# LETTERS

*We welcome letters from readers, particularly commentaries that reflect upon or take issue with material we have published. The writer's name, affiliation, address, and telephone number should be included. Letters may be edited to save space and ensure clarity.*

**MORE ON "MURDER BY MEDICARE"**

Jonathan W. Emord's "Murder by Medicare: The Demise of Solo Small Group Medical Practice" (*Regulation*, Summer 1998, Vol. 21, No. 3) describes how the AMA lobbied Congress to expand Medicare to pay for services delivered by physicians not directly associated with hospitals, unwittingly ensuring that such physicians would be required to follow Medicare's draconian rules and regulations. The AMA book catalog is now composed largely of publications telling physicians how to comply with Medicare, with many more books about rules, regulations, and code numbers than about how to maintain health or heal the sick.

The only part of medical practice now in the free market is so called alternative or complementary medicine. Almost all of the money paid by consumers for such medical treatment comes out of their own pockets. Unfortunately, trade groups of alternative medicine practitioners are lobbying for inclusion in government programs and mandated coverage by insurance companies. Such efforts, if successful, will put practitioners of alternative medicine in the same position as conventional medical doctors, that is, shackled by proliferating rules and regulations and exposed to the dangers of being fined, imprisoned, or having property seized as a result of sweeping "health fraud" rules. (For example, Congress defined any therapy not approved by the FDA to be presumptively health fraud; thus prescribing vitamin E for a cardiovascular or diabetic patient is potentially a crime.

The (il)legal principle underlying Medicare is that the federal government has regulatory authority over intrastate medical practice. The question of where interstate commerce ends and intrastate commerce begins has a convoluted history in the courts. The New Deal Supreme Court largely destroyed the distinction between interstate and intrastate commerce, even ruling that the practice of growing wheat for consumption on one's farm comes under interstate commerce because the practice, if widespread, would affect interstate commerce (*Wickard v. Filburn*, 1943). The Court thus permitted an immense expansion of federal regulatory powers over commerce that takes place entirely within a state, such as a transaction between a doctor and a patient.

Lately the Supreme Court and various lower courts have begun to restore some limits on the federal government's ability to reach into the states under the Commerce Clause (e.g., *U.S. v. Lopez*, 115 S.Ct. 1624 (1995), *U.S. v. Pappadopoulos*, Ninth Circuit 93-10577). Justice Thomas's concurring opinion in *U.S. v. Lopez* noted, for example, that "…the Federal Government has nothing approaching a police power."

We have challenged federal regulation of intrastate medical practice in *Durk Pearson & Sandy Shaw et al. v. Barry R. McCaffrey et al.* (97CV00462 (WBB)). In this case, in which we are represented by Mr. Emord, we argue the unconstitutionality of federal actions against doctors who prescribe and patients who use medical marijuana within states where that is legal, citing the First, Ninth, and Tenth Amendments and the limits of the Commerce Clause. Our case is not about whether marijuana is a good medicine; it is a carefully designed challenge to the federal government's jurisdiction over intrastate medical practices. Our briefs and oral arguments may be downloaded from www.emord.com

As Emord notes, Sec. 6204 of the Omnibus Budget Reconciliation Act of 1989 "prohibits a physician or an immediate family member of a physician from referring to Medicare patient to a clinical lab that may receive Medicare payments if that physician or family member has a financial relationship with the lab." That prohibition violates the First Amendment rights of the physician (or family member) to provide a referral and of the patient to receive a referral. The government might arguably require disclosure of any financial relationship, but it has no constitutional authority to prevent willing speakers from truthfully communicating with willing listeners, as the U.S. Supreme Court has repeatedly decided.

Emord writes that physicians cannot recover damages from the government when "health fraud" accusations are proven incorrect. The idea of sovereign immunity—that government officials and agencies are not liable for damages when they harm innocent persons while lawfully executing their duties—is a public policy badly in need of reform. Under sovereign immunity there is no incentive for government employees and agencies to avoid endangering innocent persons. The U.S. Supreme Court recently ruled unanimously that police are not liable for any damages to innocent bystanders in a high-speed police chase. How does such a ruling encourage the police to be more careful or to limit high-speed chases to important public purposes? It is said that the elimination or drastic limitation of sovereign immunity would cause government agencies to spend considerable sums of money defending lawsuits alleging damage. However, sovereign immunity is a dangerous leftover of the "divine right of kings" and should be rethought. The

balance of power between individual citizens and government has become drastically tilted in favor of government.

The government has nimbly sidestepped the constitutional guarantee of a jury trial by calling health care fraud a civil rather than a criminal matter. However, fraud is a crime and, hence, those accused of it should have the right to a jury trial. The government's use of civil suits to punish criminal acts, with the lower level of evidence required (preponderance of the evidence rather than proof beyond a reasonable doubt), complete with draconian punishments (redefined as "remedies" so that somehow a punishment isn't a punishment) but no right to jury trial, is another example of unconstitutional government gone wild.

The requirement that all twelve jurors agree that a punishment or seizure is just beyond a reasonable doubt was intended as an unbreachable final bulwark against tyranny, but Congress and complicit courts have defined the protection almost out of existence. This is especially obvious in the government's use of the medieval theory of the deodand; the government theoretically sues the property itself in order to bypass the constitutional protections of the property's owner. This is not a new outrage, even in the U.S.; for the past 200 years, the doctrine has made it much easier to seize ships carrying smuggled goods without having to prove that the owners were involved. What is new is its extensive metastasis into every form of human interaction.

Emord states that "under Medicare, physicians effectively become agents of the federal government." In activities involving federal agents, all constitutional and procedural protections apply. In *Berger v. Hamann*, for example, a unanimous panel of the Ninth Circuit Court of Appeals held that CNN reporters accompanying the U.S. Fish and Wildlife Service during a search of a Montana Ranch had become agents of the federal government and thus could be held liable for trespass or other violations. By extension one may ask by what constitutional authority the federal government (through Medicare insurance carriers) makes searches and seizures of patient records without a warrant issued "upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized," as the Fourth Amendment requires. Perhaps Congress simply decided that it would be too much trouble to get all those warrants. The usurpation of the Fourth Amendment began long before the War on Drugs, when congressional "progressives" and the judiciary decided that an all-powerful central administrative state required defining it away. The Interstate Commerce Commission's freight rate czars are gone, but federal powers of warrantless searches and seizures of citizens' persons, houses, papers, and effects have arguably become a greater threat to Americans' liberty than Russia's 20,000 nuclear weapons.

Medicare laws make a mockery of the Declaration of Independence's promise of "life, liberty, and the pursuit of happiness." We fear that, if the central government continues on its present course, and the courts are unwilling or unable to restore the Constitution's restraints, we will be left with the Declaration's final resort: "whenever any form of government becomes destructive of these ends, it is the right of the people to alter or abolish it."

We agree with Emord that disastrous federal interference in the practice of medicine must be stopped. He revealed in horrifying detail Medicare's regulatory mine field, which is having a disastrous effect upon doctors and their patients. Meanwhile, the government's regulations seem to have easily crossed the constitutional mine field. Something has gone wrong here. Emord suggests that "Congress must wean the nation of Medicare and favor the substitution of private medical insurance, tax-free medical savings accounts, and private contracting between physicians and patients." Another approach, which we favor because we are not confident that Congress can carry out these needed reforms, is through constitutional challenges to Medicare laws and regulations in the courts.

Sometimes freedom wins. For example, the First Amendment's restraints on government took a landmark leap out of the quicksands of administrative law when we won *Pearson & Shaw, et al. v. Shalala, et al*. A 3-0 decision in the District of Columbia Circuit Court of Appeals held that the FDA's regulations on dietary supplement "health claims" exceeded the bounds of the First Amendment. (See www.emord.com for briefs, oral arguments, and the decision.) We hope to convince the courts in *Pearson & Shaw et al. v. McCaffrey, et al*. that if the feds can simply define intrastate commerce out of existence, then the Constitution's limited delegation under the Commerce Clause is meaningless.

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## AN M.D. REACTS TO "MURDER BY MEDICARE"

"Murder by Medicare" ably documents the demise of what 30 years ago was one of the most robust industries in the history of human civilization, American medicine. I almost wish I had not read it. I knew things were bad, but as a practicing physician, I had no idea I was so close to a prison sentence.

Thirty years ago, times were good for everyone. Energetic well-trained physicians saw to the needs of their patients and both were happy. Today, the practice of medicine is a nightmare for both physician and patient. I cannot describe how difficult it is to stay focused on a patient's problem when I know that a trivial misstep in charting could result in a "remedy" for fraud cooked up by the federal government. Thirty years of Medicare has criminalized the entire profession.

The reason for the heinous change in the medical profession is money, too much of it. Dousing the profession with government money, for whatever reason, extinguished all market forces of price control. So, when the government's obligation to fund its program rises 25,375 percent in 32 years, some-

one has to take the blame for rising health care costs. And since it can't be the inflationary force of entitlement money, it must be the doctors.

A few months ago in Los Angeles—live on local television—a young male standing on a freeway bridge shot himself in the head and fell to the freeway below. He was distraught because his HMO was rationing the medial services he needed. Recently, a judgment against Aetna for $120 million was won for the same reason. These are iceberg tips of growing dissatisfaction with the HMO structure of medical service delivery.

In this decade the profession rushed pell-mell into *managed care*, a euphemism for rationing. In my opinion, failed attempts of the Clinton administration to fix the problems generated by Medicare by socializing the profession into a federally run HMO dramatically accelerated this trend in the private sector. The result is essentially the same.

The incentive of HMOs, even those that are well run, private or government, is contrary to the desires of people in need of medical products and services. The incentive of HMOs is not to treat; the incentive of patients is to be treated.

The question now is what to do next? How do we fix it? If we start down the path of repair, what vehicle is necessary, and when will we know we have arrived?

I submit that the solution/destination is the restoration of an unfettered doctor-patient contract (also called relationship). Now, which vehicle will get us there: the legislature, the courts, or something else?

The legislature: Not possible. The legislature caused the problem and is only making it worse.

The courts: Possibly, but like tiny tugboats trying to guide a huge ocean liner that is getting larger by the second, any substantial correction would be minuscule and require more or less constant court involvement to sustain.

Something else: It is already in place. According to Dr. Eisenberg's second study (D. M. Eisenberg et al., "Trends in alternative medicine use in the United States, 1990-1997," *JAMA.* 1998; 280(18): 1569-1575.), approximately 46 percent of the population has made 660,000,000 visits to practitioners of alternative medicine and paid $25 billion, out of pocket, for those services! As Shaw and Pearson note in their letter, alternative or complementary medicine is the only free-market form of medicine. As a practitioner of alternative/complementary medicine (only I call it good medicine), I report that I am happy with my work, and my paying patients are, as a rule, happy with my services—all of which is constitutional but probably illegal.

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**ANOTHER M.D. WEIGHS IN**

Sobering as Mr. Emord's portrayal of the potential for abuse or misapplication of Medicare's regulatory authority may have been, the reality of being a practicing physician conscripted into that administrative legal quagmire is worse by several orders of magnitude. I can attest that his assertions are not so much precautions or admonitions as they are descriptions of actual events in my life. By the very fact of my choice to offer nonprevailing medical modalities, I have gained first hand experience with the administrative process. As a physician who has chosen to integrate the evolving paradigm usually called Complementary Alternative Medicine (CAM) into my solo practice for two decades, my experience with insurance carriers and Medicare contractors supports Mr. Emord's premise that the incentives to pursue as many fraud investigations as possible will result in punishment of the innocent as well as the guilty.

The detection system for fraud and abuse is based on computer models that detect statistical deviations from the "norms" of practice patterns. Translation: if my pattern of reporting service "A" is outside the bell curve of other physicians in my "category," then I must be either abusing "A" or fraudulently reporting "A." The statistical curves that define the norms are determined by the practice patterns of specialty groups over periods of years.

For example, my practice profile, as a physician offering CAM, differs from the usual and customary profile for Family Practice. Thus the computer models flag me as "aberrant," which triggers scrutiny and conscripts me into the administrative legal process. Because Medicare contractors have broad authority to interpret Medicare regulations, determine coverage, and investigate aberrations, they can apply such techniques as inquiries, reviews, audits, prepayment audits, postpayment reviews, and rejection or denial of claims. They can elect to suspend all payments on the presumption of wrongdoing such as fraud or misrepresentation.

There are three glaring problems with such a system. First, there is no classification that describes the practice patterns of physicians who integrate CAM. Second, because the norms are based on yesterday's practice patterns, any pattern that includes advancement or innovation would necessarily fall outside the norms. (By the same token, the system perpetuates the status quo, rewards stagnation, encourages multiple low volume fraud, and disallows professional advancement or innovative practice.) Third, the investigative process can last indefinitely whether or not specific charges or accusations are ever levied.

Unfortunately, Medicare contractors have neither mandate nor incentive to protect my rights. Instead, I am compelled to participate in an administrative legal process: to provide copies of charts and professional narrative reports, to respond to endless imprecise requests to provide data and documentation, to rebut nebulous or unsubstantiated allegations, and to defend against allegations that never grow beyond the level of innuendo. The process stifles professional growth and development by usurping my time and energy and keeping me mired in paperwork, documentation, and frivolous legal disputes. It compels me to squander my intellectual, emotional, temporal, and financial resources in trivial bureaucratic machinations that have little or no potential

for positive outcome, let alone any benefit to Medicare beneficiaries. It allows my patients to be advised, without qualification, that I am the subject of a fraud investigation, that I fail to comply with regulations, that payments to me have been suspended, or that I am being paid for services when, in fact, I am not. The result is to undermine or destroy the confidence of my patients—good citizens who presume that due process and constitutional rights are working and, therefore, I must be at fault.

All of these costly, wasteful, defamatory, and punitive actions can be imposed, contrived, and controlled by the very administrative entity that intends to make an adverse determination. The auditors, investigators, arbitrators, hearing officers, and adjudicators are all selected, assigned, guided, supervised, and employed by the very entity that is the accuser. Such a unilateral process has tremendous and unacceptable potential for abuse and misapplication. The process can be politicized, can perpetuate medical dogma, stifle innovation, destroy professional reputations, and victimize innocent providers by transforming due process into a mechanistic farce. It can proceed with the presumption of guilt, without regard for constitutional rights to due process: the victim has no right to hear charges against him, to face his accusers, to contest the accusers, or to answer the charges before an impartial judge or jury of his peers. Worse yet, as designed by the accuser with abject impunity, the process must be completely exhausted before any recourse is available in a court of law, before there is any hope of impartial adjudication or reinstatement of the victim's constitutional rights.

An adverse determination could be made merely because a provider has neither the financial nor the physical resources to withstand the stresses and burdens of such a process. The costly legal proceedings demanded in defense of even the most frivolous of allegations provide a perverse incentive to negotiate settlements or consent decrees that clearly perpetuate the impression of wrongdoing. With only the expectation of financial losses or bankruptcy—and productive years squandered at the whim of third party insurance carriers or administrative agencies—many providers would view a hard-won victory as hollow vindication.

I have now entered my fifth year of immersion in a frustrating administrative process that is as inexorable and as predictably consuming as dancing in quicksand. The more I protest and struggle the more inextricable my involvement. It feels much like my fourth month as an infantry soldier in Vietnam when it seemed like I had been there forever, and would be there forever. There's no end and no way out.

We have trained a cadre of fraud and abuse investigators to presume that every physician is committing fraud. Initially they're only after the big fish, but we can assume that as the army of investigators grows the search for targets must grow proportionately, especially if promotions, incentives, recognition, raises, rewards, and agency budgets are tied to performance.

A case in point is a 1993 lawsuit against the New Jersey State Department of Insurance, Division of Insurance Fraud Prevention, filed under the RICO anti-racketeering statute and alleging that the Insurance Fraud Division was illegally extorting money from doctors throughout the state. The state ultimately settled the case for $125,000 without admitting wrongdoing, but the perverse incentive that "the first and foremost goal of the Insurance Fraud Division is to maximize the amount of money collected" led the Attorney General to realize that "Fraud Division personnel may be influenced to exact settlements from persons whether or not these payments are justified on the merits of the case." In essence, doctors who were threatened with the specter of prolonged and costly legal defenses were compelled to accept consent decrees and fines rather than risk the ravages of the administrative process.

In my senior year of high school the proposed Medicare system of financing medical care for the elderly and disabled was a hot topic of debate. It was easy to agree that the program was conceived in the spirit of altruism and humanism, but we all knew at some visceral level that government could screw up the most well-intentioned program.

Perhaps we are seeing a reaction to the entrepreneurial approach to government programs typified by the military contractors of the 1960s and 1970s, who it seems had only to submit the right paperwork to receive a check. No matter how absurd the bills, they got paid. Regulatory systems were merely viewed as challenges to be surmounted; government regulators would attempt to control the loss of funds and contractors would devise ways to circumvent the regulations and continue to access the dollars. Business as usual.

Medicare burst onto the scene as a blank check bonanza to the medical care industry. Hospitals, physicians, and other providers, contaminated by the prevailing ethos, quickly learned to play the government contractor game. A generation of entrepreneurs in the nation's new growth industry gorged at the Medicare cash feast before government finally realized that some system of regulation was necessary to control the hemorrhage of dollars. What has emerged from the chaos is our current heavy-handed, military police approach to regulation—a perpetuation of the cat and mouse game where providers become adversaries to investigators.

We live in a time of euphemism, spin doctoring, and acronyms, when HMOs have no relation to maintenance of health; where medical, surgical, and disease care are referred to as "health" care; where benefits programs that pay in the event of disease or injury are termed "health insurance"; where preventive medical care has been replaced by prevention of medical care delivery in the name of profits; and where the confidentiality of a once sacrosanct relationship between a person and his physician has been sacrificed in the pursuit of fraud and abuse. CPT and ICD-9 codes have deteriorated from their original purpose of clearly communicating and standardizing references to medical conditions and surgical procedures. They now serve as triggering mechanisms for

insurance reimbursement. If you can't honestly hammer your procedures or diagnoses to fit into the boxes, you don't get paid, or worse. We no longer have the luxury of using language to describe what transpires during a medical encounter. If you think words will work to describe medical events, just try to communicate with an insurer.

Maybe it is symptomatic of a deeper problem when physicians must expend more resources serving Medicare regulations than serving Medicare beneficiaries. We live in a society that seeks and reveres profits, yet decries profiteering. We pay lip service to honor, integrity, honesty, and ethical behavior while we often reward deceit, dishonesty, and unethical behavior as long as it's done tastefully and doesn't stray too far from the "norms" of the "dog eat dog" world of commerce. We reward CEOs of medical insurance companies with obscene compensation packages for employing cost cutting measures based predominantly on denying payment and services to subscribers. We made HMOs the darlings of Wall Street for most of the '90s when they generated enormous profits using similar techniques, enhanced with gag clauses to deter their doctors from giving subscribers too much information about useful treatments that might cut into HMO profits.

Service providers or suppliers who commit fraud should be held accountable for their fraud. The defrauded entity certainly should have the right to accuse a suspected fraudulent provider and to make a case before an impartial adjudicator. But the accuser should not be privileged to inflict a punitive and defamatory process on citizens who deserve the presumption of innocence.

The new crime of "health care abuse" is a Pandora's box that has yet to be defined sufficiently to even consider the circumstances under which adverse actions could or should be determined. How could any government agency, licensing board, insurance carrier, or health plan presume to dictate what constitutes "health care abuse"? This is reminiscent of the FDA position that required "significant scientific agreement" for health claims on labeling. The FDA's attitude was "we don't have to define significant scientific agreement, but we'll know it when we see it." On January 15, 1999, the U.S. Court of Appeals in Washington, D.C., invalidated the FDA's rule in a 3-0 decision.

We cannot allow the rote invocation of the phrase "health care fraud and abuse" to foster the suspension of constitutional rights, desecration of the physician-patient relationship, violation of confidentiality, prevention of the pursuit of health, hindrance of advancement and free choice in medical care, or perpetuation of subservience to a single school of medical thought. We cannot elevate the commercial privileges of federal contractors or the authority granted to federal agencies above the rights of human beings.

I agree wholeheartedly with Mr. Emord that we must wean the nation from Medicare and put the responsibility for health and medical care decisions back in the hands of the consumers. Given reliable information about what helps, what hurts, and how much it costs, people are capable of deciding how to spend their health-care dollars. Clearly, we need some basic benefit program to ensure a reasonable level of disease or injury care, and we need affordable insurance to spread the costs of catastrophic illnesses across the insured population. But we don't need thousands of insurance carriers with tens of thousands of benefit plans so complicated as to be indecipherable to Ph.D.s. We don't need an army of investigators trying to justify its existence by extorting money from hospitals and doctors. We don't need to continue pouring money into a Medicare system so bloated by its own bureaucracy that it can only provide care that is too little and too expensive.

The real fraud here is not the doctor who fails to play the CPT/ICD-9 game successfully. The real fraud here arises from the federal agencies whose misguided actions fail to serve the people, from the glut of federal agents whose narrow black-and-white perspective blinds them to their broader mission to serve, from our lust for techno-pharmaco-medicine at any price, from the misapplication of expensive technology as a substitute for taking the time to exercise clinical judgment, and from the mean-spiritedness that polarizes us. Let's have the courage and foresight to get off this train. Let's declare victory in the war on fraud and turn our energies and resources to creatively remodeling our system to accommodate our needs for medical care and our desires for health care. I respect Hillary Clinton for trying to tame the bear, even though it chewed her up. Surely, we can muster the integrity to set aside our self-serving motives, greed, and animosity and devise a system that serves the nation with a reasonable package at a fair price. Surely we can devise a system of checks and balances that precludes punishment by administrative process in the absence of crime.

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**SCORE ONE FOR THE FDA:**

Henry I. Miller's article on "Failed FDA Reform" (*Regulation,* Summer 1998, Vol. 21, No. 2), was on target, and the regulatory excesses he documents are real and costly. But it is important to give the devil his due, and the FDA has recently removed one costly regulation. The agency now allows direct-to-consumer prescription drug advertising on television. Such advertising is an issue that I have discussed since the mid 1980s, including an article in R*egulation* (Allison Masson and Paul H. Rubin, "Plugs for Drugs," Sept/Oct 1986). In 1997 the FDA finally relaxed its rules to allow this form of advertising, and as a result consumers now have much more information about drugs.

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**RAILROAD REGULATION IS HARDLY ONEROUS**

My good friend, Frank Wilner, argued recently in these pages that railroad

mergers are subject to continuing and "onerous assault" because of the continuing "oversight" regulation by the Surface Transportation Board (STB). (See "Blame the Shermans," *Regulation*, Summer 1998, Vol. 21, No. 3, 1998). Frank is often right, but on this one he is dead wrong. Yes, railroad regulation is necessary, and is not "onerous."

Why is it necessary? Because many rail customers are "captive," that is, they have no effective competition for the goods (mostly bulk goods) they ship. If it were otherwise, railroad mergers could be handled, as are all other businesses, at the Department of Justice. More about the captive customers, later. But the "natural monopoly" nature of railroads and their common-carrier status mean that railroads are like public utilities: they have many customers who have no other service available to them and who cannot create it because of the barriers to entry that typify natural monopolies.

Frank is under the impression that "at least when most corporations do merge, their private property is relatively safe from further tinkering by trustbusters." For businesses other than railroads, though, even without a merger, the antitrust laws are entirely capable of requiring divestitures, even in the absence of mergers. If you doubt it, ask AT&T or Microsoft. And for those who are merging, the government also requires divestitures. Witness the recent oil mergers, or even proposed mergers of such business as office suppliers. So to hold that divestiture "sword" over the railroads while approving their mergers is hardly "onerous," or any different from the rest of American business. There is no other alternative, unless we decide to let businesses that exist solely to serve the public—such as railroads—serve only their shareholders.

Indeed, rail mergers are subject to very light regulation except on environmental matters, where Frank's points are arguably well taken. "Environmental" concerns have actually masked concerns over social justice, which is an entirely laudable goal but questionable when imposed on only some private business, rather than on all of us. But in defense of the STB, there have been times when rail mergers have so impacted the environment, at least locally, that they are arguably unlike other mergers. Note the increased volume of traffic in Reno, Wichita, and Cleveland after recent mergers.

But railroad mergers are subject to regulation to protect captive customers, those customers who will lose competition as a result of the merger, and the public.

I assume that I get no argument from Frank on the value of regulation in preserving existing competition, for otherwise we might just as well allow monopolist railroads to merge at will. We do not allow any business to do so unless the impact on competition is slight or there is no other way to preserve service (remember Conrail?). We especially do not allow railroads to merge at will, at least not these days, because railroads are public enterprises who owe their very existence to a franchise from the government, including eminent domain powers (ironically, the very "taking" Frank deplores, but for a *private*, not *public*, entity). We give railroads and utilities that awesome power because we recognize that the efficiencies economists like Frank cherish would not exist without devoting property to its "highest and best use." Would we let one property owner stand in the way of a needed road or transmission line? I think not.

In any event, railroads went into their businesses having accepted the duty to carry goods for all, at reasonable rates where competition does not exist but at "any rate" where it does (a sensible distinction). In 1970, railroads were relieved of their duty to carry passengers, subject to a duty to allow Amtrak to do so at somewhat favorable trackage rights fees. But they were not relieved of their duty to carry freight under very light-handed regulation.

Part of that light-handed regulation requires the STB to protect customers and the public from the harms that may occur due to rail mergers and acquisitions. In practice, the STB has construed that power to protect only a limited group of customers (those who lose direct head-to-head competition, not those who lose less-obvious geographic competition) and not anyone else. But it does so *assuming* that the "benefits" of the railroads seeking authority to merge or acquire one another will be realized. Other agencies, such as the Federal Energy Regulatory Commission, aren't so trusting. FERC doesn't even try to determine if the benefits are speculative or actually likely to materialize. Instead, it simply focuses on the costs and ensures that customers are protected by imposing a rate freeze, if not rate reductions, so that the customers at least share in the benefits of the service that is provided at the costs actually incurred.

What if the STB accepts claims that mergers will provide benefits, and then they don't? The customers had no part to play in choosing to merge, and no part in setting the terms. So why should they pay if the alleged "benefits" don't materialize? There is no good answer to that, because the customers shouldn't pay.

In the Union Pacific Railroad/Southern Pacific Railroad merger, about which Frank wrote, I represented many western shippers who allied to seek protection. (Most of them settled, and left the proceeding.) The STB simply assumed that the benefits forecast by UP and SP would come true and that shippers would benefit from the merger. Subsequent events disprove the claims of UP, SP, and the STB. As Justice Holmes once wrote: "A page of history is worth a volume of logic." Service disasters have ensued, and shippers for the most part are not better off, and many are worse off. Hence, as part of the "oversight" process, the shippers and their allies sought relief from the anti-competitive outcome in Houston about which Frank complained.

The STB denied nearly all of the relief sought, demonstrating that its "oversight" conditions—about which Frank complains so much—are really toothless. But even if the STB had pro-

vided relief, no reasonable person could complain, for such relief would have to have been based on evidence that the outcome was not as the STB forecast. Since UP and SP asked for approval based on forecasts that (at least in my hypothetical) would not have materialized, how could they complain if the government stepped in to protect people who cannot help themselves?

But you may ask how can large companies, such as utilities, chemical companies or grain companies who are shippers of bulkgoods by railroad, not have options? In some circumstances, they do, and believe me that when they do they take advantage of the competition rather than file rate cases at the STB. (Believe it or not, just to file such a complaint one must pay a fee of $54,500. No other regulatory agency charges such fees for complaints.) But there are times when they do not have competition, where the railroad is, in other words, a monopoly. And generally speaking, the barriers to entry that define natural monopolies are nowhere more prevalent than with railroads. Frank's thesis, then, seems reduced to this: are we to say to captive customers of public enterprises that exist solely by virtue of government franchise can be allowed to abuse their captive customers, whether as a result of mergers or otherwise? If the answer to my question is "yes," we will have exempted unregulated monopolists even from the antitrust laws for, as Frank admitted, railroad mergers are exempt from antitrust scrutiny (as is the entire body of railroad matters subject to regulation). So the answer must be "no." Like it or not, whether through the antitrust laws or regulation, we depend on a competitive market as the predicate to deregulation. Where there is no market, or the market is not competitive, we regulate, whether through an agency or through antitrust laws.

Lest you have any lingering concern that railroad merger regulation has been "onerous," as compared to the antitrust review at the Department of Justice, suffice it to say that the railroad industry itself successfully opposed transferring that authority from the Interstate Commerce Commission (the STB's statutory predecessor) to the Justice Department in 1995. Again, "a page of history is worth a volume of logic." Obviously the reason for the railroad industry's position was that it preferred not-so-onerous STB regulation to that meted out by DOJ. That position alone disproves Frank's thesis about the onerous nature of STB regulation.

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