BRIAN DOLAN AND STEVEN BEITLER

Legislating Medicare Fraud: The Politics of Self-Regulation and the Creation of Professional Standards Review Organizations

Abstract: Not long after the 1966 enactment of Medicare and Medicaid, evidence emerged that unscrupulous physicians and health care organizations were gaming the system. Research over the past 50 years shows that around 10 percent of the federal government's annual cost for these programs is attributed to fraudulent claims or abuses where hospitals and treatments have been overused for undue provider profit. This article examines early congressional attention to this problem and describes lawmakers' attempts to find legislative solutions to it. It historicizes the dilemma of balancing the ideological limits of government regulation with cultural assumptions about professional self-regulation, focusing on a major 1972 law, the Professional Standards Review Organization (PSRO) Act. The law launched a 10-year career for PSROs, physician-staffed peer-review boards designed to identify and sanction efforts to overcharge Medicare. The article contextualizes multiple actors' concerns over cost containment and the crisis of faith in medical authority that persisted following failures to control professional malfeasance.

Keywords: Medicare fraud, PSRO, self-regulation, professionalization, health politics

In 1967, The Associated Physicians of Cook County Hospital incorporated as a nonprofit organization in Illinois. A number of the hospital's full-time staff physicians joined the new organization as volunteers and started treating

JOURNAL OF POLICY HISTORY, Vol. 34, No. 4, 2022.

doi:10.1017/S0898030622000173

Medicare patients. With the equivalent of a mouse click, the Cook County Hospital database reclassified 105 physicians from staff doctors to administrators, but the database did not change their hospital salaries of $20–30,000 per year ($140,000–210,000 in 2021 dollars). As volunteers with Associated Physicians, these doctors were free to bill the government for treating Medicare patients; their work for a nonprofit enabled them to evade rules that barred salaried physicians from claiming Medicare payments. Soon after incorporating, Associated Physicians back-billed Medicare for $1.5 million for addressing some 17,000 cases.

When the fiscal intermediary for Medicare, Blue Cross-Blue Shield, requested supporting documents, a hospital administrator prepared a carefully worded letter that all the doctors signed. The letter mentioned hospital bylaws that stated, "All attending physicians will care for patients without compensation from Cook County." That was sufficient for Blue Cross-Blue Shield, and by the end of 1968 the hospital had received just over $3 million ($21 million in 2021 dollars) for hospitalized Medicare patients. Two physicians who had observed this ploy spoke with a journalist for the *Chicago American*, a forerunner to the *Chicago Tribune*, informing the paper's reporter that the hospital's bylaws contained no such provision.

The Associated Physicians story has been far from an isolated case. Data gathered over the last 50 years suggest that around 10 percent of annual Medicare and Medicaid costs is attributable to fraudulent claims or abuses of misuse and overuse. This article examines how Congress and federal agencies came to understand and address this problem in the decade after Medicare became law in 1966. In those years, irregular billing practices and services were identified and gave rise to investigations and further legislation. This effort culminated in 1972, when the Nixon administration mounted a "silent revolution" against the medical profession.[1] This paper documents the creation and launch of PSROs in the early 1970s. Their purpose was to provide physician-led review and assessment of allegations of fraud and abuse in billings for physicians' services under Medicare Part B, which covered physician reimbursement. The PSRO story brings together contests over professional and governmental regulation that raised issues about the boundaries of authority in medical practice. This article focuses on how early congressional responses, in part fueled by voters' concerns over rapidly rising medical costs, enacted these debates.

Although the goals for PSROs may sound tame today, contemporary medical groups considered these review organizations an unprecedented intrusion on their ability to practice medicine. Dr. Jay Winsten, a research fellow at Harvard Medical School (later director of the school's Office of Health Policy Information), wrote in a 1973 *Wall Street Journal* article that

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

"There's no doubt on the part of friends or foes alike that it is the most radical health legislation in this country's history…. Doctors for the first time will be held publicly accountable for the quality, medical necessity, efficiency and cost-effectiveness of the health care they provide."[2] Speakers at the annual conference of the American Medical Association (AMA) that year condemned the law as unconstitutional and threatened to sue or strike. Even those supportive of the law were humbled by its scope. Dr. Harris Cohen, a political scientist in the Department of Health, Education, and Welfare (HEW), the agency that oversaw Medicare, wrote in 1975 that it was "one of the most far-reaching forays into regulation to be legislated by Congress."[3]

The provisions of this law, coupled with the alarm raised, stood out against the historic background of successful resistance to government interference by organized medicine. Much has been written about the opposition to nationalized health insurance by professional bodies such as the AMA as part of its defense of professional autonomy in the medical marketplace. Indeed, organized medicine had for decades indefatigably created the perception that medical work was so complex and technically demanding that no layperson or bureaucrat could know how to judge it. In his pioneering 1970 book *Profession of Medicine*, medical sociologist Eliot Freidson argued that the *sine qua non* of professionalism was autonomy. "In one way or another," wrote Freidson, "through a process of political negotiation and persuasion, society is led to believe that it is desirable to grant an occupation the professional status of self-regulative autonomy."[4] In 1954, the AMA had come close to saying that the state itself delegated its authority to organized medicine, reinforcing a *laissez-faire* approach to medical practice. "Much state legislation originates with the state [medical] societies," noted the authors of an AMA report published in the *Yale Law Journal*. "Bills are often drafted with the aid of counsel, and such measures are easily introduced."[5] This powerful cultural profile made the medical profession seem unassailable, even as the federal government was taking steps toward national health insurance.

In 1982, 10 years after the passage of the PSRO legislation, sociologist Paul Starr published his now-classic opus, *The Social Transformation of American Medicine*.[6] He observed that the spirit of social and political activism of the 1960s had given rise to a "crisis of legitimacy" for the medical profession that helped to explain the flurry of reforms, including PSROs, in the 1970s. "For the first time in a century," Starr wrote, "American physicians faced a serious challenge simultaneously to their political influence, their economic power, and their cultural authority."[7] But the introduction of regulatory laws was more than an automatic or ideological consequence of enabling access to

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

national health care against the forces of a medical monopoly. A major concern in Congress, as expressed in a growing public outcry, was skyrocketing health care costs. As Starr wrote, "the key was the structure of financing."[8] Since Congress had designed the structure of Medicare financing, they, in part, had themselves to blame for creating the problem.

But although costs were an impetus for Congress to act, the activities that led to the 1972 law were a response to problematic patterns of practice created by organized medicine itself. Congress was not to blame for mounting evidence that health care providers were financially abusing the health care system, defrauding the government, and potentially putting patients' lives in jeopardy. This article argues that the profession's alleged lack of moral probity was more damaging to its self-regulatory privileges than its perceived dominance over health care. In addition, we contend that clamping down on physician fraud and abuse was the "key" that unlocked the potential for broader administrative reforms in Medicare.[9]

The history of Medicare and Medicaid has received considerable attention as an element of American struggles to legislate national health insurance. Historians of medicine, including Rosemary Stevens, Ron Numbers, and Jacob Hacker, have examined Medicare's early years in the context of historiographical conceptions of the ideologies of the welfare state.[10] Publications by political historians and policy analysts such as Richard Harris's *A Sacred Trust* (1966), Theodore Marmor's *The Politics of Medicare* (1970), Daniel M. Fox's *Health Policies, Health Politics* (1986), Jonathan Oberlander's *The Political Life of Medicare* (2003), and recent reflections in the volume edited by David C. Colby, Keith Wailoo, and Julian Zelizer, *Medicare and Medicaid at 50*, examine the contentious political and ideological struggles to formulate and enact nationalized health plans.[11] From within a dense history of legislative efforts, in which Medicare and Medicaid loom large, broader narratives emerge to show how the medical profession participated in the debates and adjusted to government programs. One theme that has been largely overlooked among historians is the problem of enduring fraud and abuse against Medicare.[12]

In *License to Steal* (1996), Malcolm Sparrow, professor in the Kennedy School of Government at Harvard, demonstrated that Medicare fraud and abuse have persisted despite considerable efforts within both organized medicine (through codes of ethics and peer-review committees) and government (through regulations and laws). Sparrow's book, although primarily focused on interviews conducted in the 1990s, comes closest to a "grand narrative" of medical fraud and the history of the "failure of controls" to detect and prevent it.[13]

This article draws on congressional hearings at which testimony about alleged malfeasance was given and locates the problem within legislative weaknesses that plagued the programs. These weaknesses were due not only to effective lobbying but also to the influence of prevailing theories of government's regulatory authority and the perceived virtues of professional self-regulation. The article concludes by examining legislation that was at the time the most aggressive attempt ever made to clamp down on inappropriate conduct. We conclude with observations on why this early effort to regulate the medical profession fell short of its goals as well as the ramifications of that failure for subsequent efforts.

MEDICAL AUTONOMY AND THE STRUCTURE OF MEDICARE

Throughout the 1950s and 1960s, organized medicine—structured through the AMA, the American Hospital Association (AHA), and the American Colleges of Physicians and Surgeons—was strengthening standards of medical practice and discipline. Moving beyond the proliferation of licensing boards, a reconfigured Joint Commission on Accreditation of Hospitals (JCAH) in 1951 established rigorous reviews of staff training and patient treatments in support of improved quality control. Such self-directed surveillance enabled organized medicine to lay further claim to professional autonomy, "implying an immunity from the political process," as the profession sought to conduct its business without external interference.[14] In 1974, Robert Reiff, a professor at Albert Einstein College of Medicine, reflected on the idea that the basis of professional power was not knowledge itself, but the control of knowledge. "Not only are the helping professions given the authority to define the terms of their practice," he wrote, "but collectively they claim a legal, moral, and intellectual mandate to determine for the individual and society at large what is healthy, moral, ethical, deviant, normal, and abnormal."[15] Historically, such autonomy has been fiercely protected by organizations that have asserted the wisdom of, and their rights to, self-regulation by practitioners.

According to Freidson, "Medicine in the contemporary United States provides us with a fairly good example of a profession with considerable socioeconomic as well as technical autonomy." Examining the role that the AMA had played in this process, he added that it "has been delegated many of the powers that the state elsewhere has reserved for itself, and its practitioners have otherwise been quite free of lay interference."[16] So important was professional autonomy that when momentum for the passage of Medicare was growing in the early1960s, organized medicine stepped up its campaign to

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

oppose nationalized (also called "socialized") health care out of concern that the federal government would strip away its autonomy and dictate how medicine would be practiced and paid for.[17]

It has been well documented that Medicare emerged despite hostility not only from conservative politicians (both Republicans as well as right-of-center Democrats, mainly from southern states) but also from major health organizations—namely, the AMA and the American Hospital Association.[18] The AMA launched a propaganda war in which it warned of the dangers to patients of allowing politicians to control medical decisions.[19] This effort drew on the social and political strengths of concepts of professional autonomy and self-regulation; those strengths were on display when organized medicine was negotiating with Congress about the terms of government-structured health care administration. On congressional efforts to introduce national health insurance going back to the 1930s, the AMA had been clear and unwavering: "Organized medicine opposed anything which might divest it of any part of its control over medical services."[20]

In drafting and debating amendments to the Social Security Act (where Medicare laws were embedded) and in an effort to prevent their derailment through nonparticipation or physician strikes, lawmakers spelled out the limits of the government's powers to interfere with the business of providing health care. One of the first paragraphs of the Medicare Act (1965), Section 1801, is titled "Prohibition Against Any Federal Interference," and states that

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.[21]

According to Wilbur Cohen, one of the main architects of the Medicare program, Section 1801 was included "to offset the criticism made by opponents of the proposal that Federal legislation would give Federal officials the opportunity and the right to interfere in the diagnosis and treatment of individuals."[22] Many policy analysts and historians who have examined the structural problems that subsequently plagued Medicare have analyzed the

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

effects of the government's voluntary self-limitation of regulatory power in facilitating the AMA's work to protect its members' professional autonomy. Besides the worry that a bureaucrat would determine a diagnosis, there was concern within the AMA regarding how Medicare payments were to be made. In Eliot Freidson's words, "The issue has essentially been that of control over the *terms* of physician participation in such plans—the social organization of practice, and the type and level of physician compensation for such practice. To meet AMA approval the terms of practice in such plans have in the past had to be set by a committee representing all the doctors in the community."[23]

In Section 1801, the government made assurances that it would not interfere with "medical practice" or the "manner in which medical services are provided." A critical element of these assurances was maintenance of fee-for-service billing. But the additional language that prohibits *supervision* of any compensation to anyone or any institution rendered the administration of Medicare vulnerable to exploitation and fraud from its first days. Particular areas of compensation and accounting for reimbursement claims by physicians, hospitals, and other health care facilities received almost no oversight because of this government promise not to meddle in medical practice.

The matter was politically sensitive for all participants, not just legislators. The American Hospital Association had specifically registered its concern that a government-run insurance program would lead to bureaucratic obstacles and payment delays. The AHA pointed out that it already had a close alliance with the private health insurance industry, in particular with Blue Cross and (under separate terms) with Blue Shield.[24] However, in a surprise move, in 1962 the AHA passed a resolution in which it broke with the AMA and declared its support for a government insurance program on the condition that the program would be administered by Blue Cross. Although the leadership of the AHA and Blue Cross found themselves navigating a precarious path to consensus among their boards of directors, this collaboration was seen as crucial in gaining important support for Medicare on the House Ways and Means Committee.[25] Between 1962 and 1964 congressional hearings probed the mechanics of using insurance companies, referred to as "fiscal intermediaries," to administer Medicare payments to hospitals (under Part A of the 1965 act). In 1965, Walter McNerney, president of the Blue Cross Association, testified before Congress that delegating fiscal oversight to them "would create less of a confrontation."[26] It appears that few within Congress questioned the wisdom of this plan or worried about potential conflicts of interest.

It is an understatement to say that the AHAs had a close alliance with Blue Cross. In fact, Blue Cross was perfectly positioned to provide an administrative structure for financing health care provision by hospitals. Blue Cross had been created through the efforts of the AHA, which wanted a guarantor for hospitalization fees among a population that was unable to save money for medical costs. Until 1972, when Blue Cross became a nonprofit corporation of its own, the AHA had owned the name and insignia, an indication of its efforts to promote the monopolistic development of a private, national, health care insurer. Sylvia Law, a New York University health law expert, had characterized Blue Cross as the "financing arm" of hospitals, designed to provide stable income to hospitals through subscription costs and federal funds.[27] Within five years of the enactment of Medicare, the amount of money administered by Blue Cross as a fiscal intermediary to the federal government, as well as in its role as private insurer, was sizable. In 1970, Blue Cross provided roughly half of all hospital revenues—more than $11 billion. Public funds comprised more than half of these payments to hospitals—$4.9 billion under Medicare, $1.2 billion under Medicaid, and $545 million under other federally financed programs.[28]

All told, a payment system without disinterested checks and balances reflected what political scientist Jonathan Oberlander called "the politics of consensus" in the creation of Medicare.[29] Relegating itself to the position of a bank distributing funds that it doesn't closely monitor, the federal government established a "nationalized" program that relied on the self-regulation of the medical profession.

THE POLITICS OF SELF-REGULATION

"Self-regulation" refers to a nonspecific set of peer-review protocols that are meant to ensure standards of practice within the medical profession. Sometimes synonymous with "self-policing" or quality control, self-regulation in medicine has historically been implemented through codes of professional ethics and conduct and has emphasized the priority of patients. In 1986, the AMA noted that, "Physicians and their professional organizations have established a variety of mechanisms to protect the quality of the care of patients. The quality standards of U.S. medical education, residency training, and hospital care derive from physicians and from organizations that physicians helped establish and maintain today."[30] Despite a history that went back to the early nineteenth century, it was unclear just how effective self-regulation could be to safeguard patient welfare.[31]

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

Throughout the history of medicine in the United States, each state's government has had a pivotal role in establishing and enforcing laws of medical practice. Although the specifics vary from state to state and have evolved over the past two centuries, a state's legislature has generally set the parameters for granting licenses and has written statutes determining the course of action to be taken by medical boards when disciplining its members.[32] Medical examination boards were often appointed by, and were accountable to, a state's governor, and their actions have been subject to review by the state's judiciary. In practice, however, state officials were known to keep their distance from the boards' activities. In the 1950s and 1960s, state medical boards operated as quasi-judicial, independent agencies within state government. "In general," wrote researchers at UCLA and George Washington University, "there is no supervision of the operations of these boards except for the power of the courts to review some of their actions upon complaint of an aggrieved candidate or licensee."[33]

Although states retained the power to impose regulations and enforce laws, state licensing boards historically worked closely with legislators to compose or amend laws that affected medical practice. As a 1971 report commissioned by the federal Department of Health, Education, and Welfare put it, "The State licensing boards may work more or less discretely to present the profession's position regarding legislative proposals. In some States, professional associations work in conjunction with examining boards to initiate legislation, make additions or deletions, draft the preliminary and final proposed bills, persuade the legislator to introduce the bills, and then work for their passage."[34] Far from being boxed in by legal dictates, the medical profession has had a remarkably free hand to police itself. "In fact," wrote medical ethicists Marshall Kapp and Bernard Lo, "the medical profession has aggressively co-opted the legal system over the years and used the law's authority to serve its own ends. Illustrations of this interaction include the medical profession's traditional power to determine for itself the standards of care to be applied in a malpractice action, the standards of information disclosure that constitute informed consent, and licensure/discipline standards for determining who is allowed to be part of the medical profession."[35] When it came to ensuring standards of care and overseeing proper medical practice, these boards were afforded considerable power.

For state medical boards that were small (an average of eight people) and almost entirely composed of physicians from a local community, taking on "multiple roles of investigators, prosecutors, juries, judges, and executioners" was burdensome.[36] One pragmatic question for professional societies and

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

medical boards was where to focus their attention. "We must remember," wrote Robert Derbyshire MD, a leader in the Federation of State Medical Boards in the 1960s, "that the boards of medical examiners are legally constituted bodies of the state governments and as such they confine their activities to investigations of violations of the laws. Minor infractions of medical ethics or disputes between patients and doctors about fees do not concern the boards and are best referred to the local county societies or the hospital staffs."[37]

Although "infractions of medical ethics" may not have been as distinct from criminal behavior as Derbyshire implies, with the passage of Medicare in 1965, disputes over fees added a new dimension to self-regulation.[38] As University of Pittsburgh physician and lawyer Sidney Shindell wrote in *JAMA* in 1965, "It has become increasingly apparent that more and more aspects of the law are impinging on medical practice. Not only do we have the problems of professional liability and malpractice to be concerned with, but as there is a growing tendency for third parties to be paying for physicians' services, there must be greater concerns for the kinds of disputes which may arise between the insurance carrier on one hand and the doctor and his patient on the other."[39] However prescient was the admonition to express "greater concerns" over such potential conflicts, the full scope of the emerging problems (and struggles for federal and state agencies to address them) was still to be revealed.

As indicated earlier, state medical boards were, throughout the first half of the twentieth century, responsible for investigating and disciplining practitioners alleged to have violated professional standards. Throughout this time, little attention was paid to the actual performance of medical boards in administering discipline; indeed, their powers remained "virtually unchecked."[40] Statistics on the frequency and types of sanctions or license revocations were not gathered on any credible scale. In 1958, however, the AMA's Board of Trustees established a Medical Disciplinary Committee to collect information from state boards and medical societies in order to assemble a composite portrait. After attempting to collect data for two and a half years, the Committee published its report in 1961. Its report "recounted the failure of the Committee to stimulate either interest or cooperation from state boards" and suggested that there was a pervasive lack of disciplinary action pursued.[41] This alarming conclusion substantiated public perceptions that the profession protected physician incompetence by failing to pursue disciplinary measures. The AMA report also reinforced a sentiment expressed a year earlier by the long-time Secretary-Treasurer of the Federation of State Medical Boards Walter Bierring that self-regulation as a disciplinary framework was flawed. "If a state cannot, or does not, for just cause, revoke a license

or discipline a physician," he wrote, "a fatal weakness exists."[42] It was a conclusion similar to that reached by Robert Derbyshire in 1969 when, while president of the Federation, he declared, "As a result of many years of observing medical licensing and discipline in America," he wrote, "I have concluded that there is no system."[43]

Although the AMA's Medical Disciplinary Committee report of 1961 did make recommendations for maintaining the integrity of the profession after licensure through initiatives such as continuing medical education, events that came to the public's attention in the years immediately after the passage of Medicare reignited the concern over medical regulation.

FRAUD AND THE LIMITS OF SELF-REGULATION

The saga of 105 physicians at Cook County Hospital in 1967 (see introduction) was an early, but hardly isolated, example of efforts to exploit the new Medicare system. With other reports of questionable conduct and inflated health care costs becoming regular headline news in the years following the passage of Medicare, Congress launched investigations. In 1968, Senate Finance Committee staffers had spent a year investigating physicians' reimbursements and discovered numerous disturbing practices. In 1969, the Committee (which oversaw the budget for Medicare) held hearings that focused on "the methods to improve the programs and to eliminate any possibility of or opportunity for fraud and abuse."[44]

Senator Russell B. Long, a Louisiana Democrat and Committee chair, began a Senate hearing with additional examples. He spoke of a physician who had 49 Medicare patients and billed Medicare $58,000 for house calls. That would have meant that, at prevailing rates, each patient received a personal visit two or three times a week, every week of the year. "Who says you can't get a doctor to make a house call anymore!" Senator Long quipped.[45] Another physician visited 54 nursing home patients who, as a group, received 4,560 visits from that doctor in one year. This doctor also claimed to have provided 8,275 injections—about 60 per patient per year—for which he received $42,000.

For two days, the Senate discussed example after example of physicians or organizations that appeared to be involved in fraudulent or abusive behavior. Among those in the hot seats were two officials charged with administering Medicare: Robert M. Ball, commissioner of Social Security, and John G. Veneman, undersecretary in the Department of Health, Education, and Welfare. But this was not a criminal investigation. However egregious some of

the acts appeared, the ultimate question for the Senate Finance Committee was how to prevent overall Medicare and Medicaid costs from rising uncontrollably.

Whether the problems were caused by intentional deceit or honest mistakes, it was quickly apparent to the committee that oversight was lax and controls were few in the flow of federal health care money. Senator Al Gore, Sr., a Democrat from Tennessee, reminded those who testified that medical groups such as the AMA had staunchly opposed Medicare until various concessions were made. These concessions might have been a mistake, he added. Referencing the fiscal intermediaries, he said, "It seems to me the carriers are seriously at fault in this program and we may have erred, in the enactment of this program, in providing for an almost unbridled discretion in the carriers." When Commissioner Ball and Secretary Veneman cautioned the Senator against making blanket assertions about the conduct of intermediaries like Blue Cross, Gore pressed the point about the lack of audits. "Mr. Ball and Mr. Secretary, the picture that is unraveling here is that the carriers are, in a pro forma way, a routine way, paying every bill that comes in without investigation as to whether it is for medical necessity, for how many calls, or how many times a call is being made on a given patient. Now, something is seriously wrong, either with the administration or the law."[46] In response, Ball admitted, "When the program started out, we let the carriers do it pretty much the way they would run their own business." "I cannot imagine," Gore replied, "they would run their own businesses this way."[47]

Given these concerns, supervision of payments for Medicare services was likely to increase precisely where organized medicine did not want it to: in federal agencies that were being publicly pressed about where taxpayer money was going and why health care costs did not appear to match medical treatments. The Social Security Administration had been tasked with becoming directly involved in cases of suspected fraud, and during the Senate hearings Commissioner Ball reported that 1,200 cases had been identified and investigated, although "most of them were found to be innocent mistakes in bookkeeping or one thing or another." A mere 14 cases were forwarded to and were pending investigation with the Justice Department. Asked whether anyone had been convicted of fraud, Ball replied, "I believe that in the only Medicare case disposed of by a court so far, they entered a plea of no contest."[48]

In his preliminary statement to the Senate committee, Undersecretary Veneman pointed to structural weaknesses that he believed Congress should address in order to bolster the security of the Medicare system. One

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

observation was that professional self-regulation was inadequate. "I think we need some new machinery in addition to self-control by the providers," he said. "I find that too often, 'peer review' becomes 'peer justification' and I think that the public and the patients deserve better than that."[49] As a consequence, one clear necessity was more staffing in the Department of HEW to investigate claims. That responsibility entailed overseeing 7,000 hospitals, 200,000 physicians, 7,300 extended care and home health agencies, and 2,600 private laboratories. It also meant checking on some 130 fiscal intermediaries, mainly regional offices of Blue Cross and Blue Shield, who processed the claims of up to 9 million people a year.[50] In 1967, when the Medical Services Administration (a subagency of HEW) was established, 100 government workers were assigned the job.[51]

When President Nixon was inaugurated in January 1969, he appointed Robert H. Finch, a former lieutenant governor of California, as secretary of HEW. Just days after the Senate Finance Committee hearings in July (discussed above), Finch, alongside Undersecretary Veneman and Assistant Secretary Roger Egeberg, attended a White House press conference to answer questions about their report, "On the Health of the Nation's Health Care System."[52] When asked to clarify a statement in the report that called upon the medical profession to discipline those who are involved in abuses against Medicare, Secretary Finch replied, "Well, the most effective discipline of all is the discipline of your peer group. States can de-certify a physician who abuses —a very small percentage of them who have been involved in abuses—but to be condemned by your own medical society, I think, is the worst kind of discipline you can inflict."[53] Here Secretary Finch appeared to support the existing model of self-regulation to discourage malfeasance, and a reporter asked a paradoxical follow-up question about who would enforce what he called "self-discipline." "Is the AMA going to supervise this or are the county medical societies going to be left on their own?" Dr. Egeberg (former dean of the USC medical school, a registered Democrat, and a member of the AMA), replied, "The county societies."[54]

In addition to task forces set up by HEW, the Medicare law had established the Health Insurance Benefits Advisory Council (HIBAC), composed of people drawn from across the health care industry. The Council was charged with advising HEW on policy for Medicare's administration, and, following amendments to the law in 1967, HIBAC replaced the National Medical Review Committee. Its mission was to study the utilization of hospital and medical services "with a view to recommending improvements in the way such care and services are utilized."[55]

One area of immediate concern was whether hospital standards for ensuring quality medical care were adequate. These standards were voluntarily established by the Joint Commission on Accreditation of Hospitals (JCAH), a nongovernment agency. The JCAH had already come under criticism from the medical profession for "controls … not being uniformly applied."[56] This was a concern for HIBAC because hospital accreditation—entirely overseen by the Joint Commission—was a requirement for a hospital to qualify for Medicare and Medicaid reimbursements. Indeed, the secretary of HEW was prohibited by law from setting standards higher than the Joint Commission's for becoming a certified vendor for federal funds. The HIBAC questioned this logic, commenting that "it is inappropriate to continue statutory delegation to a private agency of all the Government's authority to safeguard quality of care paid for by a government program…. [T]he council has found reason for concern that JCAH standards are not applied with the frequency of inspection and range of inspector skills necessary to assure a high degree of effectiveness."[57]

In its first annual report to HEW in 1969, the HIBAC offered recommendations to improve Medicare, such as adding coverage for mental health services. But the very first recommendation of the report was that Medicare should be allowed to discontinue reimbursement of a physician or supplier "when one or more of the following is found: evidence of fraud; repeated overcharging of the program or its beneficiaries; a pattern of rendered services substantially in excess of those justified by sound medical practice; persistent failure to cooperate with the program in clarifying cases which may involve excessive charges or services; or documented rendering of services or supplies which were harmful to beneficiaries or found to be grossly inferior by peer review."[58] Whatever other opportunities to improve Medicare may have existed, eliminating fraud and abuse was paramount.

The fact that the Council was recommending legislative changes that would empower HEW to stop reimbursement of abusers was the first step toward increasing the involvement of a federal agency in the peer-review process. Because the outcomes of peer review would be (in part) acted upon by HEW, the proposal implied that HEW would have a greater interest in documentation that was collected that offered any "evidence of fraud." To be sure, when HEW subsequently drafted the amendment to the law, "they proposed establishing 'program review teams' to review individual cases and overall utilization data." A staff memorandum said that the new teams were charged with weeding out "bad actors" and were "not intended to supplant

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

existing peer review structures, but rather to complement and enhance present arrangements."[59]

It appeared that HEW was creating a space for itself at the table of peer review, a table that to this point had welcomed only physicians. To astute observers, these amendments foretold increased government scrutiny of medicine's self-regulation. To stay ahead of the curve, the AMA assembled its own task force to draw up plans for more robust peer-review protocols. The hope was that its preemptive efforts would influence the outcome and keep things under physician control.

The main thrust of the AMA proposal was to have state medical societies convene "Peer Review Organizations" to consider allegations of fraud and abuse of Medicare Part B (physician reimbursement) and to recommend disciplinary actions to the secretary of HEW.[60] The proposed organizations were to consist of "Local Review Panels," each with three physician members who would be a committee to which others could submit grievances. This proposal was approved at the AMA convention in 1969, though observers were skeptical of how fully it would be adopted. Reporters from *Medical World News* wrote that "while adopting this rhetoric, the delegates showed only a limited willingness to endorse specific 'get tough' policies in professional policing."[61]

In May 1970, the AMA sent its proposal to Senator Wallace Bennett, ranking Republican on the Senate Finance Committee, which was responsible for drafting amendments to the laws governing Medicare and Medicaid. President Nixon was a Republican, but the Democrats were the majority of both the Senate and House. Wallace was the only person in a position of influence most likely to support the AMA's drive for less government intervention in its professional affairs. He had a good history with the AMA. As a Senate candidate in 1952, the Utah Republican was elected with the help of the AMA, which appreciated his strong opposition to national health insurance.[62]

Upon reviewing the proposal and sharing it with Finance Committee staff, Bennett was informed that it was "definitely a step in the right direction" but that it was "unduly limited" in "making the present system workable and acceptable."[63] With an eye toward creating a "review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions," and to the dismay of the AMA, Bennett offered his own proposal to establish a "Professional Standards Review Organization" (PSRO).[64]

Bennett's proposed amendments to the law that would establish PSROs extended professional review to "include in the review groups' mandate, responsibility for reviewing the totality of care provided patients—including all institutional care."[65] In other words, the proposal affected anything that was reimbursable under Part A of Medicare (pertaining largely to hospitalization), where costs were notably skyrocketing. Bennett's proposal kept review organizations lodged in local communities, but it differed from the AMA by suggesting that groups other than state medical societies would be members of reviewing organizations; by implication, this invited participation by larger health maintenance organizations (HMOs) such as Kaiser Permanente. Significantly, Bennett's proposal suggested that if local medical societies were unable or unwilling to create a local PSRO, the secretary of HEW would work with state or local health departments to establish one.

Two other areas of Bennett's proposal departed from the status quo. First, he wanted to create a national advisory council that would assemble and compare data to derive and apply "norms of care and treatment [to] be used as checkpoints in evaluating the appropriateness of treatment," thereby establishing practice "standards" (as in the proposed organization's title). Second, Bennett suggested harsher penalties for improper conduct, ranging from monetary fines to civil or criminal prosecution.[66] This was a major change in the way "discipline" could be imposed on medical practice, as it made the criminal justice system a prospective venue for adjudicating professional malfeasance. In historic terms, Bennett's proposal weakened the foundations of medicine's professional autonomy.

After almost two years of legislative tinkering, in 1972 Bennett's amendment establishing PSROs was signed into law, stipulating that they must be established locally by January1976. (Designated PSRO regions were to be determined by January 1974.)[67] If no PSRO had been formed in a designated region by early 1976, the secretary of HEW had the authority to create one and determine its membership.

Representatives of the AMA were unhappy with this outcome. In a 1974 commentary in *JAMA*, Martin Dale, executive secretary of the Kern County Medical Society in Bakersfield, California, and author of a "primer" on PSROs, suggested that Senator Bennett had succumbed to political pressure to pass the bill quickly. The bill had passed "because he was a member of the Senate committee charged with reaching a compromise with the House of Representatives on PSRO, because Mr. Nixon needed the support of his party's ranking [minority] member on the Senate Finance Committee, and because

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

there was general support for attempts to control the cost of Medicare and Medicaid." PSROs were now law.[68]

ASSESSING SELF-REGULATION

"History will be made in June 1974, when the House of Delegates of the American Medical Association must decide whether to support the concept of PSRO … or to adopt a position of non-cooperation."[69] Thus began an article on PSROs by Claude Welch, a renowned surgeon and instructor at Harvard Medical School, president of the Massachusetts Medical Society, and delegate to the AMA. In 1973 he was appointed chair of an AMA Task Force on Guidelines of Care, a subunit of the AMA Advisory Committee on PSROs. The AMA knew its members were confused and conflicted about whether to embrace PSROs and try to manage proactively their accountability to HEW or to disavow the federal mandate by rejecting the terms of engagement with Medicare and Medicaid patients and, potentially, go out on strike. To many physicians, the decision seemed disproportionate to the ostensible cause for creating the new review system: the presence of a few "bad actors" in an otherwise honorable system.[70]

A brief overview of the structure and administration of PSROs will help clarify some of the early criticisms and confusion about their effectiveness. In March 1974, HEW produced the first *PSRO Manual*, providing guidelines for hospitals and physician groups for establishing PSROs.[71] The PSRO system was envisioned as a coordinated collaboration among hospitals' utilization review committees and community-based organizations that already practiced peer review. Membership of PSROs was limited to physicians, but nonphysician members of the community could participate in hearings.

At that time, HEW identified 195 geographic areas where PSROs would be established, with each responsible for reviewing services provided by area hospitals that received Medicare and Medicaid reimbursements. The intent of collecting data nationwide was to reduce variation in hospital utilization and to encourage standardizing on more efficient practices.[72] The PSROs required the participation of practitioners who were qualified to review the care provided by their colleagues in different medical specialties. There was broad latitude in how a local governing body, such as a medical society, could delegate review responsibility to medical staff and hospitals. Thus, the minutiae of membership, organization, and performance of PSROs across the country varied significantly by the particular requirements of expertise in any given practice review.[73]

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

One can argue that doctors' real concern had less to do with professional misconduct and more with the prospect of much wider scrutiny on why overall health care costs were rising so fast. The rhetoric of "fraud and abuse" helped create a politically useful target. Neither political party could afford to ignore an issue that could address voters' concerns and could become a key to far wider regulation of medical practice.

So, for the AMA, PSROs posed a threat to the professional autonomy they had long cultivated. According to Claude Welch, writing in the *New England Journal of Medicine* just days before the crucial AMA decision, the first question was, "Who's in charge?" Welch suggested that if the AMA cooperated, doctors might be able to set the direction of PSROs, but if they didn't, the secretary of HEW could "become a health czar," a person who by law "must approve or disapprove of any PSRO and ultimately invoke any sanctions. Because one man could not possibly carry out so many tasks, his name would become a front for an established bureaucracy that would furnish [a] true power structure."[74] Because the debate was fueled by concerns over costs, the quality of care might collapse, a scenario in which creating "standards" would lead to "cookbook medicine," a phrase that captured the essence of doctors' worries about a bureaucrat at the bedside.

There were other critiques that Welch addressed, but the problem, he went on to point out, was that the AMA might have used all its political capital and lost its bargaining power when it circulated a dossier called "Deleterious Effects of PSROs," which "served to identify the AMA with reactionary groups and has hardened the position of Congress in favor of PSRO and against the AMA."[75] The AMA had accused Congress of passing a law "that was a creature of impulse"; it said the costs would outweigh savings; the AMA claimed that the threat of fines would "stultify" medical practice.[76] Seemingly perturbed by the response to his plan by organized medicine, in April 1974 Senator Bennett took to the Senate floor to deliver a speech addressing, point by point, the AMA's allegations.

Quite simply, the AMA had played bad politics at the wrong time. Invoking an image of a federal "health czar," reminiscent of vitriolic 1950s campaigns in which the AMA warned of the dangers of "socialized medicine" and communist control over health care, did not work during the very months that the Watergate scandal caused the White House to crumble.[77] It was two months before Nixon would resign from office. The secretary of HEW in 1974 was Caspar Weinberger, former director of the Office of Management and Budget who had earned the sobriquet "Cap the Knife" for his cost-cutting

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

record.[78] This was not the time to characterize the Republican-appointed secretary of HEW as undermining the health of Americans.

Indeed, it was Dr. Welch's conclusion that the AMA should cooperate. Was there really all that much to complain about? Welch admitted that Senator Bennett had made "unusual concessions" to organized medicine, giving doctors "enormous amounts of power."[79] Given that Congress had already passed the amendments into law, Welch wanted the AMA delegates to consider what options were ultimately available to them: "Will medicine sit behind the table in co-operation with the government, which serves as the representative of the public, or will it stand on the carpet to be judged by others?"[80] Indeed, it appeared to be in the interests of the AMA, facing an increasingly skeptical public, to do some damage control, and the AMA decided to cooperate.

Public skepticism about medicine was expressed in media other than newspapers and popular magazines. In 1971 political activist Ralph Nader attacked "the often criminally negligent" conditions of medical care, saying that the "endless reports of such conditions by physicians, government investigations and other reliable inquiries and testimony present macabre scenes so repeatedly that they evoke resigned or indifferent responses."[81] Acting under the aegis of his Center for the Study of Responsive Law, a team of "Nader's Raiders," led by Dr. Robert McCleery, a former official of the Food and Drug Administration, questioned whether professional enrichment was coming at the cost of patient care and as a result of failures in self-regulation. Issues surrounding the administration of Medicare were central. "The rocketing cost of health care with the advent of socialized payment of physicians' bills through Medicare has not improved the quality of care," wrote Nader, "but it has enriched the medical profession to an unprecedented degree."[82]

The AMA's ongoing resistance to calls for more rigorous surveillance of peer review was usually couched in defense of professional autonomy. Critics countered that such resistance might be part of the collective outlook of a profession whose members feared being second-guessed, regardless of whether such surveillance might improve patient care.

Concerned that such "psychosocial" issues might work against the effectiveness of PSROs, the HEW convened a 1975 conference of social scientists and health care administrators to explore whether self-regulation could ever work. The conference examined expectations for the new PSROs within a framework of problems of "social control." Rather than assuming adherence to codes of ethical conduct, some participants took a view of these issues as embedded in the "socialization" of physicians, a process that led, in this view,

to normative behavior that worked against efficiency and, perversely, against integrity where personal enrichment was within reach. Another observation was of the depersonalization of patients—for example, physicians' "tendency to 'distance' themselves from patients, their brusqueness, insensitivity to the patients' feeling."[83]

Professional autonomy could from this perspective be reduced to the level of the individual, where clinical judgment was personal and was insulated from external pressures. In this view, a plan for peer review was likely to create suspicion and hostility. Medical sociologist Eliot Freidson, referred to earlier, spoke at the conference and contemplated the effects of impersonal interactions within the medical system. "The social psychological virtue of impersonal, automatic review," he said, "is that it avoids interpersonal confrontation and embarrassment."[84] The sociological problem with professional review, Freidson said, was that it suggested a norm that is "correct" and deviation from it as "incorrect." However, in medical practice one is socialized to view disagreements as matters of opinion rather than error. Standards in medicine were conceptualized as subjective and relative. Importantly, this applied to costs as much as to treatment. Freidson warned that it was misguided to think that physicians would automatically comply with standards—a belief he did not limit to physicians. "Most workers in most forms of work," Freidson wrote, "are not merely passive reflexes of their situations. Rather, they are active, calculating, and manipulative."[85] Although contending that health care workers, like most workers, are "manipulative," Freidson cautioned that when analyzing such behavior "it is important to rule out imputations of widespread fraud." In a nation where some people might take liberties on their tax returns, he wanted to imply a difference between intentions and interpretations of procedures. Just as patients were being objectified and reduced to units of illness tethered to billable codes, Freidson saw reimbursement forms themselves as depersonalized.

> The process of filling out forms is almost always arbitrary, and one is more likely to give oneself the benefit of the doubt in his choice of what to put in than he is likely to bend over backwards against himself. Crude words like fraud or dishonesty obscure what is an everyday, universal experience, wherever records are found. Just as we can remember how physicians "unnecessarily" hospitalized patients with Blue Shield coverage in order to gain insurance benefits for them, deliberately adapting their utilization practices to rules of

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

> insurance coverage, and just as we can recognize how physicians over the past ten years, confronted with Medicare, Medicaid, and Utilization Review standards adjusted their practices (and their claims) to gain benefits for their patients, so we can expect that to continue when PSRO standards are established. The practice of manipulating and adapting to bureaucratic forms (including the PSRO form) is one that should be considered inevitable and normal, especially if their use is tied to rewards, and if it is largely impersonal in character.[86]

Freidson applied his sociopsychological understanding of stretching the rules in an unusually favorable way in relation to the problem of fraud. Although it is true that physician practices could have changed to a degree to benefit patients, the definition of fraud, which so concerned the government that it began a push for PSROs, was that it benefited the claimant, the physician. Thus, Freidson's warning that it was "inevitable and normal" to adjust practices and manipulate claims forms suggested an inevitable failure of the PSRO legislation as an ineffectual way to eliminate practices that allegedly drove up the costs of Medicare.

INEVITABLE FAILURE?

Almost from the moment the PSRO program was established, criticisms were leveled against its structure, its limited financing, its vague language about "standards," and its lack of objectives to determine the success of the review program. According to law professor Timothy Jost, who interviewed 80 PSRO experts to assess the law, "PSROs never succeeded in meeting the expectations of their supporters or overcoming the criticisms of their increasingly vocal detractors."[87] In 1976, Odin Anderson, a professor at the Center for Health Administration Studies at the University of Chicago, wrote that

> The PSRO development is, indeed, remarkable. At first the profession fought it; now predictably it is likely to co-opt it; and I personally see no other alternative unless doctors are handed a manual of instructions to follow…. If, in their judgment, the doctors are pressed too hard, they will sabotage the monitoring system by many subtle or not so subtle means at their disposal or threaten to strike on the seemingly unassailable reason that good patient care is being jeopardized.[88]

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

Although overutilization was an overarching target for PSROs, a focus on fraud and abuse by billing for unnecessary treatments and prolonged hospital stays makes it is difficult to determine whether PSROs accomplished anything. For PSROs to work, fraud and abuse first had to be detected and reported. At that point, the review organizations had to go through the proceedings and recommend a disciplinary action. Licensing boards in the years before PSROs had experienced a problem that continued to plague the system: poor record keeping. In their eagerness to protect disciplinary data from further tarnishing medicine's image if opened to public scrutiny, there was scant data available for assessing the number, severity, or consequences of review boards' activities.[89] Furthermore, severe limits in medical licensing laws complicated surveillance on a national level. The fact that state medical licensing boards did not have a national database of disciplinary actions and didn't communicate with each other regarding sanctioned physicians allowed individuals to elude the system. A 1984 report of the U.S. General Accounting Office pointed to the "undetected movement" of physicians seeking a license in another state after being sanctioned by a medical board in their home state.[90] The intention behind PSROs was to raise awareness of best practices and to increase surveillance of billing patterns as a means of preventing fraud and abuse rather than prosecuting it post facto. The response of many medical boards was to enhance educational efforts (such as establishing continuing medical education [CME] programs) and to gesture toward what Odin Anderson (noted above) mused was a solution—to hand doctors "a manual of instructions." Yet a constant refrain of budgetary constraints and claims that the expense of enhanced peer review was greater than the savings further hampered the performance of PSROs. A 1978 Congressional Budget Office report found that PSRO program costs were double the reported savings.[91]

As a result of further hearings that highlighted fraud and abuse, Congress began to explore other means of imposing discipline on the medical profession beyond professional peer review.[92] In 1977, the Office of Inspector General (OIG) was established within the Department of Health, Education, and Welfare to coordinate all investigative functions pertaining to Medicare and Medicaid and to act as primary liaison among HEW, the Department of Justice, and the FBI. It was the first OIG in the U.S. Government, and it was a significant move to create an apparatus for future criminal prosecutions. Also in 1977, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act, which increased penalties for misconduct, required more robust reporting to HEW by PSROs, and provided federal funding for states to establish Medicaid Fraud Control Units.[93]

Although focused on Medicaid (not Medicare), these amendments enacted more formal ways to procure data and to strengthen accountability in review procedures.[94]

Ten years after PSROs had been established, it was clear that Congress was ready to repeal and replace the law. In 1983, Congress enacted the Peer Review Improvement Act of 1982, eliminating PSROs and establishing Peer Review Organizations, or PROs. Placed under administrative control of the new Health Care Financing Administration, this program was in no obvious way better than the last.

But it was not the only legislative change to the structure of Medicare and Medicaid. In 1982 the Tax Equity and Fiscal Responsibility Act was passed, changing the way hospitals were reimbursed for in-patient stays, replacing a retrospective per diem charge with a prospective "diagnosis-related group"-derived payment structure. Instead of reimbursing hospitals for the length of a hospital stay, reimbursement was now to be based on one of 468 permissible diagnoses and a predetermined cost for normal treatment.[95]

Examining the success, or failure, of these legislative reforms to the peer-review process is beyond the scope of this article. The story of PSROs invites us to reflect on the repeated inability of congressional action to affect something as publicly offensive as fraud and abuse of taxpayer-funded programs. PSROs were an administrative method of control that were designed to offer guidelines for how reviews should be conducted. Just as with the 1965 proclamation against federal interference with Medicare payments, the PSRO law was written, especially Section 1801, in a spirit of keeping governmental regulations at a minimum.

Contemporary notions of the "regulatory ideal" also contributed to this spirit. The congressional acts that established PSROs reflected a laissez-faire role for government that had long been championed in the influential publication *The Administrative Process* (1938) by James Landis, known as "dean of the regulators" as well as a guardian of cost-effective government.[96] Theorists of administrative law had debated congressional intent when PSROs were introduced. Harvard University law professor Louis Jaffe discussed the "delegation model" that proposed "that administrative powers should not be precisely defined" because the perception of "broad power" was thought to be more daunting.[97] In trying to achieve broad, loosely defined objectives, the government's role was to delegate to presumed experts the job of solving particular problems as they emerged in the field—for example, local peer review organizations dealing with local fraud issues.

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

However, Harris Cohen, working for HEW in the mid-1970s, pointed out a problem with theories of hands-off governmental delegation: the "experts" will seize on limits on government authority and will rig or co-opt the system for their benefit. "The agency is thus converted, over time, from functioning as a check on the regulated interest to that of an ally or even subsidiary of the nominal subject of regulation."[98] In Jaffe's words, "the more vague a delegation, the more likely the charge that an agency has failed to fulfill its congressional mandate."[99]

In short, when the limits of self-regulation became apparent with the rise of fraud and abuse, the government's solution—to set up additional peer-review organizations—was an example of the flaws in a prevailing regulatory ideal.[100] By letting local, physician-controlled committees assess appropriate use of medical services while billing Medicare and Medicaid for hospitalization and treatment, the intent behind the PSRO legislation was subverted. By prioritizing vague notions of cost containment, the government relinquished the authority to implement meaningful disciplinary action.

CONCLUSION

This article examined how Congress began to understand and address the problem of fraud and abuse in the years immediately following Medicare's 1966 enactment. These efforts culminated in a 1972 law that was the most aggressive attempt to date to deter and reduce inappropriate conduct by doctors and medical groups. The law set up PSROs as local, physician-run groups whose mission was to identify and sanction Medicare misbehavior. Early congressional responses, fueled by voters' concerns over rapidly rising medical costs, enacted these contests.

Beyond efforts to improve the 1972 law, the article argues that addressing fraud and abuse was the "key" that helped unlock broader administrative reforms in Medicare.[101] The failure of PSROs is attributable to weaknesses in the legislation and a blend of organized medicine's strong traditions of self-regulation and effective lobbying. Resistance from the medical profession included CME programs on Medicare, a public relations effort, and, more subtly, lax oversight of, and nonexistent coordination among, local medical societies in monitoring their colleagues.

As with earlier and later battles over national health insurance, the rise and fall of PSROs was rooted in fundamental contests over the scope and boundaries of medical authority—what they are, how they are decided, and how they are enforced. In the early 1970s, the profession was in its second

https://doi.org/10.1017/S0898030622000173 Published online by Cambridge University Press

decade of what Paul Starr had termed its "crisis of legitimacy." This wide-ranging cultural contest permeated congressional hearings, media accounts, and narratives about the wisdom of self-policing in medicine. The PSRO story shows how efforts to implement national health insurance or to alter medicine's professional prerogatives have fallen far short of their goals. Elected officials, despite pressure from voters who were paying ever-bigger medical bills, could not dislodge ideological and historical fortresses around medical practice, and could not significantly alter, much less upend, the profession's broad prerogatives in managing quality control and standards of integrity.

University of California, San Francisco
Department of Humanities and Social Sciences

NOTES

1. Harris S. Cohen, "New Directions in Regulating Health Manpower," in *Review of Allied Health Education: 2*, ed. Joseph Hamurg (Lexington: University Press of Kentucky, 1977), 19.

2. Jay A. Winsten, "Imposing Controls on Doctors," *Wall Street Journal*, December 6, 1973.

3. Harris S. Cohen, "Regulatory Politics and American Medicine," *American Behavioral Scientist* 19, no. 1 (1975): 134.

4. Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Company, 1970), 83.

5. D. R. Hyde, "The American Medical Association: Power, Purpose, and Politics in Organized Medicine," *Yale Law Journal* 63, no. 7 (1954): 958.

6. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

7. Starr, *Social Transformation*, 380.

8. Starr, *Social Transformation*, 385.

9. Although Medicare and Medicaid were both established through amendments to the Social Security Act in 1965 (Titles XVIII and XIX), this article is only focused on fraud and abuse against Medicare. Medicaid is administered differently state by state and has structural differences to Medicare, requiring a separate analysis. This article's focus on regulatory reforms to oversee the payment processing problems precludes further analysis of payment reforms such as passage of prospective payment. For that, see Robert A. Berenson and Rick Mayes, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006).

10. Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974); Ronald Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance 1912-1920* (Baltimore: Johns Hopkins University Press, 1978); Ronald Numbers, ed., *Compulsory Health Insurance: The Continuing American Debate* (Westport, CT: Greenwood, 1982); Jacob Hacker, *The Divided Welfare*

State: The Battle over Public and Private Social Benefits in the United States (New York: Cambridge University Press, 2002).

11. Richard Harris, *A Sacred Trust* (New York: New American Library, 1966); Theodore Marmor, *The Politics of Medicare* (New York: Transaction Publishers, 1970); Daniel M. Fox, *Health Policies, Health Politics: The British and American Experience 1911-1965* (Princeton, NJ: Princeton University Press, 1986); Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); David C. Colby, Keith Wailoo, and Julian Zelizer, *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care* (Oxford: Oxford University Press, 2015).

12. A note on defining "fraud and abuse." In brief, in the 1970s (the period under review) fraud was defined as "an intentional deception" resulting in "unauthorized benefit" to the person committing the act. Abuse was defined as acts by health care providers that are "inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost." These definitions have a history of their own, and a catalog of legal challenges and interpretations of each word. In the present analysis, the terms are considered together because, in the period under review, Congress was concerned about how both affected medical costs. Intentional deceit and moral probity are important issues considered here, but both fraud and abuse were equally problematic as underlying causes of rising health care costs and were brought together as targets for regulatory measures. See U.S. Department of Health, Education and Welfare (HEW), *Part A Intermediary Manual*, HIM-13 (Washington, DC: Government Printing Office, 1976), §3450–52.

13. Malcolm Sparrow, *License to Steal: Why Fraud Plagues America's Health Care System* (Boulder, CO: Westview Press, 1996), 1.

14. Louis Jaffe, "The Illusion of the Ideal Administration," *Harvard Law Review* 86, no. 7 (1973): 1168.

15. Robert Reiff, "The Control of Knowledge: The Power of the Helping Professions," *Journal of Applied Behavioral Science* 10, no. 3 (1974): 452.

16. Freidson, *Profession of Medicine*, 25–26.

17. Harris, *Sacred Trust.*

18. Numbers, *Almost Persuaded*; Oberlander, *Political Life*; also Judith M. Feder, *Medicare: The Politics of Federal Hospital Insurance* (Lexington, MA: Lexington Books, 1977); Mark McLay, "A High-Wire Crusade: Republicans and the War on Poverty, 1966," *Journal of Policy History* 31, no. 3 (2019): 382–405, for context of and shifting conservative positions toward Medicare.

19. Hyde, "The American Medical Association," 955; see also American Medical Association, "A.M.A. Advertising Program," *JAMA* 143 (June 24, 1950): 744.

20. Hyde, "The American Medical Association," 1008.

21. An Act to Provide a Hospital Insurance Program for the Aged Under the Social Security Act, H.R. 6675, 89th Cong., at 4 (1965), https://www.govtrack.us/congress/bills/89/hr6675/text.

22. Wilbur J. Cohen, "Reflections on the Enactment of Medicare and Medicaid," *Health Care Financing Review* Suppl. (December 1985): 8.

23. Freidson, *Profession of Medicine*, 32.

24. Robert Cunningham III and Robert Cunningham, Jr., *Blues: A History of the Blue Cross and Blue Shield System* (DeKalb: Northern Illinois University Press, 1997).

25. David Rothman, *Beginnings Count: The Technological Imperative in America Health Care* (Oxford: Oxford University Press, 1997).

26. Feder, *Medicare*, quoted on 38.

27. Sylvia Law, *Blue Cross: What Went Wrong?* (New Haven, CT: Yale University Press, 1974).

28. Law, *Blue Cross*, 2.

29. Oberlander, *Political Life*, 8.

30. American Medical Association (Board of Trustees), "AMA Initiative on Quality of Medical Care and Professional Self-Regulation," *JAMA* 256, no. 8 (1986): 1036.

31. Rosemary Stevens, *American Medicine and the Public Interest: A History of Specialization* (New Haven, CT: Yale University Press, 1971; revised edition Berkeley: University of California Press, 1998), 22 for development of ideas of self-regulation in nineteenth-century America.

32. Richard Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins University Press, 1967).

33. Edward Forgotson, Ruth Roemer, and Roger W. Newman, "Licensure of Physicians," *Washington University Law Review* 1967, no. 3 (1967): 262.

34. Quoted in Ruth Horowitz, *In the Public Interest: Medical Licensing and the Disciplinary Process* (New Brunswick, NJ: Rutgers University Press, 2013), 60.

35. Marshall Kapp and Bernard Lo, "Legal Perceptions and Medical Decision Making," *Millbank Quarterly* 64, no. 2 (1986), 164.

36. Robert Derbyshire, *Medical Licensure and Discipline in the United States* (Baltimore: The Johns Hopkins University Press, 1969), 76; see also Forgotson, "Licensure," 259 for composition of medical boards.

37. Derbyshire, *Medical Licensure*, 76–77.

38. Stevens, *American Medicine and the Public Interest*, 465, for background to professional independence, fee for service, and rise of corporate medical practice; Rick Mayes, "Causal Chains and Cost Shifting: How Medicare's Rescue Inadvertently Triggered the Managed-Care Revolution," *Journal of Policy History* 16, no. 2 (2004): 144–74, for reforms of Medicare's payment policies and the rise of managed care.

39. Sidney Shindell, "A Survey of the Law of Medical Practice," *JAMA* 193, no. 7 (1965): 601.

40. Stanley Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (London: Quorum Books, 1984), 107.

41. Andrew Dolan and Nicole Urban, "The Determinants of the Effectiveness of Medical Disciplinary Boards, 1960-1977," *Law and Human Behavior* 7 (September 1983): 207.

42. Walter Bierring, "The Status of Discipline in the Medical Profession," *Federation Bulletin* 47 (1960): 4; see also David A. Johnson and Humayun J. Chaudhry, *Medical Licensing and Discipline in America* (Toronto: Lexington Books, 2012), 156.

43. Derbyshire, *Medical Licensure*, xii.

44. *Medicare and Medicaid: Hearings Before the Committee on Finance, United States Senate*, 91st Cong., 1st Sess., at 54 (July 1–2, 1969).

45. U.S. Senate, *Medicare and Medicaid*, at 2.

46. U.S. Senate, *Medicare and Medicaid*, at 76.

47. All quotations from U.S. Senate, *Medicare and Medicaid*, at 81.
48. U.S. Senate, *Medicare and Medicaid*, at 99.
49. U.S. Senate, *Medicare and Medicaid*, at 52.
50. U.S. Senate, *Medicare and Medicaid*, at 105–06.
51. U.S. Senate, *Medicare and Medicaid*, at 51.
52. The text, "A Report on the Health of the Nation's Health Care System," July 10, 1969, is printed in the *Weekly Compilation of Presidential Documents* (vol. 5, p. 967).
53. National Archives and Records Administration, *Weekly Compilation of Presidential Documents*, July 14, 1969, folios 963–69, 965.
54. *Presidential Documents*, 1969, folio 967.
55. U.S. Department of Health, Education, and Welfare, Bureau of Health Insurance, *Health Insurance Benefits Advisory Council Annual Report on Medicare, Covering the Period July 1, 1966–December 31, 1967* (Washington, DC: U.S. Department of Health, Education, and Welfare, 1969), quotation on vi.
56. American Medical Association, *Report on Physician-Hospital Relations* (Chicago: American Medical Association, 1964).
57. Bureau of Health Insurance, *Health Insurance*, 10.
58. Bureau of Health Insurance, *Health Insurance*, xi.
59. All quotations from Feder, *Medicare*, 43.
60. Feder, *Medicare*, 44.
61. Robert McCleery, Louise Keelty, Mimi Lam, Russell Phillips, and Terrence Quirin, *One Life-One Physician: An Inquiry into the Medical Profession's Performance in Self-Regulation* (Washington, DC: Public Affairs Press, 1971), 91.
62. Paul Starr, "Medicine and the Waning of Professional Sovereignty," *Daedalus* 107, no. 1 (1978): 175–93.
63. Professional Standards Review Organization Act of 1970, 91 Cong. Rec. S22475–477 (daily ed. July 1, 1970) (statement of Sen. Bennett), https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1970-pt17/pdf/GPO-CRECB-1970-pt17-1-1.pdf.
64. Oberlander, *Political Life*, 117.
65. Sentor Bennett, *Congressional Record*, 22476.
66. Sentor Bennett, *Congressional Record*, 22476.
67. General Provisions and Professional Standards Review, Pub. L. No. 92-603, 86 Stat 1329, 1429–44 (1972), §249F on p. 1431.
68. Martin Dale, "Commentary: PSROs—A Primer," *JAMA* 229, no. 2 (1974): 157.
69. Claude Welch, "PSROs—Pros and Cons," *NEJM* 290, no. 23 (1974): 1319.
70. Feder, *Medicare*, 43.
71. U.S. Department of Health, Education and Welfare, Office of Professional Standards Review, *PSRO Program Manual* (Washington, DC: U.S. Government Printing Office, March, 1974).
72. Goran, Michael J., "The Evolution of the PSRO Hospital Review System," *Medical Care* 17, no. 5 (1979): 4.
73. Goran, Michael J., James S. Roberts, Meg A. Kellogg, Jonathan Fielding, and William Jessee, "The PSRO Hospital Review System," *Medical Care* 13, no. 4 (1975): 1–33, provides a good overview of PSRO organization and the process of delegation.
74. Welch, "PSRO," 1319.

75. Welch, "PSRO," 1320.

76. U.S. Senate, Finance Committee, *Background Material Relating to Professional Standards Review Organizations (PSROs)* (Washington, DC: Government Printing Office, 1974), 19–21.

77. Brian Dolan, "Socialism, Medicare, and the Yoke of European Dictatorship," *Medical History for Medical Students* 3 (2016), http://ucmedicalhumanitiespress.com/magazines/socialism-medicare-and-the-yoke-of-european-dictatorship/.

78. Clyde Farnsworth, "They Call Him Cap the Knife," *New York Times* May, 3, 1985, 6.

79. Welch, "PSRO," 1319.

80. Welch, "PSRO," 1322.

81. Ralph Nader, "Introduction," in McCleery, *One Life*, iii.

82. Nader, *One Life*, iii.

83. Scott Greer, "Introduction: Professional Review Standards Organization," in U.S. Department of Health, Education, and Welfare, *Conference on Professional Self-Regulation: Working Papers on PSROs* (Health Resources Administration: DHEW Publication No. [HRA] 77-621, 1975), 1–3, quotation on 2.

84. Eliot Freidson, "Speculations on the Social Psychology of the PSRO Operations," in U.S. Department of Health, Education, and Welfare, *Conference*, 33–38, 36.

85. Department of Health, Education, and Welfare, *Conference*, 37.

86. Department of Health, Education, and Welfare, *Conference*, 37.

87. Timothy Jost, "Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations," *Ohio State Law Journal* 50, no. 1 (1989): 5.

88. Odin Anderson, "PSROs, the Medical Profession, and the Public Interest," *The Milbank Memorial Fund Quarterlt Health and Society* 54, no. 3 (1976): 381.

89. Stanley Gross, *Of Foxes and Hen Houses: Licensing and the Health Professions* (London: Quorum Books, 1984), 87.

90. Johnson and Chaudhry, *Medical Licensing*, 202.

91. *PSRO Program: Hearing Before the Subcommittee on Health of the House Committee on Ways and Means*, 96th Cong., 2d Sess. (1980).

92. *Proposed Phaseout of PSROs and Utilization Review Requirements: Hearing Before the Subcommittee on Health of the Senate Committee on Finance*, 97th Cong., 1st Sess. (1981).

93. Congress: Medicare-Medicaid Anti-Fraud and Abuse Amendments, H.R. Rep. No. 95-3023 (1977), https://www.govtrack.us/congress/bills/95/hr3023.

94. Byron Lee, "Fraud and Abuse in Medicare and Medicaid," *Administrative Law Review* 30, no. 1 (1978): 1–43.

95. Peter Mellette, "The Changing Focus of Peer Review under Medicare," *University of Richmond Law Review* 20, no. 2 (1986): 321.

96. Donald Ritchie, James M. Landis: *Dean of the Regulators* (Cambridge, MA: Harvard University Press, 1980).

97. Jaffe, "The Illusion," 1185.

98. Cohen, "Regulatory Politics," 123.

99. Jaffe, "The Illusion," 1184.

100. Nicholas Johnson, "A New Fidelity to the Regulatory Ideal," *Georgetown Law Journal* 59, no. 869 (1971).

101. Although Medicare and Medicaid were both established through amendments to the Social Security Act in 1965 (Titles XVIII and XIX), this article is only focused on fraud and abuse against Medicare. Medicaid is administered differently state by state and has structural differences from Medicare, requiring a separate analysis. This article's focus on regulatory reforms to oversee the payment processing problems preclude a further analysis of payment reforms such as passage of prospective payment. For that, see Robert A. Berenson and Rick Mayes, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006).