RALPH NADER RADIO HOUR EP 250 TRANSCRIPT

Steve Skrovan: Welcome to Episode 250 of the Ralph Nader Radio Hour. My name is Steve Skrovan along with my co-host David Feldman. 250, that's a nice round number, right David?

David Feldman: Can you believe that? It's my batting average.

Steve Skrovan: Yeah, it's a mediocre batting average, but it's a great round number. It means we're approaching five years with the Ralph Nader Radio Hour. We also have the man of the hour, Ralph Nader, hello Ralph.

Ralph Nader: Hello everybody.

Steve Skrovan: We've got another great show of course. We have discussed the topic of health care on this show many, many times. In fact you could probably design a college level course just using the transcripts of our episodes as the text. We have spoken to doctors, nurses, scholars, business people and advocates of all stripes during the course of the 250-episode history of this show. Today we're gonna add yet another chapter to that textbook. Our guest today is Dr. Fred Hyde who is an independent consultant on public health issues with affiliations at Columbia, Fordham and Georgetown Universities. We're gonna focus on Medicare, its recent history and its future. That's the first half of the show. In the second half we are going to plow through a whole bunch of our listener questions. We've got a lot to catch up on in our inbox. In between, we have a great half-time show. No, it's not Beyoncé; it's even better. It's our very own Corporate Crime Reporter, Russell Mokhiber, the tireless watchdog of the corporate crime beat. It's another great, informative show for you today. David, let's get on with it.

David Feldman: Dr. Fred Hyde is a consultant to hospitals, medical schools and physicians as well as to unions, community groups and others interested in the health of hospitals, health care facilities and organizations. Dr. Hyde is also the publisher of the daily health policy newsletter called DC Medical News. Welcome to the Ralph Nader Radio Hour, Dr. Fred Hyde.

Dr. Fred Hyde: Thank you.

Ralph Nader: Welcome indeed Dr. Hyde. This is a special educational program for our listeners like no other so I hope they'll stay with it, because if they're not on Medicare or about to go on Medicare or they have parents on Medicare. And there's all this talk about this federal judge who just ruled that

Obama Care is unconstitutional, roundly condemned by conservative and liberal lawyers for different reasons, raising doubts about the present system; it's time to really get caught up so when we talk to our neighbors, friends, co-workers, we can get some good civic initiatives underway. Dr. Hyde has a medical degree and a law degree from Yale, and an MBA from Columbia. A very hands-on person, I don't know anybody in the country that has more academic and in-the-field experience in real organizations of a great variety. Let's do a little background here. The real threat that is the theme of this program is the commercialization of Medicare. It just seems to be continuing with United Health Care and other companies wanting to get more and more of the Medicare profits and getting into the Managed Medicaid, which is even more regressive in terms of when it started. So the commercialization of Medicare, when did this begin, Dr. Hyde?

Dr. Fred Hyde: Well thank you Ralph, and I hope we can do a good job for your listeners here. In 1997, during the Clinton Administration, what were called demonstration projects were formalized into Medicare Part C or Choice, as it was called. And then it became more popular in 2003 when it was renamed Medicare Advantage. Today, it has something like 21 million of the 60 million Medicare beneficiaries enrolled in managed Medicare called Medicare Advantage.

Ralph Nader: Yes, and they are now having lunches and seminars--the health insurance companies all over the country--inviting elderly people to sign up, not for traditional Medicare, but for this corporate managed Medicare Advantage. Awhile back you told me about an interesting strategy when they invite them to lunch. It's a kind of a pre-selection. You want to explain that?

Dr. Fred Hyde: Sure. In the early years of Medicare Advantage, the government actually paid the health insurance plans more than they would have spent on traditional Medicare. That reached a peak of something like 14% more in 2009. More recently, the government has tried to cut back this extra amount which they spend and one of the results is that with the fewer enrolment efforts, for example, amongst Medicare beneficiaries who might be disabled or in nursing homes, or otherwise compromised and more enrolment efforts amongst Medicare beneficiaries who are like you and I, are walking around and still relatively healthy. This is an old technique of the HMOs and that is enroll healthy people and get paid more on a capitation basis than you would be if you had enrolled people who have chronic diseases or other expenses, which are going to detract from your underwriting profit. The bottom line is, earlier this year, one of the big, public accounting firms, Deloitte, found that almost 60% of the underwriting profit of the health insurance plans came from the government programs--Medicare Advantage and Managed Medicaid.

Ralph Nader: Well what's interesting is if they can get to a lunch to be given a spiel about Medicare Advantage, that means they're less likely to be chronically sick people. That's the way they cream off the top, so to speak, and reduce the number of claims that they have. We're talking about these health insurance companies like United Health Care. By the way listeners, you should know that if you have relatives in traditional Medicare, they are subsidizing this corporate-managed Medicare Advantage and

our government in Washington is actually doing things that preference Medicare Advantage. You want to describe how that works?

Dr. Fred Hyde: There are three things, Ralph, that are very important to the individual. First is that in Medicare Advantage, there is an out-of-pocket, an annual out-of-pocket limitation on expenses, but there is no such limit in traditional Medicare and that's the government rule, if you will. So, in a sense, if you look at the government as an employer, the employer is putting more and more expense on the traditional Medicare beneficiary with regard to out-of-pocket limitations. Medicare Advantage, the capitation payments which the plans receive are sufficiently generous that they can say, we're gonna have an out-of-pocket limitation every year. A second piece of the information is that the Medicare Advantage people may have narrow networks. They, on average, only have about half the hospitals in a given area signed up because they like to have contracts with the hospitals that guarantee a higher volume, for perhaps incrementally lower cost. In traditional Medicare, people enter whenever they want because almost every doctor, almost every hospital takes traditional Medicare. But the narrow network is another technique for trying to squeeze profit out of the Medicare Advantage programs. And then finally there's a new trick this year; there's something called prior authorization, which drives physicians nuts. It amounts to having your office staff spend endless amounts of time on an 800 number talking to somebody who's probably not clinically trained to try to get approval for something the doctor has already prescribed. Prior authorization is not allowed in traditional Medicare, but they are now allowed in the Medicare Advantage program. And one other new trick this year is called step therapy. Step therapy also drives doctors' nuts. It basically says, this is the drug your doctor thinks you need, but before we pay for that, we want you to try a bunch of other drugs that we don't think are gonna work as well, which are less expensive. Step therapy for pharmaceuticals, prior authorization for everything, narrow networks to constrain the choices the that the Medicare beneficiary has--these are all tools which the Medicare Advantage program has. And you'll recognize they're traditional HMO tools—the kind of things that we threw out in the beginning of the early 1990's—but here they are back again in the Medicare program.

Ralph Nader: Well when the insurance companies at these lunches or seminars try to tempt older people, they say, well, you get more services under Medicare Advantage than you do under traditional Medicare. Once you told me, it's not what you pay, it's what you get when you need payment for your health care. Can you explain that? And what happened when Aetna didn't like certain services under Medicare Advantage?

Dr. Fred Hyde: Well that's absolutely true. Aetna early on in the Medicare Advantage program had a lot of difficulties living with the benefits that had been prescribed. Here's a headline from April of 2015, 'Federal officials have slapped Aetna with a million dollar fine, after misleading subscribers about in-network pharmacy coverage.' Aetna's not the only carrier which has had trouble, if you will, living up to its promises, but earlier on became infamous for throwing out a good number of people who were no longer profitable to cover. Now today, the game is not to throw out subscribers or even to mislead them, it's to use the HMO cost management techniques to have limited networks, prior authorization

for services, step therapy for pharmaceuticals--all of these tools that essentially try to make up for the fact the government is no longer paying a 14% bonus, but the companies still need to make a profit.

Ralph Nader: Their opinion is 7%, aren't they, bonus?

Dr. Fred Hyde: The bonus varies, Ralph. It's a tricky calculation. And you can well imagine it employs a lot of lawyers on both sides, year in and year out. The companies claim they're merely coding properly, and coding is the key to all of this stuff. It's the recording, if you will, and transmitting of information associated with billing. And it affects what's called a risk adjustment, which in turn affects the capitated amount which the health insurance plan gets, which varies also by county, by the way. All of that feeds into the question of whether or not there's going to be a monthly premium for the Medicare Advantage beneficiary. Most plans today try to live without having a premium, which is a relatively small amount of money compared to what they could be paying if they had all of the hospitals and all of the doctors in the plan, because as your question implies, the really expensive stuff in health care is the hospital, medical technology, big pharmaceuticals and the access to all the doctors who would be the doctors that the beneficiary would want to see, as opposed to the doctor who accepts the Medicare Advantage plan.

Ralph Nader: Well, listening to you, it's like these insurance companies are trying to suck the elderly into the commercial health insurance marketplace with all its deceptions, false promises, denied claims, narrow networks. And that to me seems like they're trying to continually undermine Medicare, which started out with a simpler plan. I saw the Medicare manual put out by the federal government for people and it's like a hundred pages; that's how complex it is. I once showed it to a Canadian and he said, "Are you sure you call this Medicare? In Canada we have Medicare, but we don't have more than a page and we just have a little, plastic card and we hardly ever see a bill." That's of course the single-payer system, public funding, but private delivery of health care with free choice of doctor and hospital. It comes in at about half the price per capita, covering everybody in Canada from 45[00] 4600 dollars per capita and in our country, we're coming close to $10,000 per capita average, and 29 million or so people aren't covered still under Obamacare. So, I'm sure our listeners are saying, 'this thing is driving us up the wall here'. It seems like Medicare Advantage really means financial advantage for the health insurance companies. How do we get out of this mess Dr. Fred Hyde?

Dr. Fred Hyde: Well, you're correct Ralph in pointing to the complexity of the American health care system and what you might expect, which is the attendant cost of that complexity. The other side of that, and there was an economist at Princeton--really, lovely, elegant man--Uwe Reinhardt passed away last year. He used to point out, and he's quite right, that "my expense is your revenue." We have an economy, which during the Obama administration grew frankly because we had tremendous growth in the health care field. From January of 2014 through December of 2016, which was the period of full roll out of the Patient Protection and Affordable Care Act, our economy added 32,000 benefited jobs in health care every month, month after month. And that was what really dragged us out of the so-called

Great Recession. We had this tremendous jobs growth. How many of those jobs, honestly, do we need to deliver health care services? And, the answer is, with the complexity we have, we probably need all of them. But if we didn't have this complexity, and goodness knows, we wouldn't need quite as many. Here's a number that you might want to take away. If you said to yourself, how many people do we have in support roles compared to the number of doctors and dentists that we have actually delivering services? The answer is, it's on an order of about 20 times that number of people who are actually involved in employment in the health care field. It's really astonishing when you think about it.

Ralph Nader: And all that involves bookkeepers, accountants, bill collectors, and shifting costs here, trying to negotiate there. The most amazing thing in this whole Medicare Advantage thing, it's really hard to see how our own government is trying to push elderly people into Medicare Advantage. In the 1990's, the Congress prohibited Medicare from negotiating volume discounts for drugs. The Veteran's Administration has been doing it for years. The Pentagon has been doing it for years. But somehow, the 450 drug companies who were swarming over Capitol Hill about 22 years ago, got a prohibition. But then, according to what you've written Dr. Hyde, while the government prohibits Medicare from negotiating with pharmaceutical companies to obtain the price discounts that would be associated with Medicare's volume purchasing power, Medicare Advantage Corporations don't operate under the same constraint. Can you explain that?

Dr. Fred Hyde: Beginning next year, the rules that the Centers for Medicare and Medicaid Services or CMS sets will allow some negotiation for the companies--the plans that are running the Medicare Advantage programs. The negotiation will look at the so-called protected classes of pharmaceuticals. There are number of different categories of pharmaceuticals that need to be covered and the manufacturers know this. They can see what the requirements are. CMS will now allow the Medicare Advantage plans to negotiate, to leave out some of the so-called protected pharmaceuticals. A second tool is one I mentioned previously, but it's worth lingering just for a moment to see how this works. The second tool is the business of step therapy. Step therapy is not allowed in Medicare at all. But beginning next year, it will be allowed in the Medicare Advantage plans. You have to, if you've ever known anybody who's gone through step therapy, think about this for a moment. You and your doctor are talking about how to deal with a problem that you have. And your doctor takes into account what he or she has seen from other patients, what they've read, what they've learned, what they know and they come up with a prescription for you. That prescription may not be what the health plan is willing to pay for. Now they have the right to tell you, oh no, we're not gonna pay for that, we're gonna pay for some less expensive pharmaceutical that you're gonna have to try and fail on for a certain period of time and then you can come back to us and try the next least expensive drug. This is, Ralph, a spanner in the works. That's all it is. It has nothing to do with science. It has to do with, how can we keep people who need particular prescription drugs from getting them? And we can keep them from getting them because we can force them to take a pharmaceutical product, which their doctor never prescribed, and did not intend for them to have, in hopes that somehow, they will go away, that they won't be back with the prescription for drug A; instead they'll get tired and disgusted with the symptoms of side effects of drug B, and they won't appear again. It's literally throwing a spanner into the works. What Medicare is doing, and there's a great headline from the December 1, 2018 New York

Times, Robert Pear, who's so smart about all of this stuff. The headline is "Trump Administration Peppers Inboxes with Plugs for Private Medicare Plans". That's what they've done. They have put a thumb on the scale, in terms of what the Medicare Advantage people can do, as you were asking with regard to pharmaceuticals, but also, what they can pay for. They can actually pay for some at-home meals now under Medicare Advantage--much less expensive, by the way, than allowing top-ranked academic medical centers in as participants in your network.

Ralph Nader: And you've said there's no evidence that Medicare Advantage, under corporate management, has saved money for the government, or in the long run, for the consumer--for the Medicare consumer who's been lured from traditional Medicare into these, what some people call, rackets.

Dr. Fred Hyde: Well, absolutely. I don't want to hammer the same point too often, but if you go up to 30,000 feet, and you take a look at the health insurance world, ever since 1974, with the Employee Retirement Income Security Act and the organization of large employers to be self-insured, which of course takes away underwriting profit for the large groups from the health insurance. Ever since then, they've been looking for a way to substitute the profit which they've lost, because they're no longer underwriting the large groups. How do they do that? Well today, the way they do it is by government programs. That's where the profit comes from. This Deloitte report that basically said that for the last five years, 60% of the underwriting profit of all the large health insurance plans has come from government programs, that has to come from some place. Where is that coming from? It's coming from what they've managed to either be overpaid for, or under performed for in both Medicare and Medicaid.

Ralph Nader: It's hard to know where to start here. It seems like there is more than a little deceptive marketing here. Isn't that something that should attract the attention of the Federal Trade Commission? [FTC] And is it?

Dr. Fred Hyde: Well, that's an excellent observation. One of the ironies in American Health Care is that our most prestigious award, generally for biomedical research, but also for lifetime achievement - essentially the American Noble Prize in medicine - is the Albert Lasker Award. Mr. Lasker was best known for his genius in the advertising industry. That's where the money came from. So, you have to ask yourself, what do we gain by having direct-to-consumer advertising of pharmaceutical products, by having this enrollment period which concluded, of course, December 7th, but which comes on every year, in which we're bombarded with advertisements that show gracefully aging models in warm family situations enrolling in Plan A or Plan B. All of that, it isn't deceptive per se, it's part of the American milieu. I tell my students, we have a course in health care financial management, and sometimes they have to forgive me overstating things, but the American business model--what has made our economy so large--is we spend money we don't have for things we don't need. That's the model. And health care exemplifies that model. We spend money we don't have, because of course the trust funds that are

supposed to be funding Medicare periodically - the Perils of Pauline, look like they're gonna run out of money - we spend money we don't have for things we don't need. What we need is access to doctors who are capable of caring for us without becoming mini-bureaucrats at the same time, and hospitals that are capable of accommodating what those doctors need to do, but we have a lot more. And we really don't need, to put it frankly, all of what we are paying for.

Ralph Nader: Bottom line, before we get into what's going on in hospitals, non-profit and profit, where you're such an expert Dr. Hyde, bottom line is to people over 65, stay in traditional Medicare, or if you've been lured into Medicare Advantage, corporate managed, how do you get back to traditional Medicare? Can you advise people?

Dr. Fred Hyde: Yes, every year you get an opportunity to bail out or to bail in, depending upon which direction you're going. That begins in beginning of November/the end of October, depending upon the year. It generally ends around, as it did this year, around December 7th. So be attentive, and ready if you will, to make your choices when the time comes. You won't find, unlike other kinds of insurance, you won't find, and this is too bad, too many people helping you to do this. You won't find insurance brokers busily trying to get you out of Medicare Advantage, because they don't make any money doing that so in the scheme of things, it really has to be the individual or the individual's family who is aware of when the open enrolment periods come along and is poised to make a change when that happens.

Ralph Nader: The avarice of these health insurance companies knows no boundaries, and we're gonna see some of that in the database next month from the Trump Administration. I mean good news, people are gonna realize that for the same kind of operation or procedure or treatment, the prices in Akron and Topeka and Phoenix and Atlanta and New York vary hugely. And they just can't be explained, can they, by a higher cost of living in one city after another. Can you explain this? Is this gonna get a lot of publicity?

Dr. Fred Hyde: Yes, it is. And I can tell you that if you're in my field or anywhere in the health policy area, your inbox is filled with alternately consternation and suggestions for what hospitals should do. All roughly 5,000 acute general-care hospitals, beginning January 1, are required to post their charges in a publicly available manner in machine-readable format on their website or other accessible area. What does that mean? Journalists everywhere are gonna be looking to see how their hospital compares to others. Hospitals everywhere are gonna be saying, oh no, that's just charge information. That's really meaningless information. The truth is, you have to post the DRG information as well--your average payment for DRGs. So, it's not meaningless information.

Ralph Nader: What's DRG?

Dr. Fred Hyde: The so-called Diagnosis Related Group, which is the basis upon which hospital in-patient care is paid, is standardized by Medicare. And, it's one of the ways in which you can present much more meaningful information than merely the charges. It's the average, actual payment received by the hospital from all of the people who pay on a per-case or per-discharge basis.

Ralph Nader: This is gonna embarrass some hospitals and gratify others? Is this gonna stimulate lower prices through competition?

Dr. Fred Hyde: One of my students in the small-world category, very interesting, we were talking about this in class, and this young man, very smart, he's an ophthalmologist in this health care management program, sent me a notice from his local hospital, which was called Tower in Pennsylvania. They were lowering their charges by a miraculous 30%. You'd think that something really had happened to lower the cost of health care. But it had nothing to do with lowering the cost of health care. They were merely taking preventive action, prophylactic action if you will, to avoid headlines that showed they were at least 30% out of line with their competitor.

Ralph Nader: The Trump administration is not gonna interfere with this?

Dr. Fred Hyde: They actually promote it. You have to, in terms of giving the Devil his due, you have to take a look at a couple of things. One is the proposal to compel the pharmaceutical companies to advertise the cost of their products when they are advertising on television, which has a certain shock value. It's an antidote to the evils of direct to consumer advertising in the first place. Then secondly, this business of publication of the prices, that comes from the Trump administration. There is nothing at all like that left over in the Obama Care or any of the tail of the comet, so to speak, from the Patient Protection Affordable Care Act. Advertising, they apparently believe in it, as a means of, if not anything else, at least shocking the marketplace. I'm sure there are going to be a lot of red faces. The question is, what happens after that?

Ralph Nader: What happens is they're gonna start advertising sales, for appendectomies, or for heart surgery, or for orthopedic surgery. They're gonna start talking about, you get a better bargain for this and that. This can be in the same city, not just miles away between Akron [Ohio] and Passaic, New Jersey or Bridgeport, Connecticut, right?

Dr. Fred Hyde: Well the big guys already get the sales. You don't get them and I don't get them, but if you're Walmart, you've already figured out this game, and you've got so-called centers of excellence. It means that you got a lid on what the prices are that you're gonna pay for the expense of orthopedic and the cardiovascular procedures. And, there's nothing new about that. What is new here is this bizarre business we have of pricing having no relationship whatsoever to cost-- none. That is going to be

exposed, and it may put some emphasis on the more responsible parts of the field that are interested in studying cost. The cost business, that's another semester, but it's a very tricky business to try to get a handle on what things actually cost as opposed to these artificially inflated charge numbers or any other numbers that we happen to throw around based on charges.

Ralph Nader: Well stay tuned, it's gonna be all in the media, on TV, radio, newspapers, listeners. I want to ask you a number of quick questions on what's going on in hospitals, because you've served as a chief executive, a non-profit hospital, chief executive of a physician-owned ambulatory surgery center, chief executive of an HMO, as vice president of a major university teaching hospital, as director of a medical school faculty practice plan, and a consulting manager of physician practices, so, you know what's going on. Now we've talked about this Johns Hopkins Medical School study of a little over two years ago. They estimated, at the most conservative level, that about 5,000 people a week/250,000 [people] a year, die in hospitals in our country due to preventable problems, like hospital-induced infections, medical malpractice, et cetera. What do you see? When somebody asks you about that, how can you advise them in terms of their choice of hospital? Do you think that study, which is a peer-reviewed study, is something that should command the attention of Congress and the federal executive branch among others?

Dr. Fred Hyde: It should, Ralph, much more than it does. Let's put a little more history here. The quality problems, becoming aware of the quality problems, something that goes back to the early 1990's, when a very talented physician, who now by the way is the chief medical officer of the CVS-Aetna combination, co-authored a study in the New England Journal of Medicine that reviewed all of the adverse incidence reports in New York State hospitals, and basically found something like ten percent of hospitalizations had something really serious that had happened that could have led to the loss of life and should have been noted, if you will. That in turn was part of the lead up to the 1999 and 2000 Institute of Medicine study, which estimated based on whatever numbers they were using, somewhere between 49,000 and 98,000 deaths per year in American hospitals. The study you've mentioned is even more sophisticated and farther down the road. There's no reason to think it's not in the right calibre, if you will, order of magnitude of unnecessary deaths and certainly morbidity and mortality. What's the problem? A big part of the problem is that we don't have enough nurses in hospitals, and we don't have enough respect for nursing to give it a prime position that it should have in hospital expenses. When Medicare came along, labor costs were about two-thirds of the total expenses in hospitals; now they are about 50%. So, whenever a hospital has trouble from, for example, neighboring institutions consolidating and getting preferred contracts--whenever a hospital has trouble, one of the first things that occurs is, let's throw some people under the bus. Let's have fewer nurses. Let's have less-well qualified nurses. Let's not pay the nurses for the particular things which they do, continuing education and so forth. And, let's substitute for that mandatory overtime--one of the few forms bonded indenture that we have in America today. We really are not putting our money in the hospital world, from my point of view, where we should be putting it, and that is on the people whose actions are going to make a difference to the outcome. Where are we putting it? We're putting it on information systems where it just creates headaches for doctors and nurses alike. This is an industrial model. This came from the corporatization of the American hospital, and the idea that throughput and productivity is what we're

looking for. We're not looking for throughput and productivity. We're looking for enough nurses to be able to answer the bell when the bell is rung. So, there's a real tension between what might be called the corporate model and a more personal-care model. I'm sure I'm sounding like an old guy in saying that, but the truth is, that we don't pay enough attention to what individual patients need. We pay too much attention to what we need and also to what we're told we need. For example, the Obama administration--one of the first things they did was they made a 35 billion dollar bet on an immature, incomplete technology, namely electronic health records. And what we've gotten for it is headaches and lots of expense, and lots of money that might have gone in some other direction. So, your question, why don't we pay more attention, you know the Agency for Health Care Research and Quality [AHRQ], which is the one federal agency that tracks these things, is the target of Republican efforts this year to get rid of it; sort of barely survives from year to year. It's not as though somehow it's a big priority. To the contrary, it's a nuisance to have people studying these things and bringing them to our attention, because then implicitly at least, we have to do something about them.

Ralph Nader: But we're not seeing much reduction in executive compensation for the bosses of these hospitals and HMOs. You've noted that in the past. Can you talk a bit about that? And tell our people, what differences do you see between non-profit hospitals and for-profit hospitals? Let's start with the bosses' salaries.

Dr. Fred Hyde: Well, executive compensation is always a hot button. If you're raised with a certain reticence in your life, it sounds almost rude to talk about what other people are being paid. But the truth is that we know a lot more than we used to. First, because the non-profit hospitals have to record executive compensation in their 990 tax return forms. But secondly, because the publicly traded companies also report, through the securities filings they make, on the extraordinary compensation of their executives. The truth is that we have, for example, in the Borough of Manhattan, we have a half-dozen executives making four million dollars or more in non-profit hospitals.

Ralph Nader: Each?

Dr. Fred Hyde: That's each. I didn't mean aggregate. No no, each. We have leading the pack, we have a six-million-dollar executive. Then of course if you've got a salary compensation like that, structure like that, you have a lot of a little two-million dollar, and one-million-dollar executives who also have to keep up. So, in the scheme of things, somewhere around 20% of our hospital expenses are in the general and administrative area, or GNA. And they're promoted, in part, by executive compensation that would strike most people as being excessive. Now, people will say, "Well so what Fred, isn't that what we need to get and retain top executives?" The truth is that there are very few parameters that boards of directors of non-profit have with which to measure the effectiveness of individuals. You almost never see health outcomes. You almost never see malpractice suits, adverse incidents--anything that would be a proxy for bad outcomes as one of the measures. You see profitability, you see adherence to so-called quality metrics, which are government collection of information, which are subject to a lot of

gaming, but you don't see a lot of outcomes. You almost never see surveys of public attitude--what do you think about x hospital? Did they take care of you recently? What was your experience like? No one's ever seen that. So we're paying people without, frankly, having a lot of bottom lines. You could at least say, with regard to the investor-owned hospitals, at least they have a bottom line. They know how much money the place is making. They know what kind of dividends, if any, are going back to the investors. They know what kind of share appreciation is taking place; the non-profits, not so much. Very difficult to see a relationship between outcomes that matter to patients and compensation that matters to executives.

Ralph Nader: It's interesting. How would you recommend people, they got a choice to a non-profit or profit hospital.

Dr. Fred Hyde: Well, I'm fortunate Ralph. In our family, we have an actual family practitioner. We have a doctor, who by the way, is very young but he doesn't use electronic medical records. He went to Harvard, but we forgive that. He's an excellent doctor. That's what I recommend people get, is get somebody who's an insider, who's a doctor, who cares about these things rather than listening to all of this nonsense, this advertising and the promotion--this is on sale and that's on sale. Frankly, there's no other tool that you have that's gonna be anywhere near as good as a doctor who knows you and who knows the system.

Ralph Nader: …And who knows where he can recommend that you go for specialized treatment. You know, there have been all these mergers--hospital mergers, doctor practice mergers. You mentioned once that the cardiology practices are almost now all under the wing of some hospital; they've lost their independence. Doctors have lost so much of their professional independence to this corporate model of medicine. Under Bill Clinton, under George Bush, under Barack Obama, and under Trump, the antitrust division doesn't seem to be too vigorous in blocking these mergers, which always reduce competition and seem to increase prices to insurance companies and to individual patients. What do you say about that briefly?

Dr. Fred Hyde: Well you're right on. It's been many years since we've seen any real interest in prohibiting anti-competitive activity in the health care field. We take for granted the arguments about increased efficiency; it turns out that's false. About integration of doctor and hospital practices; it turns out that's false. About more effective community service--no evidence of that. And we let these things go. Even our most effective attorneys general, recently in Massachusetts, Ms. [Maura] Healey, who's an excellent, outstanding public servant, really muffed it completely, in terms of another big merger there between Beth Israel and Lahey. It isn't as if somehow we don't know that this is an issue. If you listen to the academics in this field, the outstanding people, (Indecipherable) Daphne (sp?), Martin Gaynor, Zack Cooper, you read what they have written, and you can't help but come to the conclusion that some percentage--what is that percentage? Is it 10%? Is it 30%-- of what we're paying--is nothing more than the gains, the rent-seeking, if you will, of monopolist activity so we really have had no particular interest

in doing anything about it and I don't see any change coming along. I know the FTC has been going through a business of having hearings on their thoughts about anti-competitive activity just generally for the future and that's all to be applauded, because at least there's a pulse there.

Ralph Nader: Well, I know our listeners are now saying, this is all so overwhelming; it's confusing. What is the ideal health insurance system if Dr. Fred Hyde was the single decider? He could say, suddenly, never mind political obstacles, corporate lobbyists, and never mind blurring this distinction between health insurance and health care. I mean you can have great health insurance, but not great health care--focusing on prevention, diet, exercise, all the way through to the treatment for serious ailments. Tell our listeners, what would you like to see, and how does Canada favourably compare?

Dr. Fred Hyde: Again, it's an excellent, but also a very complicated question as you know, Ralph. When my students press me, I feel like Voltaire's Candide, that having seen the Intifada, if you will, I'm content to till my garden. Here's the garden that I would till because it's the most meaningful one--universal access. There's no reason why we should have to mortgage our lives in order to get health care. Health care is the kind of thing that should be there, should be there in our lives, should be like a basic tenant of civilization--that we shouldn't have unnecessary pain and suffering by people who have to work their way through a system that is blindingly and damagingly complex. Now, having said that, what's the next step? You accurately pointed to the fact that after of all the sturm and drang about the Patient Protection Affordable Care Act, what we did was we reduced from 50 million to 30 million the number of uninsured people in the country. Most of that gain, by the way, came through the Medicaid program; didn't come through these expensive exchanges that occupy so much of our political capital, in terms of mandatory insurance and subsidies to companies through the silver loading and so forth. It came through the expansion of the Medicaid program. Something needs to be done at the federal level, which however is compatible with the interests of the states. That's what Medicaid is, it's a state/federal program, to expand Medicaid eligibility, so that we don't leave 30 million people, more or less, on the street. That's where we need to begin. The second place is we need to have some sense of cost effectiveness in our system. We have an outfit, a non-profit outfit, called ICER [Institute for Clinical and Economic Review], which is now becoming increasingly influential with regard to pharmaceutical products, but before you know it, they'll be in medical devices and a lot of other things and they should be because we have no interest at the governmental level in having what the Europeans have either its European Medicines Agency or the National Institute for Clinical Effectiveness, the NICE Group in Great Britain. We have no interest in cost effectiveness at least not from the point of view of the manufacturers. We have to have something which is like a Good Housekeeping Seal that says, basically, this is a waste of money. A certain number of people will still say, okay, but I'd like to waste my money. Well, our answer should be, waste your own money. A combination of expanding Medicaid or some kind of safety net program and implementing something that looks like cost effectiveness that labels things as being a complete waste of money and a fraud or something that at least moves you forward. You get your money's worth, you know the great fight promoter, Don King, was famous amongst other things for saying, "You don't always get what you pay for, but you always pay for what you get." So, we need to have a philosophy that combines universal access, but access to what? Access to things that work.

Ralph Nader: Well, what do you think of the Canadian system? They look like us, Fred.

Dr. Fred Hyde: The Canadian system, first of all, I'm not as familiar with it as I am with the US. Secondly, a lot of it is done in the provinces, just like the Medicaid program is done here. Third, they do seem to be way ahead of us in terms of quality scores and cost-effective scores, and so forth. But we don't have to necessarily have anybody else's system, because we don't have anybody else's culture. We have our own culture. It's ours, whether or not it's ideal for a health care system. But I think if we just took what we have now, I think this is far more realistic than adopting another country's culture. If we took what we have now, and said, our mantra is universal access to things that work, and kept that as a guide, if you will, in front of us, we'd be okay.

Ralph Nader: No networks and reasonable price controls?

Dr. Fred Hyde: This is an example from a small thing. The federal government tries to measure quality by having reports from hospitals about important adverse events--something called hospital-acquired conditions, which included hospital-acquired infections. When they started having financial penalties, associated with hospital-acquired infections, you know what happened? A lot of patients suddenly turned out to have POA infections--present on admission. Who knew that you had your urinary catheter infection or your central cell line infection? Well it's just nonsense. What happened was, as soon as you put money incentives or money limitations--wage and price controls on these things--the people who are being paid a lot of money on the other side, figure out a way to game it. So, the POA infection sort of took away from the success, which people were announcing, namely a decline in the hospital-acquired infections. We didn't have any decline in hospital-acquired infections. We had a decline in the net number that were attributed to the hospital, because so many of them were so-called POA or present on admission. Now, that's a small example, and it's subject to a lot of shaving around the edges. I'm not sure, I really like the idea of control so much. I do like the idea of making sure that there is transparency, and that we do not have the agglomeration of market power, which gives disproportionate influence to the larger networks, corporations, investor-owned chains--whatever they are. We don't need to have the markets skewed at the outset. Transparency and some kind of competitive climate, but of course, most of the people who espouse competitive climates are amongst the most anti- competitive of our legislators--some kind of competitive climate that essentially says, that if we can persuade your doctor that this is a good place, then your doctor will persuade you to come here when you need a hospital.

Ralph Nader: Well, you would go for a reasonable price provisions on pharmaceuticals--we have the highest priced pharmaceuticals in the world because we have no price control, like every other country does.

Dr. Fred Hyde: Right now, we do need something like that. And again, in giving the devil his due, this international price index that the administration has put forward as a means of assessing the reasonableness of pharmaceutical products--frankly, the last administration didn't do anything like that. It will be interesting to see if they can press it and get away with it, if you will, but it still is a league ahead of where we've been in the past. Yes, unfortunately, right now Ralph, there's no choice but to have some kind of price limitation because all of the factors that lead to excessively overpriced pharmaceutical products are there. It begins by the way, at the very basics. I remember in business school, we used to have discussions of the cost to producing a new pharmaceutical product. And the most widely cited study was one from the Tufts Center for Pharmaceutical Studies. Well the Tufts Center is supported by the pharmaceutical industry. That's why we think it costs two billion dollars to get a new drug. No, it probably costs a tenth or less than that, if you have people looking at these things that have access to information and can perform the studies that are not skewed.

Ralph Nader: Our economist Jamie Love took that Tufts study apart years ago. It's massively inflated. Just to be clear, Dr. Fred Hyde, you would get rid of managed Medicare and managed Medicaid in terms of your expansion for universal service, right? You'd have to get rid of that kind of gouging and deception.

Dr. Fred Hyde: We haven't talked very much about managed Medicaid. Managed Medicare or so-called Medicare Advantage clearly works to the advantage of the health insurance companies, and your policy is gonna have to be, what do you think about health insurance companies? Do we want to keep all the people employed or not? Managed Medicaid is worth just a 30-second addition here. Whereas Medicare Advantage works by trying to attract the Medicare beneficiary into the program, Managed Medicaid works by telling the state that you're gonna do it for less. And, you're gonna keep secret and opaque all of the contracts that you have that enable you to spend less. So, the Medicaid beneficiary who thinks that he or she or their family is being enrolled in a safety net, is gonna have a few more rips in the safety net than they anticipate.

Ralph Nader: Unfortunately, Dr. Hyde, we're out of time. However, before we leave, tell us about your daily health policy newsletter, DC Medical News, because we hope to have some congressional hearings in the House of Representatives on this whole corporate health insurance mess.

Dr. Fred Hyde: Well, I'm happy to hear from your listeners Ralph, if they wanted to send an email to news@dcmedicalnews.org I'd be happy to put them on a trial subscription list. It's something that, in my own garden, I started with my wife, who is the editor and amanuensis, if you will, and we do it every day that the House or the Senate is in regular session. We try to keep track of these things and we try not to have an opinion. We try to have information, context, and source documents so happy to hear from any of your listeners who would like to give it a try.

Ralph Nader: Very good. Thank you very much Dr. Fred Hyde. Thank you for all your good work over so many years.

Dr. Fred Hyde: My pleasure, Ralph.

Steve Skrovan: We have been speaking with clinical professor and health consultant, Dr. Fred Hyde. We will link to his work at ralphnaderradiohour.com. When we come back, we're gonna work our way through our inbox, and Ralph will answer the questions you have submitted, but first, let's get the latest from our Corporate Crime Reporter, Russell Mokhiber. You're listening to the Ralph Nader Radio Hour. Back in a minute.

Russell Mokhiber: From the National Press Building in Washington DC, this is your Corporate Crime Reporter "Morning Minute" for Friday, December 21, 2018. I'm Russell Mokhiber. More than 28,000 pounds of Jimmy Dean sausage has been recalled over metal tainting fears in meat distributed to 21 states. Five consumer complaints of metal-infused sausage led the USDA's food safety office to trigger the alert after the sausage left a Tennessee-based facility and was distributed across the country. CTI Foods, the product distributor, began the recall of Jimmy Dean Ready to Eat [Heat 'n Serve Original] Sausage Links made from turkey and pork. The USDA assigned the recall a class one, the most serious classification spectrum. Products recalled under that designation are health hazards that pose a reasonable probability that the use of the product will cause serious adverse health consequences or death. For the Corporate Crime Reporter, I'm Russell Mokhiber.

Steve Skrovan: Thank you Russell. Welcome back to the Ralph Nader Radio Hour. My name is Steve Skrovan along with David Feldman and Ralph. Let's open up the mailbox, shall we? David, do the honors.

David Feldman: This first one comes from Sam Mansour. He says, "Hello Ralph, I was inspired by one of your talks where you mentioned in passing putting public school science labs to work for the greater good of the community. Can you please connect me to other teachers or groups that are involved with this--particularly matching current high-school science curriculum with efforts to protect students, their families, and communities?"

Ralph Nader: Yeah, this change can have great results. For example, the students can test local drinking water as part of their physics class or chemistry class. They can test local soil contamination, part of their biology class and publicize it in the community. They can monitor the voting practices of their state legislators or members of Congress and publicize it. Let's me suggest you get in touch with Kim O'Neal who knows all about this. She's a social studies teacher [by] background. She is at the National Board for Professional Teaching Standards. It's nbpts.org. N as in Nancy, B as in baseball, P as in

Pauline, T in Teresa, and S as in Sam dot O-R-G, nbpts.org. The phone number is 703-465-2700, 703-465-2700. Thank you Sam.

Steve Skrovan: I think you just named all my nieces and nephews. This next question comes from Henry Hakamaki and he says, "Dear Ralph, first off, you've always been one of my political heroes, and I want to thank you for all you've done over the course of your career. The question I have is in relation to consolidation of media sources." He says, "90% of the major American media outlets are owned by six corporations and they continue to buy more and more outlets in all media markets." He asked, "Do you think that this hyper-consolidation of the American media is an attack on the freedom of the press? Or is this simply the capitalists running the major corporations, doing what capitalists do in trying to create monopolies?"

Ralph Nader: Well, it certainly is an attack on the freedom of the press, because they own the press. It used to be 50 media outlets when Ben Bagdikian started writing his books on the subject, 30 some years ago and now it's down to six--maybe five have the majority of the TV, radio audience, and magazine newspaper circulation and they're stupefying everything. The news is being degraded. The kind of exposes and reports and testimony that we had in the 1960's, 1970's would never make the national media today. Auto safety would never have gotten attention. So, it's even worse than you think Henry, because they have taken away the public airways from us, by and large. Just look at afternoon network TV programs. Look at Saturday afternoon network TV. You know, it's comedies, it's infomercials, it's sports—it's like nothing else is going on in America that needs attention, that needs activity, that needs recognition, that needs hope, that needs solutions. So, keep raising objections on this. More and more concentration of media in fewer and fewer conglomerate, corporate hands is shredding the First Amendment--the one that is used by the people in this country.

David Feldman: This next question comes from Aaron Omlie. I hope I'm pronouncing that right. He says, "Ralph, I continue to hear about California passing laws that potentially violate international trade agreements. Will the laws stand or will the WTO, their secret tribunals prevent them from going into effect without a heavy fee--for example, laws banning animal-tested cosmetics or farm-animal welfare regulations--Proposition 12?

Ralph Nader: It all depends with the companies who are banned from certain marketing activities in California take the State of California via the national government, to these secret tribunals under the World Trade Organization in Geneva, Switzerland. Thus far, the California Labelling Law on food, which is one of the strongest in the world, has not been challenged in Geneva, Switzerland and the country of origin label requirement has been challenged. That was a national law, so you go to supermarket, and you know where your meat products come from--whether they come from the US or Brazil or Canada, or Mexico. That was overturned by the World Trade Organization in Geneva and the Congress repealed the law. Like who's in charge here? It is our federal government or some bureaucrats whose names we

don't know, posing as judges in closed-door tribunals in Geneva, Switzerland? The Democrats were the ones who pushed that through and Trump made them pay the penalty in 2016.

Steve Skrovan: Our next question comes from listener Rory Mellinger. He says, "Single Payer Action.org is offering personally signed books--To the Ramparts and the How the Rats Re-Formed the Congress for a $100 donation. Does Ralph support the promotion, and does he personally sign the books?"

Ralph Nader: Yes, I do. I helped start Single Payer Action.org. If you go, you'll see what the situation is around the country in health insurance rackets, as well as efforts to support single payer. And I do sign it. In fact, today, I just signed 125 books. I have a tired wrist to prove it.

Steve Skrovan: Yeah. I'm not gonna make the joke that I was gonna make on that. Well, thank you for your questions listeners. Keep them coming on the Ralph Nader Radio Hour website. I want to thank our guest again today, Dr. Fred Hyde. For those of you listening on the radio, that's our show. For you podcast listeners, stay tuned for some bonus material we call "The Wrap Up". A transcript of this show will appear on the Ralph Nader Radio Hour website soon after the episode is posted.

Steve Skrovan: For Ralph Nader's weekly column, it's free, go to nader.org. For more from Russell Mokhiber, go to corporatecrimereporter.com.

Steve Skrovan: We talk about them all the time, but Ralph has got two new books out. The fable of How the Rats Re-Formed the Congress. To acquire a copy of that, go to ratsreformcongress.org and To the Ramparts: How Bush and Obama Paved the Way for the Trump Presidency and Why It Isn't Too Late to Reverse Course. We will link to that also. The producers of the Ralph Nader Radio Hour are Jimmy Lee Wirt and Matthew Marran. Our executive producer is Alan Minsky. Our theme music, "Stand up, Rise up" was written and performed by Kemp Harris. Our proof reader is Elisabeth Solomon.

David Feldman: Join us next week on the Ralph Nader Radio Hour when we speak to Ronald Fraser, author of the book, America, Democracy and You: Where Have All the Citizens Gone? Merry Christmas Ralph.

Ralph Nader: Merry Christmas, [Happy Holidays and] Happy New Year to everybody. I just got on Fox News on the book, How the Rats Re-Formed the Congress. Left, right coalition perhaps?