie Plott and his colleagues at CalTech ran... and we ran it at the

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University of Maryland as well... where we put the bidders in a situation, give them a particular cost, have them bid, and this is just explaining how a standard auction works.

Where in essence, what we have is a supply curve that's formed. On the X-axis is Quantity; on the Y-axis is Price -- that's what economists love, you'll remember this from your principles class -- and we order the bids in increasing order. And that gives us a supply curve. Which is, each bidder's willingness to supply into the market.

Now the way normal markets work is, you look at the first excluded bid. Which in this case we have a demand, the red line, of 7... the first excluded bid is bidder number 8. Okay? The seven lower guys are in the money, they've won, and the price is set by bidder number 8. That's the market clearing price. And that's what we see in regular markets. So that all the winners offer the service at a sustainable price where they can make a little bit of money.

What CMS does can be called the Median Price Auction with Cancellation. In this auction, they do essentially the same thing -- take the bids, order them from lowest to highest, start with the lowest -- but now what they're going to do... this is with cancellation, so the bids aren't actually binding... after the auction's over they're going to ask you whether or not you'd like to supply the service. But what they do, they have to say what the price is first.

So what they do, is they look at the- they need 7, so they count up the seven bids, the seven lowest, and they take the median of those seven. Which in this case is right here. And that's the market price that they use.

Now they ask bidder number one: "Are you willing to supply at this price." And bidder one says, "Yes;" bidder number two, are you interested in supplying at this price? "No;" okay, we go to bidder number three, "yes;" four, "yes;" five, "yes;" six, "yes;" seven, "no"... so now we're two

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short. We've gone through the seven that set the price, but now we have to keep asking people because we're two short. We had two say "no." So we ask bidder number eight, we ask bidder number nine, and now we've got seven acceptances. So supply equals demand... we don't raise the price up, the price stays here, this median of the seven lowest, and that's, in a nutshell, the CMS process.

Now there's a serious problem with that. The most important thing when it comes to auctions -- actually, one of the very most important is binding bids. Bids have to be binding, or you have terrible incentive properties.

The second important thing is checking the incentives. What incentive does a bidder have to bid. In a proper auction, like this auction here, the first excluded bid, the incentive for the bidder is to truthfully bid their cost. That's the best that they can do, regardless of the behavior of the other participants. It's quite a remarkable result.

In contrast, in the CMS auction design, there's extremely strong incentives not to bid your cost. And in fact, you have no interest, really, in figuring out what your cost is.

What you want to do, in this case, if I was -- I often give bidders advice in auctions -- and in this auction, if I was retained to give advice, I would give the following advice.

Think of the lowest number you can think of, and bid that. Don't worry about figuring out what your costs are, that'll come later when you are asked whether to supply. Just think of the lowest number and bid that. Why? You'll be a winner! CMS will knock on your door and ask you if you want to supply. And they'll tell you what the price is. And that fact that you thought of the lowest number possible, didn't affect the price much at all. So that's an outstanding strategy.

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It's very bad to have an auction where the outstanding strategy that's recommended by the auction experts is to think of the lowest number you can think of and bid that, and don't even bother figuring out what your costs are.

So we have very strong incentives with this pricing rule and the non-binding bids to low-ball bid, or suicide bid. And that is what the theory tells us.

So when we analyze this with our theoretical auction models, the most plausible equilibrium is complete market failure. Everybody bids the lowest number possible, the median price is one that's above everybody's costs... I'm sorry, it's below everybody's costs, and as a result, everybody rejects the contract.

That didn't actually happen. So what's going on? Is theory wrong? Well, we ran it in the lab. With CalTech subjects. What happened. Extensive low-ball bidding. Nearly complete market failure. We had efficiencies well below 50-percent. But there were some transactions that did take place in the lab, in contrast to the theory.

However, what about in the field. CMS used this, collecting bids in November of 2009; the bidders then were asked in late 2010, and we were informed who the winners were one year later in November of 2010 who the winners were... and in fact, lots of people said "yes."

So why? How can this work in the field, and fail so miserably in theory and in the lab. Well the reason is, because there's an enormous lack of transparency. And this lack of transparency enables CMS to manipulate the prices until the median price is within the realm of reason. And this is exactly what they did.

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I didn't learn that actually in my initial study, I learned that after having the conversations with Jonathan Blum and Assistant Secretary Glied.

So what happened is like this. So again, I've got my price and quantity access with my demand curve at 100, I need to satisfy the demand of 100 percent of the market; we take the bids, we open them up, and this is what we get.

The median... a 20 dollar price for this particular product region. Well, everyone knows that in fact, the invoice price from the manufacturer, without all the necessary services -- let's say this is oxygen; there's all kinds of services that are required -- is way more than 20 dollars per unit. So they know that this could not at all be sustainable.

So what do they do? They discount the quantities. The bidders report quantities in the qualification stage back in November of 2009. CMS has the right, under the rules, to manipulate those quantities any way they choose in a completely nontransparent process... in fact to this day, no one knows what the quantities are for any bidder in any market for any product. So they do that.

So they could discount by .5... well, it brings it up to 30 bucks, we're getting close, but that's still below invoice... ah, a discount by 25 percent. That brings the median up to 50 dollars. I don't know what the cost is for this thing, and the services, but you know, I bet they could do it for 50... and in fact, for this oxygen product, notice that there's one large national player that put in a bid of 50 dollars. So we've actually brought in as a winner, this one national player. And that's going to give some comfort to CMS. And in fact, they did that in every single product region. And as a result, what do we have here.

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What I have described is not remotely an auction or competitive bidding process. What I've described is an arbitrary pricing manipulation in which participants have strong incentives to not bid their cost, not even think about their costs.

To me, that's a scandal. And that is why I'm here talking to you about this today, and that's why the rest of us are here as well. Because it's very important for Congress to hear this.

CMS comes to you on a regular basis and tells you that all is well. The reason that they can do that, actually is hard for me to understand, but you should be asking some tough questions.

But one of the reasons that they can say that the train hasn't crashed yet, is because they have total flexibility to set almost any price they want. So it's worse than administrative pricing, it's administrative pricing without the transparency. And that's the single payment amount for this product region, 50 dollars.

Okay. So we've looked at it with theory, we've looked at it with experiment, we've looked at the very limited field data that CMS has made available to us... all of it points to very severe problems, these are all extremely well documented on my website, I urge you to look at that.

Here's a second important fact. Modern auction methods apply to health care. That's why Congress suggested in 1997 that CMS adopt auctions. And you've picked out the one area that was the easiest to implement auctions within Medicare.

It's also the case that the design of auction markets is a very well-established science. There's been several Nobel prizes won by economists developing modern auction methods. For the last 18 years I've been spending a hundred percent of my time designing and implementing auction

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markets around the world. These have been very important markets involving many tens of billions of dollars of assets in many different countries.

I'm currently engaged by the United States Government in a very important project designing auctions for wind rights off the outer continental shelf on the East Coast... it's extremely important to our energy future; I'm engaged by the United Kingdom in extremely important spectrum auctions releasing the spectrum that's required by our smartphones; I'm currently engaged by the government of Canada designing and implementing their spectrum auctions for the very same reason. So I think it's the case that I actually know what I'm talking about.

Obama has actually insisted that regulation be based on the best available science. This was the Executive Order of January 18th of this year.

Look at those principles of regulation. They are all extremely sound principles that I'm sure both Democrats and Republicans would strongly support. Yet every one of them is harshly violated by the CMS auction program.

The market design process begins by engaging auction experts to build the markets, just as you would engage an auction expert if you were building a bridge. Not an auction expert, a bridge expert. Right? It would make sense. This is something that's technical, there's a lot of experience, there's a lot of information, and yet CMS has never done that, despite the fact that they've been doing this for so long.

So like I said, some agencies in government have demonstrated that you can give them auction authority and they know how to use it. The FCC is one example. The Bureau of Ocean Energy Management is a second example, which I just mentioned.

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CMS is not such an example. And so what Congress must do is be more explicit with CMS. You must tell them: Oh, no, we didn't actually mean an arbitrary pricing process. We actually meant an efficient auction. So just tell them to do an efficient auction. And I'll give a couple of other hints, too, and I'm sure our panelists are going to give some very good hints as well.

So then we take the auction experts, we bring them together with industry and government and other stakeholders, and have a rule-making process where we come up with what's right and what works. Extremely effective.

That's not what's happened here, unfortunately. We start with theory; we use simulation to test the theories; we then, for critical aspects of the design, use experiments in the lab to further test and refine the theories; then we go and do pilots in the field.

And each of these steps -- it's not a linear process, there's actually a lot of back-and-forth, we're constantly refining and improving with our goal to satisfy the objective of having an efficient, sustainable auction that yields prices that are least cost for the taxpayers, and yet maintain high-quality goods and services for the Medicare beneficiaries. That is not the process that we've seen at CMS.

On April 1st at the University of Maryland to demonstrate this approach, we brought together stakeholders, many from government -- I think we had eight different government agencies represented; representatives from Congress, from eight other agencies in the Federal Government; we had many dozens of Medicare providers; we had a smaller number of Medicare beneficiaries, but every group was there.

And what we did, was a nearly full-scale mock auction using modern auction methods. And I think it was extremely powerful; the whole thing was recorded and is available online on my

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website... there's 260 minutes of video, we didn't actually record the bidding, but all the speaking is recorded, and it actually involves a lot of thought and a lot of effort by a lot dedicated people -- I should say something I haven't said yet, is I'm doing all of this pro bono, I've spent about a thousand hours or more on this since August 24th, and I'm not paid for this. I actually have a very high opportunity cost, and I actually am typically paid. So this is quite unusual, but I feel that strongly about it. And I'm not the only one.

Many of my colleagues also contributed all of their time and talents to pulling this together. It is really quite dramatic. Rather than getting near complete market failure, instead we achieved high efficiencies in a nearly full-scale mock auction. We had 50 bidding teams competing against one another in 54 different product regions. And the prices were almost spot on competitive equilibrium prices. Which are the efficient lowest-cost prices that are sustainable.

The efficiency of the mock auction was 97 percent. This was a mock auction that was done with inexperienced market participants. They were given a business plan, but they had never experienced... they'd just experienced CMS auctions. They had never experienced a modern auction.

And so they were brought up to speed, everything was explained, we answered questions, and then we did it. It was all done in a matter of hours. So to me, that's quite compelling proof that it can be done and can be effective.

Now one thing about the current- another thing about the current process, is it's simultaneous sealed bid of many, many related products. And the problem with that, is the bidders business plans demand—to be profitable—a portfolio of products. You can't just win diabetes in Sacramento and call it a business. Or oxygen in Riverside. You have to have a portfolio. And in

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fact, the beneficiaries need a portfolio of products. And the beneficiary, or the hospital -- whoever is making the call -- is going to call the guy that can provide that portfolio.

When you're doing simultaneous sealed bid, if you think about it just for a minute, product by product, it's a crap shoot. It's especially a crap shoot when the incentives are all screwed up.

The modern auction, the one that we use, enables a lot of price discovery, so in fact the bidders can piece together a profitable portfolio of products that fit their business plan. And that's one of the things that we've learned in the last 15 years of doing auctions. That it is possible to do these advanced auctions.

Now. Just a very quick few highlights from the conference... we're actually going to pull up a quote from Tom Bradley in a moment, he's the Chief Cost Estimator at Medicare-- I'm sorry, at the Congressional Budget Office on Medicare; Evan Kwerel I've already mentioned at the FCC; and Nancy Lutz, the Director of Economics at the National Science Foundation. These are the remarks that they said at the meeting... the conference on April 1st. Very powerful.

The last thing I'll say, and then we're going to turn it over, is oversight. Two of our panelists... Barbara Rogers and Tom Milam, are PAOC members. The PAOC was instituted by Congress in the legislation as an oversight and advisory board to CMS. It's an organization of stakeholders.

As a result, CMS conceals almost all the information about the program to the PAOC. And they'll describe that in a moment. And that's a very serious problem.

What we use in complex auction markets around the world is what's called the Independent Market Monitor. Which is a much stronger version of the PAOC. So the PAOC's a good idea,

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you should have the PAOC, but more importantly, you need to have the independent market monitor.

And the independent market monitor is not a stakeholder, they're independent. They have access to all the confidential information. They can observe whether rules are being followed. They can suggest, they're an expert, so that they can suggest improvements of the rules when problems are found. This is very important, it's what's done in every functioning electricity market in the United States, and most of the ones in the world. And it's something that needs to be included in enabling legislation for auctions for CMS.

My view is that repeal is not what you want... that's an incomplete strategy; legislatively what you need is repeal with replacement of an efficient auction. Then you've got something that's good for everybody. Including CMS. Administering a seriously flawed auction program is a heck of a lot more work than administering an efficient one.

So basically nobody, as far as I can tell, is opposed to the idea of an efficient auction. It's quite remarkable, except for CMS, there's a lot of inertia with respect to the status quo.

So now, it's next steps, I think that legislation is needed; a CBO score will be required... it's my understanding that CBO would look favorably to an efficient auction. Tom Bradley fully understands the problems of the current system.

I believe this will receive bipartisan support, and can be implemented in a schedule that will yield significant benefits to everyone. The industry, the Medicare beneficiaries, and the American taxpayers.

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So now what I want to do is just very quickly show a couple of clips... let me just put this away... we're going to show a couple of quick clips from the conference, and then, so that I make sure [Remark off-mike]... okay, then, unfortunately Barbara Rogers, who represents Medicare beneficiaries, she has a web conference that she's hosting involving hundreds of people, that she must race off to at 10 after 12. [Off-mike remark.] And so... and then come back to the video. Okay. That sounds good. Okay... then okay, let's do that.

We'll start with the panel, Tom Milam will go first; Tom, as I said, is on the PAOC, and has been in the industry for many, many, many years, and is quite knowledgeable. Tom.

Tom Milam: Well, thank you Peter. Let me do that real quick, my name is Tom Milam, as you already know, I'm from Nashville, Tennessee, and in fact, we're were right next door to Congressman Jim Cooper's office, he was on the flight coming up yesterday as well.

I'm going to speak to you real quickly from two perspectives -- my service on the PAOC, this is a cause, an issue I've been dealing with since 2007, actually the original round one and the like, and service on the PAOC; and also from my perspective of having been a supplier from late '02 through the end of 2009 -- I'm not a provider at the present time now, I'm a partner in a firm called Tatum, which does Office of the CFO support coast to coast. Several hundred partners, and I'm one of those.

I was a CFO the first half of my career actually for a great company, and you know, a certified public accountant though in private practice. And then got into operating.

And I don't know. Have you heard that they're placing accountants at the bottom of the ocean now? [laughter] Does anybody know why? Deep down, they're really not so bad. Tongue in cheek, as we say; but then I got into a business, turned around an advisory like in 1999, which

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led me to this very small and broken supplier -- Medicare was the dominant part of the business, diabetes supplies by mail-order -- and like many HME-DME providers, it was a part-time assignment for me, but I became very enthralled and committed to it after about six months, after showing the owners of this business what was wrong and what needed to be done for it to attract customers properly, to service them properly, etc.; when a very, very dear friend, a surrogate brother, the older brother I never had who is a good bit older than me, actually died on dialysis of a massive heart attack.

And I just got to thinking there was a different way that would be a better way and that's what became AmMed direction, we grew from like 2500 customers to about 190,000 customers; so I know what it's like to take something small and have to wrap up very quickly as well... I think that was part of the reason for my selection to the PAOC. A: the financial background; and then B: the fact that having successfully grown a business with a commitment to service.

But as I mentioned, I'm not a provider now, I really haven't been for about a year and a half. But I'm very concerned. You know, gravely concerned, more and more so every day...

So first as a PAOC member. You know the PAOC was selected ideally that we're people with expertise in the field, we know what's going on, we see what's going on, we can provide advisory and oversight advice to CMS. If they would only listen to us.

You know, we all took the Federal oath, which I'm sure all of you have taken as well in your roles in our government, and to well and faithfully discharge the duties that I have been assigned to me, I am very committed to it. I've got military service in my background as well, I know what an oath means, so I do care.

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But from the very beginning, and really, for instance, we've only met three times, we've had a couple- some conference calls, but going back to the beginning in 2009, there were obvious, and without knowledge of Peter Cramton nor his colleagues, and the expertise that there were... bridge experts, if you will, in the field.

You know, there were very specific suggestions which I wrote up and documented and forwarded on to the competitive bidding team, and what happened is what's still happening today. You never hear anything back, you're marginalized, you're ignored when they were sound suggestions; and now in the last six and eight months to hear Professor Cramton say basically the very same things, but more eloquently and more well thought-through, uh, very, very, frustrating.

Financial standards are actually mentioned in the enabling legislation for the PAOC was- is formed. Or was formed. Authorized to be formed. And, you know, we're supposed to advise- provide advice on financial standards. But CMS will not share with us the financial standards. It's just a... you know, it's a door that they refuse to open.

You know, with my good old accounting background, I actually prepared a schedule, you know, to show them for each product category to take the examples. You know the... the best proof that someone can do something, it's like: Show me the money. Show me that you've got the money to do what it is you say you're going to do. Otherwise, I don't believe you're going to be able to do it.

So I created this schedule to say: here's one approach, can you use this. You know, no response, you never hear anything back. And that continues to be the case today.

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And over the last two years I've actually been told by the Congressional Budget Office and others, that: oh, we fully expect the larger companies to be the winners. Because they've got the buying power already. They can negotiate the better price; they can gain the most efficiencies in operations, that's who we expect. That's not what has happened.

You'll hear Paul Gabos talk about it in oxygen for instance, and diabetes, the top 20 companies account for over 80 percent of all distribution in the country. And only one, who accounts for less than 2 percent, actually won the bid in I think four cities. Four CDAs. And they're also the most financially unsound of the top 20. But that- so that is, you know, again, it's just not what happened.

I suggested, based on a 25-year ago, the original demonstration projects in the mid-80s, I suggested to Jon Blum and Laurence Wilson: Look, the PAOC's your board of directors. Look and see how much the market is changing. I came up with a way to say: Okay, you know, who is providing before that is providing now; who's new that's going to be providing for the very first time; who's got to grow a million percent or whatever... since I know that that takes, you can't do it overnight... so I had this very, you know, elaborate schedule, but then Peter comes in and shows it much more explicitly, I think.

Did they have you play red light green light growing up? Am I right? If you have your... so if I hold this up, does it look like red light or green light. And this is Peter's depiction of the market turnover. In other words, the red indicates people that have got to change- find brand-new suppliers overnight. You know, January 1, 2010. That's what the design also creates, is massive disenfranchisement of the Medicare beneficiary.

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And it's not right, and it goes back to the original person that it hit, or who attested it, who said that: you've got to have at least x-percent -- I think he said over 50 percent of the current providers still with you, or you're certain to have market failure.

The PAOC has been asking for data consistently. In November on a conference call we were told that CMS has their new tracking tool, almost real-time; eventually on April the 5th we were shown data, as perhaps some of you have heard.

This is the data packet Dr. Calvin [sp?] provided, you know, all this data, and we're pouring over it for the very first time being shown this and having about five minutes to digest it, and there was a quiet in our meeting at CMS, and finally the question was asked: Could you please tell us what cardio-pulmonary access group is. Or what the diabetes access group means. And there was a pause, and finally someone said: Well, that means all the people in that CBA who we know have diabetes, PLUS, all of the Medicare beneficiaries in the CBA who we expect to have diabetes.

It's like, we're scratching our heads. So I mean, it's double, triple, the number of people. So, I don't know, but if you divide ten by a hundred you get 10 percent... but if you divide 10 by 300 you get 3 percent... 3.333 percent... and that's what's occurring. It flattens out the curve. You can't see anything.

So we weren't satisfied at all with the data is bottom line, which led to a May 6 letter that we delivered to Jon Blum, also copied Dr. Berwick and Marilyn Tavenner, signed by 12 of the 16 PAOC members that said, you know, it was a very professional letter, we figured it would be published so, and sure enough it was, but we said: We need to see data that we think properly depicts what is occurring in the field, and what we need to know about it.

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And I'm sure anyone would be glad to share a copy of this letter... we're not satisfied with the data, and we heard that CMS has been saying on the Hill as recently as last week that the PAOC is pleased with the data, and in fact, 12 of the 16 say: No, we're not pleased; give us that data that will allow us to properly advise you.

And if they're coming and showing you this data-- if I was the president of the company and a person came in and showed me this, they'd be out on the street. And I'd be hiring a person who would do it properly and truthfully, because this is not truthful information.

And for the diabetes market, just real quick, with my experience there, as you may or may not know, the diabetes market was bifurcated... okay, retail, you can walk in and get it, or mail order... the models are really pretty similar, there's not much difference except the price of real estate in one, and call center agents in another, both advertise, both buy the same product.

But if you look at what the diabetes market did, the one thing that CMS did do, is say that: well, the diabetes group, we're not sure what's going on, we're going to be tracking it closely. And if you dive into it, what you actually see is that since January 1, there has been a roughly 20 percentage point swing from mail order distribution to retail distribution. And the reason is because the beneficiaries cannot get the product on which they and their physician depend to daily check their blood glucose to keep it at the most stable condition to avoid having an acute episode, going back to the upside-down pyramid. Don't go to the hospital... that's a \$115 billion dollars of total cost.

And we have many documented examples of people moving into a CBA from out of town and having no idea there is such a program; people who can't handle these offshore strips that are being provided that are very tiny; they've got arthritis, if you have diabetes and you're elderly

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you typically have arthritis, they can't handle the product; they've been used to using AcuCheck or whatever that's a larger test strip that you can grip and hold properly... you know, the product that they need for daily life support has been taken away from them.

And so what do they do? They go to retail. So, a: Medicare loses all the savings, and not only that, pays about 20-percent more than they would have paid for mail order to begin with. It's almost triple the concocted price that Professor Cramton showed you.

And it's really tragic... if you haven't seen it there's a really nice summary, just four pages prepared scholars at the University of Minnesota that shows the history of competitive pricing projects in Medicare -- there have been nine failures, this is the last man or woman standing; there have coronary artery bypass graft tests; there have been cataract tests; there's been lab services more than once... it's all the same basic design that Professor Cramton has just been talking about...

It's tragic, you know... so I hope you will take this to heart, this initiative that we have to get right; and I will tell you from three years almost in working with CMS, they're not going to get it right, they are wedded to what they do, they're not going to change... and it's up to the bright and shining faces in this room and the people you work with. Thank you.

Peter Cramton: Thank you very much, Tom.

Now we're going to quickly turn to Barbara Rogers, who I had the great fortune of meeting on April 5th at the PAOC meeting. She is an extremely bright and talented Medicare beneficiary, and has been a wonderful advocate and an informed advocate of the Medicare beneficiaries.

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Barbara Rogers: Thank you. I would personally like to thank Congressman Johnson and Professor Cramton... and Tom, who gave the invitation, for inviting me to speak here, and the opportunity.

You're probably too young to remember Joan Rivers in her heyday, but it's sort of like "can we talk." And I guess I'm going to be maybe a little harsh in what I'm saying, but at this point I'm very frustrated and I'm very concerned.

I look out at your faces and you're bright, and you're young, and you're healthy, and that's great. So I'd like you to think as I'm talking, think about your mothers and your grandparents. You know, your parents, and your grandparents, your aunts, and your uncles, and how they would fare in this system.

I'm going to talk from two perspectives. One is as a beneficiary, and then as a PAOC member.

As a beneficiary, let me say that I have been receiving home care services for 22 years. For 22 years, I use a ventilator every night to sleep on; I use oxygen periodically; I have a respiratory assist device; I have a nebulizer; and I have an IPPB, and Intermittent and Positive Pressure Breathing Machine.

I also have an Oximeter and a scooter that are not provided by Medicare that I paid for out of pocket.

I also happen to run a national organization, the National Emphysema/COPD Association, fortunately a disease I don't have. But our constituents of between 24 and 30 million people and it's the fourth leading cause of death, or now I think estimated as the 3rd leading cause of death

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currently in this country and worldwide, and the majority of the oxygen beneficiaries. So I have a lot of experience.

I also work on a daily basis with ventilator users, had the privilege of working with Christopher Reeves.

During the 22 years I've been in home care, I have never once been re-hospitalized or visited an emergency room. And that, I will tell you, is definitely due to the home care services that I am provided with.

And one of the things that greatly concern me are services, the term services, that we get from people like Rob and other providers, are an invisible part of the payment. They're sort of lumped in with the rental of the equipment. And I'll talk a little bit about that when I talk about the PAOC part.

But without these services, without the visits from the respiratory therapist, without the advice, without being able to call them, without being able to have them look at my equipment and give me tips and advice -- you know the average patient in this country gets to spend between 6 and 8 minutes with their physician.

And actually there was a study done in the UK that says during those 6 to 8 minutes, the average physician interrupts a patient every 20 seconds.

So you really, for people like myself, home care providers are our first and most important line of defense. And they are quickly disappearing.

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The majority of beneficiaries have been serviced by local companies. And these companies, from the competitive bidding process, are effectively being put out of business. They are not able to sustain as Professor Cramton said, you know, the buying power and big purchases.

Now I have to say, there is a place for national companies in the system. But they should be part of the system, not the entire system. Because what happens is, then they control accessibility; they control what products we get; they control costs; they control services, and they control everything.

And what we're seeing is an elimination, as CMS is slicing and dicing in an inappropriate way, we are seeing an elimination of the services and of the options that are being given to beneficiaries.

I am serviced by a very large regional company in New York. And I will tell you that I recently moved part of my services, my ventilator and other... my ventilator mostly, to a small mom and pop company 650 miles away because they're actually able to give me the options I need and service me better and are more caring than this very large regional company I had been with for 20 years. Now that is not always the case, but we're seeing more and more of "that is the case."

So it's really disconcerting to me that as a beneficiary, we don't get choices. You know... good and bad, people aren't dying the way they used to die. You know, maybe from an economic point, it's a problem. But things that used to be fatal are now chronic. And we're able to take care of people and keep them alive and comfortable and hopefully happy at home.

But we also have the responsibility to give them a quality of life, to make them feel safe, and to make them feel secure in their home. And when you have something like competitive bidding, where we're seeing people are forced to change companies, change products, such as the strips

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you were talking about, we're getting a lot of complaints... you know, the elderly are older, they can't see the strips, and they're having problems.

Well you know, I was on some task force dealing with oxygen reimbursement. And there- you know, and talking to people that used to work at CMS and now are working in private industry, you know, I've been told on more than one occasion, when they were at CMS they looked at oxygen equipment as a widget. Now that they're looking more into it, they understand the complexity of dealing, of providing this safe and life-sustaining service.

Well, I will tell you, when I go to bed at night and I turn my life over to my ventilator -- I get emotional here -- when I do that, it's not a widget to me. You know, it is my life. And people's life and death are affected by this program. And it's my experience that CMS has no concept, or else they don't care.

When I ask CMS as a PAOC member for information or suggestions, 90 percent of the time I'm given two answers. It's a legislative issue, we don't deal with it; or it's confidential and we can't tell you.

So to me, who are they accountable to? You know, they don't seem to be accountable to anybody.

I will tell you as a PAOC member, I was very pleased to be appointed to this committee. You know, it's a Congressionally mandated committee, we took an oath as Tom said, we're all doing it pro bono, we get no compensation for it.

And I went there because I really cared. I cared about the people, and the beneficiaries that I work with on a daily basis. And yet I am seeing that it's totally an exercise in frustration.

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For the two and a half years I've been on it, we've had three in face or person-to-person meetings. Three public hearings. We've had maybe one call a year, maybe more, not much.

And honestly... well let me not get emotional and read a little bit while I walked... I, um, I wrote. Since I've been on the PAOC, I feel that we've had very few interactions; I requested at one point that the PAOC representatives, because I couldn't believe that they are clearly as clueless as they appear to be, I asked them to make a site visit to a provider and to a beneficiary, to see in real life -- because it's one thing on paper, it's another thing in real life -- what went into it.

So five CMS people came, and at first I think they were kind of jaded. And then, it's okay we're here. But then they had some real a-ha moments, it appeared. You know, the home care companies showed them how onerous some of the Medicare rules are compared to private industry. Setting somebody up on oxygen. Private industry, the file was this big. Medicare it was this big. Very labor intensive. Very costly. And we went through to see what it took to bring in dirty equipment, to make it clean, to make it safe.

We went to a beneficiary's home. Who- you know, the average oxygen patient is a 73 year old woman who lives by herself. And you know, her frailness, her challenges, you know, her vulnerability.

And they said "Oh," you know... they really seemed to have some insight. And yet the only thing they did with it, was be able to announce at a public hearing that they went. So they got the brownie point, but that's been over a year, and they have done nothing.

You know, just like they wanted a brownie point for going for 15 minutes to Professor Cramton's Conference on April 1st. But they have done nothing about it. They don't listen to our concerns;

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we ask for information on how the bids are being calculated before the program went live, we weren't given. We were locked out of input into the questionnaires... I've been a market research professional for over 15 years. I've worked for major corporations in New York. Fortune 100 companies, and I was totally shut out of this process.

During a teleconference -- and I think Tom alluded to this -- with CMS where they reviewed to some degree the evaluation process they were going to use to assess the effectiveness of beneficiary satisfaction and program impact, I asked if we could see the criteria being used and see some results in aggregate. I was told we couldn't.

Everything seems to be highly confidential, and yet we weren't asking for identifying factors, we were just asking for aggregate numbers.

When they were rolling out the year before last, the education program for the competitive bidding areas for beneficiaries, I voiced concern back in March that the roll-out was going to be very late, and it wasn't going to be enough time for beneficiaries to really be fully informed, I was totally ignored.

The majority of the education program was rolled out in November, in the height of Thanksgiving and Christmas. And this program went into effect January 1st.

As a PAOC member I just feel that we're totally ignored, we're not, you know, taken into account; and honestly, CMS is always concerned about fraud and abuse, but quite frankly I have a personal dilemma, because I really feel as a PAOC member I am helping CMS perpetuate a fraud. A fraud to all of you, to Congress, to taxpayers... we have a PAOC so we have the illusion of legitimacy and credibility... we're supposed to give oversight, we can't give oversight and say

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a program is legitimate when we're given no facts and figures, and yet, CMS goes up on the Hill and we're told, says that we're very happy.

I just have a couple of things that I just want to end with. And one of them is to give you the issue of... or to get you to understand really how frail and vulnerable this demographic is.

I conducted with our organization the largest needs assessment survey ever done in the United States for the COPD population. And we interviewed 3,000 patients, the majority of them beneficiaries. And 75 percent of them said they were limited on a daily basis by activities. 93 percent said they had symptoms that were active almost every day, and the majority of them was shortness of breath. That's for your oxygen.

Over 75 percent rated their health status as fair, poor, or very poor. And I will show this. This is the general population's... how they rate their health, as opposed to the- given by the CDC, and on the bottom is your COPD patients. You can see they are well below the national average.

The average COPD patient... 50 percent has 6 to 10 comorbidities, the second highest of which is diabetes. 20 percent had over 11 comorbidities. 59 percent took more than 5 pills a day; 27 percent took more than 10 pills a day, and that's often in combination with inhalers and nebulizers.

You know, these are people that are American citizens that did the right thing... they paid into the system, they worked hard, and they had the expectation of being protected.

Since CMS tells me on everything that it's a legislative issue, I'm turning to you. You're the ones, Congress, are- you know, representatives and senators, are the ones that we trust to protect us, to safeguard us, and to look out for our good.

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And I beg you to hold CMS accountable, as a taxpayer, as a beneficiary, and for you at Congress.

Peter Cramton: Thank you very much, Barbara. Everyone in this room very much appreciates your public service.

Barbara Rogers: Thank you.

[Applause]

Peter Cramton: Next is Rob Brandt, who is... oh. [Remark from background.] We're going to do a couple of quick clips, hopefully... so the first is Paul Gabos, who is also a Medicare provider... a bid winner, and the Chief Financial Officer of Lincare, which is publically traded company and one of the largest providers in the United States.

And the second is Joel Marks, who is also a bid winner.

[Begin clip of Paul Gabos:]

Paul Gabos: Good afternoon, I'm Paul Gabos, Chief Financial Officer of Lincare Holdings, we are probably the largest provider in most of these product categories in the country with a particular focus on oxygen and CPAP and respiratory disease... by most measures we are, I think, the singly most profitable company in this space, in terms of aggregate dollars as well as margin.

So in some respects you might expect as the most efficient provider in these markets, theory would indicate that we would have been a significant winner of contracts. Of the 73 contracts that we bid on, we won two.

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Needless to say we were shocked when we saw the results of the auction. Prices down 25 to 40 percent in some of these categories.

Now we fashion ourselves pretty smart guys. You know, when we went into the bidding process, our bid strategy was to essentially bid at a price that we felt would clear the market. We know from publically traded company information; we know having been an acquirer of hundreds of businesses over the years; we have a very good sense of what profit margins in the industry look like.

We felt that bidding down 15 to 18 percent would clear the market, ensure contract wins in the markets that we desired, and allow us to gain substantial share in those markets. And when we see prices down 25 to 40 percent, and then understanding that those prices are based on median prices, so that half of the winning bidders actually bid less than that, you really start to question the integrity of the bid process.

Now we were told there were protections that had been developed since the first round that would ensure that bids were bona fide. Well let's examine what some of those protections were. Like providers or bidders were asked to submit cost data. Invoice cost data. Okay, so I can tell you that in most of these product categories the cost of the product itself represents roughly 20 to 25 percent of the total cost picture. Payroll is 50 percent of my costs. Vehicles and facilities, another 10 to 15 percent of my costs. None of those costs were evaluated.

And so the opportunity for a bidder to submit a price at substantially below the cost he could operate at and make profit, was not prevented.

Furthermore, we were asked to submit financial data. We were asked to submit our 2008 tax returns. Well, the bidding occurred in late 2009. The economics in our business in late 2009

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looked nothing like they looked like in 2008. In 2009 we had a 9 1/2 percent across the board price cut; in the oxygen space there was an additional 2.3 percent cut for what's called the budget neutrality adjustment; there was an implementation of a 36-month rental cap, which by our estimates was somewhere between an 18 to 24 percent price reduction off the 2008 levels.

And so the data that was presumably used by CMS to evaluate whether bidders were bona fide and could make money at the prices submitted, was clearly outdated and irrelevant at the time that it was submitted. That's highly concerning.

Was there any attempt to do a pro-forma analysis. In other words, even looking at the 2008 data, could that company make money at the prices that it was submitting with the bid process. I suspect that none of that evaluation occurred.

And so these are very concerning, and I think enough's been said about the flaws in the design in the auction process. I think this concept of suicide or low-ball bidding became the prevailing bid strategy, and we see tremendous dislocation in these markets.

What are we seeing in these markets today? I think it's very early. And I think that some may be gaining a very false sense of comfort about how these markets are actually operating.

I think the real cash flow impact to companies in these markets is just now being felt. Because, you know, in January and February, you're working down your 2010 receivables. So while your profit and loss statement shows the full impact in January and February, your cash flow is still benefiting by older receivables.

I can tell you that, you know, by luck or by design there is a national provider in every market, in every product category. And I can tell you that the nationals are willing to subsidize these

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markets with their significant out-of-market operations. What that tells you -- and that was- you know, if it was by design, great. And we saw Peter's example of how the pricing could be set very arbitrarily in each of these markets because of the lack of a defined quantity. And so CMS had the discretion to look and say: at this price, I guarantee myself a national provider in this market. And that will prevent dislocation.

So I think that we are getting a very false sense in these markets. Because companies like ours and the two markets that we're competing in, where we are losing money by providing those product categories, those markets are immaterial to me in the aggregate. And so in the interest of patient care we're also a grandfather provider, we continue to provide products to our existing patients, we do that in the interest of continuity of care and preservation of our patients.

We have been inundated with requests by winning contract providers to purchase their companies. You know, it's very well known that Lincare, a very well capitalized company, did not win a significant number of contracts. I can tell you that we have confidential information from over 30 companies that have won bids, and we've been contacted by at least twice as many as that.

I can tell you that these companies are broke. They were broke before January 1st, and they're even more broke now. Some of these companies are not able to take new patients until an existing patient comes off service. Because they can't buy a new piece of equipment.

What are the long-term implications of that? That the fleet of equipment that is being provided to these patients is going to be old and outdated within 6 to 12 months, with no investment in new technology or equipment.

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What does it tell you when winning a contract, which according to efficient theory, should have been a good thing; it should have been at a price that you should have made money... now everybody is looking to get out of those businesses.

[Begin clip of Joel Marks:]

Joel Marks: Good afternoon, everyone. I'm Joel Marks, I'm with Medical Service Company, we're a provider based in Cleveland Ohio; we won contract for many items, most of the items in the Cleveland, Cincinnati, and Pittsburgh markets.

My comments in three parts: my thoughts on the program right now; comments on what Mr. Blum said earlier this morning; and my thoughts on the revised bidding process that we all enjoyed today.

So I won five product lines in the Cleveland market; I won them in Pittsburgh and Cincinnati; at the time we bid we did not have locations in those markets. At the time we bid we did not provide consumer power wheelchairs, which we won in those markets. So we won contracts for products that we didn't sell for markets that we didn't serve. And these are the people that the beneficiaries are supposed to have confidence in.

I'm doing what the rules said. They said I could bid anywhere. They asked how many power... consumer powered chairs we had provided last year and I said zero. That asked: what's your closest office to Pittsburgh. And I said: about a hundred miles away. And they said: good, you got a bid. Because your price was there.

I mean, this... so it sounds a little silly to me.

Peter Cramton: Okay. So... oh. Nancy Johnson's going to step in for a moment...

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Nancy Johnson: I'm going to just interrupt the clips, because Sue Myrick has joined us from the floor of the House, and I wanted her to have a moment to welcome you, and then we do have one more clip and Rob Grant, who is a winning bidder, and you'll get a first-hand sense of his experience.

But I want to welcome Sue here. Sue represents an area that was one of the 9 competitively bid districts. And so she's sort of seen the prelude. But she's particularly interested, as am I, in getting the information to evaluate the 9 districts before we go and expand this to 90, and then eventually to nationwide.

Sue is a good friend of mine, she's always been very interested in the substance of a matter, and whether not only is a policy correct theoretically, but is it practically effective in our lives. So thank you for joining us for a few minutes, Congresswoman Sue Myrick from North Carolina.

[Applause.]

Sue Myrick: Well, I'll only take a minute, because I just wanted to say thanks to all of you for being here and to the panelists as well, who hopefully are going to shed some light on this complicated competitive bidding process.

It is true that Charlotte was one of the markets chosen, but you know, we need to have more information on how this rollout has gone so far. And I think that's what concern's all of us. Charlotte-Gastonia, by the way, is the area I represent, and it was one of the test markets.

As we all know, this process has been controversial, particularly for those areas who were subject to the first round, and what was going to happen, how it was going to work, etc. So I think there's still a lot of questions that remain about the fairness of this whole thing... you

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know, how it's going to turn out; potential long-term cost savings, which is what were all interested in of this auction process, you know, that was selected.

Several of my colleagues and I have voiced concerns about this on behalf of patients, and of course small businesses in their own districts, throughout this process on a regular basis. And I suspect that you'll probably get more of an update on these details from the people who are here today.

I think, you know, competitive business, or competitive bidding overall, when you look at government, is probably a good idea. I don't think there's a question about that, and it's a good idea with Medicare at its basic level. Because the purpose of Medicare, you know, is not just to keep small businesses afloat, but to serve the patients and find a solution to the problem, effective health care for seniors.

But it should be designed so that patients have proper access, vendors have all the information they need to compete, and I think that's one of the areas where there's been concern expressed throughout this process; and then of course that it does save money as a result of the impact on the market forces, which is what we all want to do in these tight budget times, when we're looking at what's going to happen in the future and how we can make everything work better, to really, the ultimate result is serve the patient.

So I just... I'm glad that there's an opportunity today for you all to get an update on this, and I'll look forward -- I can't stay, or course, I'm sorry -- but I'll look forward to getting a review of what you all talk about. So I'll have the updated information, too, and just thanks to all of you for your efforts.

[Applause.]

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Peter Cramton: Thank you very much. And now we're going to turn directly to another bid winner, Rob Brandt, who... well, he'll describe it. You won one market. How's it going?

Robert Brandt: Okay. Thank you, Professor Cramton. My name is Robert Brandt, I'm the former co-owner of City Medical Services, North Miami Beach, Florida, in the Miami competitive bidding area. I began my business in 1997, I was joint commission accredited nine years before it was required.

In July I accepted a bid for oxygen, the Miami CBA, even though the bid rate was far lower than what I bid at. And even though I did not win bids in other areas I bid on -- which is CPAP and Respiratory Assist Device, enteral tube feeding and supplies, hospital beds, diabetic supplies, and walkers.

Last month I decided to close my business after getting a call from one of my oxygen patients, Jean. Jean requires continuous oxygen; she uses about 6 tanks a week, an average of 24 tanks a month, and Medicare was at the- previous to the bid rate was reimbursing out \$28.70 a month for as many tanks as Jean needed.

And on that particular day she called for more tanks, well the new single payment rate, because of the competitive bidding, was reduced to \$21.66. And that's per month for as many tanks as she needs.

Now as was mentioned on the video that Medicare advertised this bona fide bid rate, which was saying that they would make sure that no bids were below cost, but I couldn't even drive one of our vehicles out to Jean's house and honk my horn and drive away for \$28.70 a month, let alone make multiple trips within a month.

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Over the last few years, because of cuts in reimbursement, cuts in the number of months that we were paid, increased documentation and ongoing documentation requirements, our annual revenue dropped from a million dollars per year to \$600-thousand in 2010.

In preparing for life under competitive bidding, I laid off half my staff -- I had six employees -- in December I laid off half my staff, because I was unable to continue to provide the CPAP supplies, enteral feed supplies, diabetic supplies, and there was an over 30 percent cut in oxygen reimbursement.

So I was looking at a \$25,000 per month drop in revenue, which would have a total of \$300,000 in losses for 2011. And I just could not sustain a business for that... a business that used to do a million dollars a year, now at \$300,000 dollars a year, and still take care of patients like Jean, and also be able to continue to employ licensed respiratory therapists -- which is a requirement in the state of Florida; pay for rent, pay for my vehicles, insurance, and overhead. So in order to cut my losses, I closed my business on April 30th.

In the wake of the program, four of my former employees are still unemployed; one of my employees, my office manager, took a job with a local company, but she replaced two employees that were laid off there. She took a 20 percent pay cut, and she also no longer has health care benefits that I was providing for her.

But more importantly, the closing leaves a severe gap for patient access in my area, as I was the only oxygen contract winner in the ___ [?] through North Miami Beach area. And I had to leave 800 active patients that were getting respiratory services from our company.

And the problem is, is that when these patients call for service, when their oxygen concentrators are alarming, and they're no longer-- alarming with low oxygen, and the filters haven't been

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changed periodically, the patient's going to call up, they're not going to find us there, they're going to call 1-800-MEDICARE, and be I guess one of the 54,000 inquiries that they had looking for some type of answers or new service; but the biggest problem is, they're not going to be able to get service, because for any new contracted winner to take over service, that patient's going to have to prove medical necessity, they're going to have to go back to their physician and have a face-to-face examination and most likely be retested to see if they need the oxygen, and that typically takes about two weeks or a month for that to happen.

The one flaw on this program that really frustrated me, was when I decided to close my business I contacted a local bid winner that was within 10 miles away that won multiple categories who I knew, and I asked them if they would take over 150 CPAP and respiratory assist patients just like Barbara Rogers, and they refused; and when I asked them why, they said they never provided respiratory assist devices before, but they only bid low so that they could win the contract in order to try to sell their business, or maybe woo a company like Lincare, as Paul Gabos explained.

So these people created the single payment rate, they have no experience; I have 14 years of experience, I lost the bid, and I had to close my business. This program is unbelievably flawed in that... example.

And, you know, the fact that as a company like mine, with 14 years experience, local, one mile away from a hospital, I had to close my business as inexperienced, out of area, and financially bankrupt companies won bids is just wrong, and this program has to be stopped before it goes nationwide, and those companies start bidding later on this year.

Thank you. [Applause.]

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Peter Cramton: Thank you, Rob. Now let me turn the floor over to Congresswoman Nancy Johnson just for a couple of minutes, and then -- because we really are running out of time. I know we'd like to take questions, but I think it would be better to get a couple of remarks from Nancy Johnson, and then you can email me, or email any of us with your questions and we'll respond to your questions. I apologize for the short time that we've had. Nancy?

Nancy Johnson: Let's take questions. Well take a couple of questions, I have one sentence to say, that's all you can- guess what it is, it's a thank you. Let's take questions if there are questions.

Attendee Sue Morris, KCI: Yes, we have been told that the feedback from CMS in rebuttal to your proposal is that you are not a health care auction expert, but there are effective health care auctions for a wide range of products and services. Can you tell us how your proposal compares with those effective auctions.

Peter Cramton: It's actually very similar. So I have experience in many, many industries, in many, many countries, and I understand the peculiarities of particular industries... there's a lot of similarities as well, such as guaranteeing a performance and obligations and so on that Tom spoke about, and that you are very familiar with in the private sector auctions that occur routinely with Blue Cross/Blue Shield and other private sector providers.

So in fact, I feel at this point, when Nancy first called me up, I did not feel extremely competent with respect to health care. But in nine months, I'm a quick study. And I've actually learned a lot. And I've spoken to a lot of extremely knowledgeable people that you've heard from today.

And in that process now, I can assure you that I know a lot more about health care auctions than anybody in CMS ever has.

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Nancy Johnson: Let me just say that one of the reasons we got into this, was because competitive bidding, I mean, I chaired the committee that held the hearings on competitive bidding, and when we put competitive bidding in the Medicare Modernization Act, we put it in on a bipartisan basis, but we also didn't really know how to do it. But we figured the private sector knew how to do it. Because every time Blue Cross, Blue Shield, or United, or anyone contracts with anyone in the healthcare sector, that is a competitive bid situation.

They know what the bid requires, they know what the standards are, they know what the services are they're supposed to bid on, and any big health insurance plan looks at and bills the network. And they do that through competitive bidding.

And yesterday I was talking with a company who constantly is involved in providing one of the most sophisticated services that we provide in health care, and they were describing the competitive bid situation that they deal with in the private sector all the time.

So don't let the word "auction" throw you off. One of the reasons this has turned out to be so important, as we were looking for a way to improve the system that CBO would accept as being economically responsible and powerful in an era when Medicare is going broke.

And one of the things that's so important about this system -- and I can't emphasize it enough -- is that the auction process does publically what insurance companies do privately. They get together with suppliers and knowledgeable people... it would be the auction expert, the suppliers, and CMS for the public... and in a public, transparent fashion, they discuss what the standards should be.

If they had discussed what the financial standards should be... invoices as the sole indicator of a company's financial capability would never have passed mustard.

[Medicare Auction Update]

So that process of transparency, of setting the quality standards for product, the quality standard for service, it deeply pains me that if you look closely behind the scenes, we are offshoring the production of durable medical equipment.

So you ask people: where was their meter made. This replacement that they got. I don't want to get too far into that, because it's like in every other area, and I know a lot about this in manufacturing, you know, there's a component of offshoring in a lot of things.

But you absolutely stop dead the innovation, the technology development that you see in the American diabetic arena. Where improved quality of meters is the reason there is improved quality of compliance and management, and a reduced number of diabetic patients going to the emergency room in the hospital.

So there's a lot at stake here, and transparency is crucial to getting standard- financial standards of viability -- why didn't they have any standard of ramp-up. Show us that you can feel the capital that will allow you to go from a thousand patients to five thousand patients. I mean, you might ask that question.

So transparency is very important; auction systems, competitive bidding is done all the time in health care, and this would just make it, for Medicare as a provider, a publically transparent system that was run with the purpose of serving seniors. Of getting product to seniors, and where appropriate, services to seniors.

So I don't want the word auction. That's often thrown at us. Well, he does electricity. Well, he does this. Well, believe me, those markets are very complicated, but they are unlike healthcare, but it's not rocket science. It's the fundamental process that matters. If you don't have the process right, you can't get the product right.

[Medicare Auction Update]

I really believe, and one of the reasons Sue and I are friends, and there's lots of people on both sides of the aisle who think this way, that's why they want to keep competitive bidding in play... they have the belief that if we do it right, the outcome will be right.

You know, so right can't possibly be going into something with half the people losing business every time they serve a patient. It's just too illogical. It doesn't work in life.

Peter Cramton: Thank you very much, Nancy. Let's end on that good news that we *can* do it right. And it's going to take some hard work, but it can be done, and it can be done on schedule, and Congress just needs to insist on it.

So please insist on it... thank you very much, everyone... [Applause.]

Nancy Johnson: I just want to thank the panelists. Because they all come on their own time, and Peter, for all he's done. And I want to urge you to get involved on behalf of your member and the seniors you represent in helping us get information, or any aspect of this program that you'd like to be more involved in. Thank you very much for being here.

[End presentation.]