

**GRANNY DEALING DRUGS ON THE
GOVERNMENT'S DIME: WHY MEDICARE
AND MEDICAID SHOULD HAVE
SAFEGUARDS IN PLACE TO PREVENT
ABUSE**

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The increased ability of senior citizens to easily obtain reduced or free prescription pain medications from enrollment in Medicare or Medicaid has led to a rise in elders abusing these services, and selling prescription pain medication on the black market. Elderly citizens are rarely questioned when obtaining large quantities of prescription pain medication, yet they are frequently struggling to make ends meet at or below the poverty line. Medicaid and Medicare have both turned a blind eye to the extent that elders purchase and redistribute prescription pain medication. This creates a unique opportunity for struggling seniors to profit from the black market without punishment from regulatory or enforcement agencies. This Note calls for increased oversight from Medicare and Medicaid to prevent criminals from wasting social resources.

I. Introduction

While drug dealing is certainly nothing new, one typically envisions a “drug dealer” as a college age person in a hoodie and jeans, or homeless people living on the streets feeding their addictions. There is a very clear societal picture of the drug dealer, the addict, and the criminal. However, these stereotypes are limiting, especially because illegal drug activity touches the lives of millions of Americans, from

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all walks of life.¹ Societal stereotyping of drug dealers needs to be eliminated to keep up with the current drug epidemic, and hold accountable those profiting from it.

Recent years have brought along a rise in elderly drug dealers, selling their prescription pills for profit, and breaking stereotypes. Old age does not prevent a person from committing a crime. In fact, a majority of seniors are struggling to make ends meet and desperate to pay their bills.² The impoverished desperation that comes along with some of the hardships of old age is the perfect catalyst for this unlawful activity. The distressed elderly feel forced to turn to illegal means for making the money they need to survive.

Currently 3.4 million seniors age sixty-five and older live below the poverty line.³ Millions more are barely making ends meet just above the poverty line.⁴ While the elderly face numerous expenses, healthcare is one of the largest costs that elderly Americans face on a limited budget.⁵ These large expenditures for daily living, coupled with the health issues plaguing the elderly, cause high poverty rates.⁶ Easy access to prescription drugs has created a growing section of the elderly population who sell their medications on the street, in order to support themselves financially.⁷

The elderly are increasingly becoming a main source for prescription drugs.⁸ Officials at Medicare and Medicaid are wasting large amounts of money by allowing people within the programs to sell their prescription medications for profit, and thus need to recognize this is a problem worth looking into. Programs such as Medicare and

1. See generally, JEFFREY S. NEVID ET AL., *ABNORMAL PSYCHOLOGY IN A CHANGING WORLD* 291-327 (8th ed. 2011).

2. Alexandra Cawthorne, *CTR. FOR AM. PROGRESS, ELDERLY POVERTY: THE CHALLENGE BEFORE US 1* (2008), <https://www.americanprogress.org/issues/poverty/report/2008/07/30/4690/Elderly-poverty-the-challenge-before-us/> [hereinafter Cawthorne].

3. *Id.*

4. *Id.*

5. Shoshana Walter, *Officers See More Sick and Elderly Selling Prescription Drugs*, N.Y. TIMES, (Sept. 18, 2010), http://www.nytimes.com/2010/09/19/us/19bcdealers.html?_r=0 [hereinafter Walter]; see generally *Percent of People 65 Years and Over Below Poverty Level in the Past 12 Months*, U.S. CENSUS BUREAU, factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_GCT1703.US01PR&prodType=table [hereinafter *Percent of People*].

6. *Id.*

7. See generally Walter, *supra* note 5.

8. Carolyn Thompson, *NY Bust: Medicaid Patients' Rx Drugs go to Dealers*, YAHOO! NEWS (Dec. 5, 2010), <https://www.yahoo.com/news/ny-bust-medicaid-patients-rx-drugs-dealers.html> [hereinafter Thompson].

Medicaid, which cover at least some, if not all, of the cost of prescriptions,⁹ are creating an opportunity for the elderly to sell those prescriptions, as the low cost of the drugs creates a cheap entry point for building a supply. Cognizance of the problem and its financial effects will be useful in future reform for these organizations.

Medicare and Medicaid patients are largely elderly individuals who live on fixed incomes and have trouble making ends meet. Health care is one of the largest expenses the elderly are burdened by,¹⁰ making it hard for the elderly to live off of fixed incomes that do not account for inflation (e.g. social security or pensions) to pay their bills. It is no wonder that the current drug epidemic¹¹ has given rise to these elderly patients selling their prescription drugs, specifically pain pills, in order to pocket a little extra cash. This influx of income is likely not being used for nefarious purposes, but rather could be used to help elderly individuals keep their lights on or pay for their other necessary medication.

Prescription drug abuse, specifically pain medication, is the nation's fastest-growing drug problem.¹² As such, there is a large demand on the black market for pain pills, something that the elderly have easy access to.¹³ It is not unusual for a month's worth of these prescription pain pills to sell for in excess of four hundred dollars on the street,¹⁴ easing the large financial burdens elderly individuals face.

9. See generally *Your Guide to Medicare Prescription Drug Coverage*, CTRS. FOR MEDICARE & MEDICAID SERVICES (June 2014), https://www.medicare.gov/Pubs/pdf/11109_Your-Guide-to-Medicare-Prescrip-Drug-cov.pdf [hereinafter *Guide to Medicare*]; see also *Prescription Drugs Medicaid.gov*, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/prescription-drugs.html> (last visited Nov. 9, 2016) [hereinafter *Prescription Drugs*].

10. See discussion *infra* Section II.C.

11. *Popping Pills: Prescription Drug Abuse in America*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/info-graphics/popping-pills-prescription-drug-abuse-in-america> (last visited Nov. 9, 2016) [hereinafter *Popping Pills*].

12. Exec. Off. of the President of the United States, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*, WHITE HOUSE, https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf [hereinafter *Epidemic*].

13. See discussion *infra* Section II.b.

14. A 30mg morphine pill will sell for around \$15 in New York City, 30mg pill of Codeine for \$10 in Chicago, and OxyContin 15mg pill for \$12 each in San Francisco. STREETRX: LATEST STREET PRICES FOR PRESCRIPTION DRUGS, <http://streetrx.com> (last visited Nov. 9, 2016). Felice J. Freyer, *Researchers Use Black-Market Drug Website to Gauge Public Health*, BOSTON GLOBE (Apr. 18, 2015), <https://www.bostonglobe.com/metro/2015/04/17/crowd-sourcing-website-reveals-black-market-drug-prices-but-its-purpose-public-health/cSMUlc9JrURxckanwygfFN/story.html>.

Medicare and Medicaid have programs to help lower the expense of prescriptions,¹⁵ and elderly citizens enrolled in these programs can profit greatly by selling painkillers illegally. Medicare and Medicaid are essentially footing the bill for the elderly's supply of pain pills being filtered through the black market.

Creation of committees, whose jobs are to implement safeguards, should be in place to ensure that anyone who is receiving aid through Medicare or Medicaid is actually using the medicine that they are prescribed. Part II provides background information regarding elderly poverty, prescription painkiller misuse and abuse, an overview of Medicare and Medicaid, as well as a synopsis of doctor shopping laws. Part III of this Note analyzes the importance of having Medicare and Medicaid create committees whose purpose is to implement safeguards to ensure that patients are not turning around and selling the pain pills prescribed to them and covered by these programs. Part IV of this Note discusses the legal and policy implications of creating committees and implementing additional safeguards into these programs.

II. Background

The combination of elderly poverty, prescription painkiller misuse and abuse, and the lack of safe guards in place by Medicare and Medicaid have created a rise in elderly drug dealers, wasting resources expended by these programs. It is important to understand the role that each plays in this growing problem.

A. Elderly Poverty

Growing numbers of older Americans are spending their retirement years in poverty, according to a recent Employee Benefit Research Institute Study.¹⁶ Currently, 3.4 million seniors age sixty-five and older are living below the poverty line.¹⁷ Many of these elderly

15. See generally *Guide to Medicare*, *supra* note 9; see also *Prescription Drugs*, *supra* note 9.

16. Emily Brandon, *Poverty Increasing Among Retirees: The Gap Between the Wealthiest and Poorest Retirees is Growing*, U.S. NEWS, (May 21, 2012, 11:50 AM), <http://money.usnews.com/money/retirement/articles/2012/05/21/poverty-increasing-among-retirees> [hereinafter *Brandon*]; *Employee Benefit & Research Institute*, https://www.ebri.org/pdf/notespdf/ebri_notes_04_apr-12.eldpovty.pdf (last visited Nov. 9, 2016).

17. Cawthorne, *supra* note 2, at 1; see generally *Percent of People*, *supra* note 5.

individuals fall into poverty as they age and spend down their savings.¹⁸ While the poverty rate among elderly has fallen to around 9.4% in 2006, the problem of elderly poverty still persists.¹⁹ There are many reasons why the elderly are more susceptible to poverty. Limited incomes, entitlement programs, and health issues are all intricate parts of elderly poverty that need to be understood in order to fully cognize what drives the elderly to sell their pills for profit.

Aside from those living below the poverty line, millions more are barely making ends meet just above the poverty line.²⁰ If there were a better measure of poverty, it would likely show that those numbers are low, and the elderly poverty rate would be considerably greater.²¹ This means more and more elderly people are finding themselves in a position where they need to take extreme measures to afford day-to-day living, because Social Security, pensions, or other retirement plans they have in place are simply not enough.

Most elderly Americans live on limited incomes that are typically fixed and have modest savings.²² Essentially, when the elderly stop working, they do not have the savings or financial security that they expected would be in place to help them remain financially sustainable in retirement. In 2013, citizens enrolled in Medicare had incomes less than \$23,500, which is equivalent to two hundred percent below the poverty line in 2015.²³ Combining low incomes from entities like Social Security, with limited savings is an integral part of many elderly people's struggle to afford daily expenses.

Social Security is the largest entitlement program in the United States today.²⁴ While employed, individuals pay into Social Security in order to receive benefits later on when they retire.²⁵ An individual

18. Brandon, *supra* note 16.

19. Cawthorne, *supra* note 2, at 1.

20. *Id.*; *Percent of People*, *supra* note 5.

21. Cawthorne, *supra* note 2, at 1.

22. Juliette Cubanski, et al., *Poverty Among Seniors: An Updated Analysis of National and State Level Poverty Rates Under the Official and Supplemental Poverty Measures*, THE HENRY J. KAISER FAMILY FOUND. (June 10, 2015), <http://kff.org/medicare/issue-brief/poverty-among-seniors-an-updated-analysis-of-national-and-state-level-poverty-rates-under-the-official-and-supplemental-poverty-measures/> [hereinafter Cubanski].

23. *Id.*; *Percent of People*, *supra* note 5.

24. Peter Diamond & Jonathan Gruber, *Social Security and Retirement in the U.S.*, NAT'L BUREAU OF ECON. RES. 437 (1999), <http://www.nber.org/chapters/c7258.pdf> [hereinafter Diamond].

25. *Ultimate Guide to Retirement: How does Social Security Work?*, CNN, http://money.cnn.com/retirement/guide/SocialSecurity_basics.moneymag/ (last visited Nov. 9, 2016) [hereinafter *Ultimate Guide to Retirement*].

born after 1929 must have worked for at least ten years to earn the mandatory credits necessary to start collecting social security.²⁶ Once credits accumulate, then the individual generally must wait until they are sixty-two or older to start collecting the benefits.²⁷ Thus, like Medicare, Social Security is in place to give aid to the elderly.

The only significant groups of individuals not covered by Social Security today are select state and local government employees.²⁸ However, state and local government employees typically have their own retirement systems in place, comparable to Social Security.²⁹ An example of this type of retirement system is the Teachers Retirement System of Illinois ("TRS"), which provides retirement annuities, disability, and survivor benefits for educators employed in public schools outside of the city of Chicago.³⁰

More than ten million older Americans depend on Social Security for the majority of their income.³¹ Among all older Americans in 2012, almost half relied on Social Security for fifty percent or more of their family income.³² Furthermore, one in four elderly Americans relied on Social Security for ninety percent or more of their family income.³³

While both are entitlement programs, Medicare and Social Security are actually quite distinct. They are both giving aid to elderly individuals, but they serve different purposes. One program to supplement incomes after retirement, and the other to make healthcare

26. *Ultimate Guide to Retirement: Am I Eligible for Social Security Benefits?*, CNN, http://money.cnn.com/retirement/guide/SocialSecurity_basics.moneymag/index4.htm?iid=EL (last visited Nov. 9, 2016).

27. *Id.* (Focusing on the general distribution of social security for the elderly and not social security benefits for disabled individuals).

28. Diamond, *supra* note 24.

29. See generally Alan L. Gustman, et al., *Perspectives: The Social Security Windfall Elimination and Pension Offset Provisions for Public Employees in the Health and Retirement Study*, SOC. SEC. OFF. OF RET. AND DISABILITY POL'Y (2013), <https://www.ssa.gov/policy/docs/ssb/v74n3/v74n3p55.html> (last visited Nov. 9, 2016) (discussing non-covered employment by social security and this type of employment's role in benefits).

30. TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS, PUBLIC RECORD REQUESTS/FOIA, <http://trs.illinois.gov/contact/FOIA.htm> (last visited Nov. 9, 2016) (discussing the purpose behind TRS and its enabling legislation, 40 ILCS 5/16-101, as required by the Illinois Freedom of Information Act).

31. Mikki Waid, *Social Security is a Critical Income Source for Older Americans: State-Level Estimate* (2012), AARP PUB. POLICY INST., http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2014/social-security-critical-income-source-AARP-ppi-econ-sec.pdf.

32. *Id.*

33. *Id.*

affordable. Medicare benefits are commonly considered as part of Social Security benefits, although technically Medicare is a separate program.³⁴ Medicare contributions are withheld from paychecks in the same way as Social Security, although each is withheld separately, as the programs are distinct.³⁵

According to a 2009 report by the U.S. Government Accountability Office, it is estimated there are sixty-five thousand elderly individuals, in five states, who go to six or more doctors to acquire duplicate prescriptions for controlled substances.³⁶ Those sixty-five thousand individuals represent only ten percent of the states who are receiving aid.³⁷ Imagine how that number would grow if the survey took into account all individuals engaging in this behavior, in the other ninety percent of states receiving aid. It is logical that if there are so many drug dealing elderly people in only five states, acquiring duplicate prescriptions for controlled substances is a serious epidemic.

Elderly individuals' limited income can be greatly diminished by high medical bills, leaving little money for other necessities.³⁸ Transportation, energy, food insecurity, and healthcare are only some of the ways in which an impoverished elderly's income can become depleted.³⁹ One of the biggest drivers of poverty in old age is failing health and the associated medical costs.⁴⁰

Almost all senior citizens living in poverty have some sort of health condition.⁴¹ A 2012 report by Fidelity estimated that a sixty-five-year old couple retiring in that year required \$245,000 to cover medical expenses through retirement, more than a fifty percent increase from the estimate in 2002.⁴² Today, it is probable that medical

34. *Ultimate Guide to Retirement*, *supra* note 25.

35. *Id.*

36. U.S. GOV'T ACCOUNTABILITY OFF., GAO-09-957, MEDICAID: FRAUD AND ABUSE RELATED TO CONTROLLED SUBSTANCES IDENTIFIED IN SELECTED STATES (2009) [hereinafter MEDICAID: FRAUD AND ABUSE]; *see also* Thompson, *supra* note 8.

37. MEDICAID: FRAUD AND ABUSE, *supra* note 36; *see also* Carolyn Thompson, *Traffickers Buy Medicaid Patients' Prescription Drugs for Resale on Street*, ASSOCIATED PRESS (Dec. 5, 2010), http://www.cleveland.com/nation/index.ssf/2010/12/traffickers_buy_medicaid_patie.html.

38. Cawthorne, *supra* note 2.

39. *Id.*

40. Brandon, *supra* note 16.

41. *Id.*

42. *Estimated Health Care Costs in Retirement Rise to \$245,000 for a 65-Year-Old Couple Retiring this Year*, FIDELITY BROKERAGE SERVS. LLC (2015), https://www.fidelity.com/bin-public/060_www_fidelity_com/documents/estimated-health-care-retirement-cost.pdf.

costs for the elderly are even more extensive.⁴³ Especially when these large medical expenses are coupled with other bills, it is unreasonable to think that most of the elderly will be financially secure and able to support themselves comfortably later in life.

B. Prescription Painkiller Misuse and Abuse

Prescription painkiller abuse is the fastest growing drug problem in the United States.⁴⁴ The Centers for Disease Control and Prevention classify prescription drug abuse as an epidemic.⁴⁵ From 1999 to 2010 painkiller sales increased by over three hundred percent; from 1.75 kilograms per ten thousand people to 7.1 kilograms per ten thousand people being sold.⁴⁶ Nonmedical use of prescription painkillers has an estimated \$72.5 billion impact to healthcare annually.⁴⁷

Opioid painkillers can be used to treat moderate-to-severe pain and are often prescribed following a surgery, injury, or health conditions, such as cancer.⁴⁸ There has been a dramatic increase in acceptance and use of prescription opioids for the treatment of chronic, non-cancer pain, such as back pain or osteoarthritis.⁴⁹

Narcotics, or opioid pain relievers, are used only for pain that is severe and not helped by other types of painkillers.⁵⁰ When used carefully and under a doctor's care, these drugs can be effective pain relief.⁵¹ Some common narcotics include: Codeine; Fentanyl; Hydrocodone; Hydromorphone; Meperidine; Morphine; Oxycodone; and

43. Niles Williamson, *Increasing Number of US Seniors Living in Poverty*, INT'L COMM. OF THE FOURTH INT'L (March 26, 2013), <https://www.wsws.org/en/articles/2013/03/26/seni-m26.html>.

44. Joel Roberts, *Elderly Turn to Drug Dealing*, CBS NEWS (Dec. 13, 2005, 10:36 AM), <http://www.cbsnews.com/news/elderly-turn-to-drug-dealing/> [hereinafter Roberts].

45. *Epidemic*, *supra* note 12.

46. Joanna Shepherd, *Combating the Prescription Painkiller Epidemic: A National Prescription Drug Reporting Program*, 40 AM. J. L. & MED. 85, 92 (2014) [hereinafter Shepherd].

47. *Understanding the Epidemic, When the Prescription Becomes the Problem*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/drugoverdose/epidemic/> (last visited Sept. 13, 2016) [hereinafter *Understanding the Epidemic*].

48. *Id.*

49. *Id.*

50. *Pain Medications—Narcotics*, MEDLINEPLUS, <https://medlineplus.gov/ency/article/007489.htm> (last visited Nov. 9, 2016).

51. *Id.*

Tramadol.⁵² Although they can be effective pain relief, narcotics can be addictive, and thus, are often abused.⁵³

In 2013, nearly two million Americans had abused prescription painkillers.⁵⁴ Each day, almost seven thousand people are treated in emergency departments for using these drugs in a manner other than as directed, and many other abusers go untreated.⁵⁵ The staggering abuse of prescription pain pills correlates directly of their demand on the black market.

The “perfect storm” of pain control versus risk of misuse and abuse of prescriptions medications is challenging physicians across the country.⁵⁶ Doctors prescribe pain medication to their patients far more often than they did twenty years ago.⁵⁷ From 2007 to 2012, the number of patients sixty-five and older getting Medicare prescriptions for powerful opioid pain medications rose more than thirty percent to upward of 8.5 million.⁵⁸ Not only are the prescriptions for these types of medicine on the rise in general, but there is specifically an increase in the number of elderly individuals receiving the prescriptions.⁵⁹ The elderly make up thirteen percent of the population and yet receive one-third of all prescribed medications.⁶⁰

It is eye-opening and troubling that senior citizens are selling their legally obtained prescriptions.⁶¹ The Oklahoma Department of Corrections records show that about nine percent of the nearly twenty-six thousand incarcerated individuals are older than fifty-one years old, and nearly thirty percent of the prison population is serving time

52. *Id.*

53. *Id.*

54. *Understanding the Epidemic, supra* note 47.

55. *Id.*

56. *Use, Abuse, Misuse, and Disposal of Prescription Pain Medication Time Tool Clinical Reference*, AM. COLL. OF PREVENTIVE MED., <http://www.acpm.org/?UseAbuseRxClinRef> (last visited Nov. 9, 2016) [hereinafter *Use, Abuse, Misuse*].

57. Teresa McQuerrey, *Elderly Selling Pain Medications: Expert Says Dramatic Rise in Prescriptions has Spurred Illegal Sales, Lethal Overdoses*, PAYSON ROUNDUP (Jan. 29, 2013), <http://www.paysonroundup.com/news/2013/jan/29/elderly-selling-pain-medications/> [hereinafter McQuerrey].

58. Peter Eisler, *Seniors' Use of Potent Meds via Medicare Staggering*, USA TODAY (June 10, 2014, 7:15 PM), <http://www.usatoday.com/story/news/nation/2014/06/10/senior-citizens-prescriptions-addiction/10088759/> (referencing a graph created by USA TODAY based on data from the Centers for Medicaid and Medicare Services) [hereinafter Eisler].

59. *Id.*

60. *Use, Abuse, Misuse, supra* note 56.

61. Vallery Brown, *Seniors Might Die in Prison*, NEWSOK (April 3, 2011, 8:26 AM), <http://newsok.com/article/3555145> [hereinafter Brown].

for prescription drug crimes.⁶² One offender admitted that he had multiple doctors in two states.⁶³ He indicated that some drugs were obtained from Veterans Affairs hospitals, and some were bought at different pharmacies and paid for with Medicare Benefits.⁶⁴ This phenomenon is troubling from a financial standpoint, as the elderly abusers are wasting social resources. These illicit sales are also dangerous to social health because elders who illegally sell prescription pain medications increase the amount of dangerous drugs being misused and abused.

Despite a national crackdown on prescription drug abuse, doctors churn out an ever-larger number of prescriptions for the most potent, dangerous, and in-demand controlled substances to Medicare patients.⁶⁵ In 2012, Medicare was financially responsible for nearly twenty-seven million prescriptions for powerful narcotic painkillers and stimulants.⁶⁶ These prescriptions have the highest potential for abuse and dependence.⁶⁷ Given the high potential for abuse and dependence, these prescriptions are the most in demand on the black market, and some of the most profitable.⁶⁸ This makes drug dealing by the elderly an opportunity crime, affording the elders maximum profit with minimum oversight.⁶⁹ This is especially true if the drug-dealing elder has no history of drug abuse or dependence.⁷⁰

While elder drug prescriptions were increasing, use of commonly abused painkillers, like hydrocodone and oxycodone, increased more than fifty percent between 2007 and 2012.⁷¹ What sparked the increase in these types of prescriptions? Many attribute it to the fact that medical professionals are almost obligated to prescribe painkillers to patients in pain or they run the risk of facing lawsuits.⁷² Medical professionals are facing this troubling compulsion to prescribe painkillers

62. *Id.*

63. *Id.*

64. *Id.*

65. Charles Ornstein & Ryann Grochowski Jones, *As Controlled Substance Use Rises in Medicare, Prolific Prescribers Face More Scrutiny*, PROPUBLICA (Dec. 15, 2014), <http://www.propublica.org/article/as-controlled-substance-use-rises-in-medicare-top-prescribers-face-scrutiny> [hereinafter Ornstein].

66. *Id.*

67. *Id.*

68. See generally McQuerrey, *supra* note 57.

69. Brown, *supra* note 61.

70. *Id.*

71. Eisler, *supra* note 58 (referencing a graph created by USA TODAY based on data from the Centers for Medicaid and Medicare Services).

72. McQuerrey, *supra* note 57.

because every patient has the fundamental right to adequate pain control,⁷³ and many patients have the attitude that they should not be in pain.⁷⁴

Approximately one out of twenty Americans report abuse or misuse of prescription painkillers.⁷⁵ It is likely that a laissez-faire attitude towards writing prescriptions is to blame.⁷⁶ As the fastest growing drug problem in the United States, prescription painkiller abuse is classified as a health epidemic by the Centers for Disease Control.⁷⁷ Yet, officials at Medicare and Medicaid have turned a blind eye to wasting resources in furtherance of this epidemic.

The prescription drug epidemic has created a strong and favorable market for those looking to sell prescription pills at a profit. Elders on Social Security, with a limited income of \$500 per month, can turn around and sell their pain pills for ten dollars a piece.⁷⁸ When elders realize how profitable it can be, they will sell half of their medication in order to pay bills, keeping the other half for themselves.⁷⁹ Jails across the country have taken notice that, with the rise of the painkiller epidemic, there are more and more elderly inmates, where a few years ago it used to be a rarity.⁸⁰

Elderly people are looking for a way to bring in a little extra money, and selling drugs is an easy way to do it.⁸¹ While it is more socially acceptable for college students to sell pills for extra cash, it is not a far stretch to think that seniors could be doing it too,⁸² especially with their easy and unquestioned access to larger quantities of prescription pain medication. The “perfect storm” of pain control versus risk of misuse and abuse of prescriptions medications, increases the influx in elderly drug crime and leaves Medicare and Medicaid in a dreadful predicament.⁸³

73. *Use, Abuse, Misuse, supra* note 56.

74. McQuerrey, *supra* note 57.

75. Shepherd, *supra* note 46; *see also* Roberts, *supra* note 44.

76. Roberts, *supra* note 44.

77. *Id.*

78. *Id.*

79. *Id.*; StreetRx, <http://streetrx.com> (last visited Nov. 9, 2016).

80. Roberts, *supra* note 44.

81. *Id.*

82. *Id.*

83. *Use, Abuse, Misuse, supra* note 56.

C. Medicare and Medicaid

Medicare and Medicaid are two different government-run programs that were created in 1965.⁸⁴ The programs were created in response to the inability of older and low-income Americans to buy private health insurance.⁸⁵ Medicare is a federal program that provides health coverage to individuals sixty-five and older or individuals with a severe disability, no matter the income of the individuals.⁸⁶ In contrast, Medicaid is a state and federal program that provides health coverage for individuals with very low income.⁸⁷ Individuals can qualify for both if they are eligible for both, and the programs work together to provide those individuals with exceptional health coverage.⁸⁸

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources.⁸⁹ Each of the multiple Medicaid programs has unique coverage and limitations. Medicaid is a resource that the elderly take advantage of.⁹⁰ This is not surprising, as the elderly are a group that consistently has limited income and resources at their disposal. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.⁹¹

Although pharmacy coverage is an optional benefit under federal Medicaid law, all states currently provide coverage for outpatient prescription drugs to all categorically eligible individuals, and most other enrollees, within their state Medicaid programs.⁹² Large amounts of beneficiaries are taking advantage of this optional program in more ways than one. After opting in to this program, elderly individuals could make back the cost of the prescription and more by

84. *What is the Difference Between Medicare and Medicaid?*, MEDICARE INTERACTIVE.ORG, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=1670 (last visited Nov. 9, 2016).

85. *Id.*

86. *Id.*

87. *Id.*

88. When individuals are eligible for both it is called dual eligibility and they are able to take advantage of both, *see id.*

89. MEDICARE.GOV, <http://www.medicare.gov> (last visited Nov. 9, 2016) [hereinafter MEDICARE].

90. *Seniors & Medicare and Medicaid Enrollees*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html> (last visited Nov. 9, 2016).

91. *Id.*

92. *Prescription Drugs*, *supra* note 9.

selling their prescriptions for profit, the very same prescriptions they got through this federal pharmacy coverage.

Unlike Medicaid, Medicare offers prescription drug coverage for everyone with Medicare.⁹³ This coverage is called "Part D."⁹⁴ Medicare drug plans are run by insurance companies and other private companies approved by Medicare.⁹⁵ The type of drug coverage received by recipients depends on the type of Medicare Advantage Plan they have.⁹⁶ Medicare prescription drug coverage ("Part D") helps recipients pay for both brand-name and generic drugs, and is available for an additional charge.⁹⁷ Part D now covers about 38 million seniors and disabled people.⁹⁸ It also pays for more than one of every four prescriptions dispensed in this country.⁹⁹

It is fairly easy to see how such full and widespread coverage could enable the elderly recipients of the program to profit off of abuse. It is important to fully grasp the concept of doctor shopping and how it can be used to exploit programs such as Medicare and Medicaid.

D. Doctor Shopping Laws

Doctor shopping is when abusers obtain prescriptions from different doctors, allowing the abusers to obtain large quantities or frequent refills of prescription painkillers, when an individual doctor would refuse to issue such quantities.¹⁰⁰ Doctors and pharmacists might not fill or prescribe these medications if they knew that a patient was getting five or six prescriptions for the pills from five or six other doctors. The main tool that doctors possess to learn about a patient's history is the patient himself or herself.¹⁰¹ This means, if there are no laws in place mandating patient disclosure, doctors have fewer dependable resources to use when it comes to their prescribing practices.¹⁰²

93. MEDICARE, *supra* note 89.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. Ornstein, *supra* note 65.

99. *Id.*

100. Shepherd, *supra* note 46, at 92.

101. See generally PETER R. LICHSTEIN, CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LAB. EXAMINATIONS (Walter Hk et al. eds., 3d ed. 1990).

102. *Id.*

Because doctor shopping is such a prevalent issue, “all fifty states and the District of Columbia have a general fraud statute adopting verbatim—or with slight alteration—a provision in the Uniform Narcotic Drug Act of 1932 or the Uniform Controlled Substances Act of 1970.”¹⁰³ The Uniform Narcotic Drug Act states, “[n]o person shall obtain or attempt to obtain a narcotic drug, or procure or attempt to procure the administration of a narcotic drug . . . by fraud, deceit, misrepresentation, or subterfuge [] or . . . by the concealment of a material fact”¹⁰⁴ “The Uniform Controlled Substances Act was introduced much later and included similar language; however, it did not include the phrase ‘concealment of material fact.’”¹⁰⁵ This means that if a doctor does not ask about other prescriptions the patient is currently being prescribed, the patient does not need to disclose that information.

The National Alliance for Model State Drug Laws has compiled all of the State Doctor Shopping and Prescription Fraud Statutes allowing for easy comparison.¹⁰⁶ This compilation shows that in addition to the general fraud statutes that all fifty states have enacted, an additional twenty states have also enacted specific doctor shopping laws that appear as standalone laws or provisions within general doctor shopping laws.¹⁰⁷ Unlike the general fraud statutes, specific doctor shopping laws prohibit patients from knowingly withholding information from practitioners the patients are currently seeing about controlled substances or prescriptions they have received from other healthcare practitioners.¹⁰⁸

“States with general doctor shopping laws prohibit patients from obtaining drugs by any or all of the following means: fraud, deceit, misrepresentation, subterfuge, or concealment of a material fact.”¹⁰⁹ “While all states and the District of Columbia have general doctor shopping laws, the language used in these laws varies across jurisdictions.”¹¹⁰

103. CTRS. FOR DISEASE CONTROL & PREVENTION, *Doctor Shopping Laws*, <http://www.cdc.gov/php/docs/menu-shoppinglaws.pdf> (last visited Nov. 9, 2016) [hereinafter *Doctor Shopping Laws*].

104. *Id.*

105. *Id.*

106. See *State Doctor Shopping & Prescription Fraud Statutes*, NAT’L ALLIANCE FOR MODEL STATE DRUG LAWS (2010), <http://www.namsdl.org/library/169D4DEB-65BE-F4BB-A497350950AD9EC8/> (last visited Nov. 9, 2016).

107. *Doctor Shopping Laws*, *supra* note 103, at 2.

108. *Id.* at 4.

109. *Id.* at 2.

110. *Id.*

“About one-third of states and the District of Columbia have enacted general doctor shopping laws that contain only the Uniform Controlled Substances Act Language.”¹¹¹ “Other states contain language only from the Uniform Narcotic Drug Act.”¹¹² A third group of states “with general doctor shopping laws have used language from both the Uniform Narcotic Drug Act and the Uniform Controlled Substances Act.”¹¹³ A fourth and final group have general doctor shopping laws that do not follow either uniform act verbatim, yet adopt their principles.¹¹⁴ States that fall into this category include Kansas, Maine, and Kentucky.¹¹⁵

“In contrast to general doctor shopping laws, specific doctor shopping laws make it illegal for patients to withhold from practitioners that they have received either any controlled substance or prescription order from another practitioner, or the same controlled substance, or one of similar therapeutic use.”¹¹⁶ The South Dakota doctor shopping law, representative of the ‘specific’ doctor shopping laws, states in part “[a]ny person who knowingly obtains a controlled substance from a medical practitioner and who knowingly withholds information from that medical practitioner that he has obtained a controlled substance, violates the law.”¹¹⁷ The key difference from general doctor shopping laws is in the language “knowingly withholds,”¹¹⁸ which is a blatant focus on disclosure.

“The specific doctor shopping laws may specify disclosure timeframes, types of drugs, and detailed disclosure requirements.”¹¹⁹ “Several states with specific doctor shopping laws define the timeframe within which a patient is required to disclose his previous controlled substance activity.”¹²⁰ Some states use thirty days, or a month, as the measure of proximity.¹²¹

An example of a specific law with a timeframe in place is Montana, “which makes doctor shopping illegal by prohibiting a patient from ‘knowingly or purposefully failing to disclose to a practition-

111. *Id.* at 2-3.

112. *Id.* at 3.

113. *Id.*

114. *Id.* at 4.

115. *Id.*

116. *Id.*

117. *Id.* (quoting S.D. Codified Laws § 22-42-17 (1990)).

118. See generally *id.*

119. *Id.* at 4-5.

120. *Id.* at 5.

121. *Id.*

er . . . that the [patient] has received the same or similar dangerous drug or prescription for a dangerous drug from another source within the prior [thirty] days.”¹²² “Wyoming also provides a good example by prohibiting an individual from ‘receiv[ing] the same or similar controlled substance . . . within the prior thirty (30) days.’”¹²³

Other states require disclosure of controlled substances or prescriptions received within a concurrent timeframe.¹²⁴ This is especially important because there are elderly individuals who are doctor shopping while on Medicaid or Medicare in order to sell the excess prescriptions on the black market.¹²⁵ Unfortunately, only eight states with specific doctor shopping laws require a patient to disclose previous drugs or prescriptions,¹²⁶ when the current practitioner is proposing treatment by a controlled substance with the same or similar therapeutic use as those already received or prescribed.¹²⁷

In addition to time and drug type provisions, two states have additional disclosure requirements.¹²⁸ Louisiana requires a patient’s disclosure to include “the name of the controlled dangerous substance, the date of the prescription, the amount of the controlled substance prescribed, and the number of refills if any.”¹²⁹ Maine prohibits failing to disclose “the particulars of every narcotic drug,” by another prescriber within thirty days.¹³⁰ Connecticut and Hawaii have specific doctor shopping laws that also take a different approach to prohibiting non-disclosure of information to obtain controlled substances.¹³¹ Connecticut prohibits non-disclosure of such information only with “the intent to obtain a quantity of controlled substances for abuse.”¹³² Hawaii’s law specifies that a patient’s nondisclosure is a violation of the specific doctor shopping law only if the “total quantity of drugs

122. *Id.* at 5-6 (quoting MONT. CODE ANN. § 45-9-104 (2011)).

123. *Id.* at 5 (quoting WYO. STAT. ANN. § 35-7-1033 (2008)).

124. *Id.* at 5.

125. Brown, *supra* note 61.

126. Ornstein, *supra* note 65.

127. *Id.*

128. LA. REV. STAT. ANN. § 40:971(B)(1)(i) (2016); *see also Doctor Shopping Laws, supra* note 103.

129. LA. REV. STAT. ANN. § 40:971(B)(1)(i) (2016); *Doctor Shopping Laws, supra* note 103.

130. ME. REV. STAT. ANN. tit. 17 § 1108 (2016); *Doctor Shopping Laws, supra* note 103.

131. *Doctor Shopping Laws, supra* note 103.

132. CONN. GEN. STAT. § 21a-266(n) (2016); *Doctor Shopping Laws, supra* note 103.

prescribed would exceed what a single practitioner would prescribe for same time period and legitimate medical purpose.”¹³³

While these laws were not created specifically with elderly patients in mind, they address the potential illicit activity that elders feel the need to partake in to stay financially afloat. The overarching concepts and themes from each state are essential for officials at Medicare and Medicaid to understand, especially if beneficiaries’ violation of state law will affect their benefits.

III. Analysis

As their fixed financial resources deplete faster with growing medical costs, the elderly must seek other ways to make ends meet. Not only are growing costs a problem, the fact that some of the elderly’s fixed incomes do not account for inflation creates a growing financial issue. Desperate to pay the bills, and focused on survival, the elderly are turning more and more to unlawful activities. Drug dealing is one of the illicit activities that can bring in large amounts of money with relative ease.

Elderly persons are fighting an uphill battle trying to make ends meet. They are not able to live off the income they are receiving from social security, especially when it becomes depleted due to astronomical medical expenses. An estimated forty percent of the elderly are selling their pain medications to supplement their Social Security incomes.¹³⁴ While there has been slight progress, more needs to be done to recognize the problem¹³⁵ we are being faced with so that reform will be effective.

It is clear that the current prescription drug epidemic coupled with the elderly’s easy access to pain medication creates a solution to poverty some elderly people are not willing to walk away from. Harvey Fraley, age sixty-nine, was arrested for taking prescriptions obtained through legitimate providers and putting them on the black market for distribution.¹³⁶ Sadly, Fraley is not alone, elderly individuals into their eighties have been arrested for distributing narcotics in

133. HAW. REV. STAT. § 329-46 (2016); *Doctor Shopping Laws*, *supra* note 103.

134. McQuerrey, *supra* note 57.

135. Cawthorne, *supra* note 2.

136. *69-Year-Old Man Accused of Selling Prescriptions, Officials Say*, WSOCTV.COM (June 10, 2015), <http://www.wsocvtv.com/news/news/local/69-year-old-man-accused-selling-his-prescriptions-/nmZty/> (last visited Nov. 9, 2016).

recent years, according to law enforcement officials.¹³⁷ Doctor shopping gives way to easy access to multiple prescriptions, allowing the elderly the means they need to deal drugs. While doctor shopping laws are in place—making these types of actions illegal—there is simply not enough monitoring to effectively enforce them.

Often at no charge, under Medicare and Medicaid, beneficiaries can see one, or several, doctors and come away with prescriptions for narcotics that they can then sell to a dealer or addict.¹³⁸ These prescriptions can retail for as much as \$1,000.¹³⁹ Medicaid and Medicare then are billed around \$1,060 for the prescription along with another charge for the doctor's visit.¹⁴⁰ While free prescriptions and doctors visits make this lucrative and relatively painless for the elderly, the exorbitant cost to these programs coupled with the flood of addictive and abused drugs into the streets should be enough to emphasize the need for reform.

A 2011 report by the U.S. Government Accountability Office found that, in 2008, approximately 170,000 Medicare beneficiaries received prescriptions from five or more medical practitioners for the frequently abused controlled substances.¹⁴¹ These prescriptions accounted for \$148 million in prescription drug costs, most of which was covered by Medicare.¹⁴² In 2012, Medicare covered nearly twenty-seven million prescriptions for powerful narcotic painkillers and stimulants with the highest potential for abuse and dependence.¹⁴³ This was a nine percent increase from 2011, compared to a five percent increase in Medicare prescriptions overall.¹⁴⁴

If an elderly person meets certain income and resource limits, they may qualify for the Extra Help program from Medicare to pay the costs of Medicare prescription drug coverage.¹⁴⁵ In 2015, the individuals who qualified for the Extra Help program from Medicare would be paying no more than \$2.65 for generic prescriptions and no

137. *Id.*

138. Thompson, *supra* note 8.

139. *Id.*

140. *Id.*

141. Shepherd, *supra* note 46, at 92; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-699, MEDICARE PART D: INSTANCES OF QUESTIONABLE ACCESS TO PRESCRIPTION DRUGS (2011) [hereinafter MEDICARE PART D].

142. Shepherd, *supra* note 46; *see also* MEDICARE PART D, *supra* note 141.

143. Ornstein, *supra* note 65.

144. *Id.*

145. MEDICARE, *supra* note 89.

more than \$7.40 for brand name prescriptions.¹⁴⁶ This means that the potential profit for the elderly enrolled in this program is much larger than that of individuals paying full price for their medications.

Sixty-five thousand Medicaid recipients, in five states, had gone to six or more doctors to acquire duplicate prescriptions for controlled substances.¹⁴⁷ The cost to Medicaid for these drugs alone was sixty million dollars, and that excludes the cost of the doctors' visits.¹⁴⁸ Thus, it is reasonable to assume that the amount of resources that Medicaid expends on drugs for its beneficiaries would be greatly reduced if this problem were resolved. Doctor shopping laws and databases are in place to prevent, or at least limit, this behavior, and yet they are not enough because they are not being utilized by Medicare and Medicaid.

Although this is obviously a serious problem, a national spokeswoman for the DEA stated that the DEA does not keep track of how many defendants in drug cases are Medicaid Recipients.¹⁴⁹ The lack of DEA tracking shows just how little the federal government has done to address this problem. Tracking this type of information could prove to be essential to future reform. There are no possible means for eliminating abuse within the system—unless the DEA begins tracking this information, doctor shopping laws are being enforced, or databases are being utilized.

Furthermore, if elderly individuals, who think that what they are doing is harmless, know that their name and information will be placed in a database, they are much more likely to give drug dealing a second thought. Prescription Drug Monitoring Programs ("PDMPs") are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.¹⁵⁰ These databases are an excellent indicator of doctor shopping. PDMPs can be used as a tool to not only monitor and share information about drug abuse and misuse,¹⁵¹ but also as a deterrent. The elderly, once con-

146. *Id.*

147. Thompson, *supra* note 8.

148. *Id.*

149. John Fauber, *Narcotic Painkiller Use Booming Among Elderly*, MILWAUKEE J. SENTINEL (May 30, 2012), <http://www.medpagetoday.com/Geriatrics/PainManagement/32967> [hereinafter Fauber].

150. *Prescription Drug Monitoring Programs (PDMPs)*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/drugoverdose/pdmp/index.html> (last visited Nov. 9, 2016) [hereinafter PDMPs].

151. *Id.*

fronted with the fact that they are being monitored, might not go through with selling their prescriptions.

While thirty-seven states had fully operational PDMPs,¹⁵² they are not as fully implemented as they need to be. Medicaid Programs are typically provided access to information about Medicaid members or providers.¹⁵³ However, certain programs, such as Medicare and Medicaid, need unlimited access to PDMPs and ultimately need to make use of them. This is important because elderly doctor shoppers may go to multiple states to get prescriptions, and their illicit activity must be tracked.

With the new regulations in place, it is possible for states to track the prescribing and purchasing of pain medications.¹⁵⁴ PDMPs are already helping officials monitor who is getting what types of pills and in what quantity. The database system is useful in ensuring that patients are not doctor shopping and getting multiples of the same prescriptions filled in order to sell the excess pills. These are all benefits that could be an integral part of reformation for entities like Medicare and Medicaid. If access to state and federal databases were shared with Medicare and Medicaid, then the entities would prevent or limit the elderly from abusing the system in order to make a quick buck.

Part of the reason that a database is needed is because of the medical field's lackadaisical attitude towards pain and pain medication. Leading pain and addiction medicine experts say there is increasing evidence of doctors being scammed for large doses of prescription drugs, particularly addictive opioids such as OxyContin.¹⁵⁵ If doctors take the attitude that no patient, especially an elderly one, should be in pain, then they are opening the door for immense amounts of abuse. This attitude towards pain management makes it essential that doctors cross reference patients' medical history with the database.

"Enhanced interstate data sharing is essential if a PDMP is to help identify sources of prescription drug abuse, misuse, and diversion, and encourage early intervention and prevention," which is something that states should be working towards.¹⁵⁶ Currently, only eighteen states allow for the exchange of PDMP data with other out of

152. *Id.*

153. *Id.*

154. McQuerrey, *supra* note 57.

155. Thompson, *supra* note 8.

156. NAT'L CONF. OF INS. LEGIS. (NCOIL), NCOIL BEST PRACTICES TO ADDRESS OPIOID ABUSE, MISUSE & DIVERSION (2014) [hereinafter NCOIL].

state PDMPs and the entities that are authorized to use them.¹⁵⁷ If more states allowed for interstate sharing or even allowed access to their programs by Medicare and Medicaid, there could be a significant crack down on elderly misuse and abuse of prescription pain pills. In fact, a 2002 U.S. Government Accounting Office report concluded that state PDMPs provide a useful tool to reduce drug diversion,¹⁵⁸ and thus should be utilized as such.

Each state approaches the PDMP system differently, and along with the various approaches to data, the term “authorized user” varies from state to state.¹⁵⁹ More work needs to be done to maximize the effectiveness of PDMPs.¹⁶⁰ Essentially, not having certain authorized users, like Medicare and Medicaid, in place could be preventing the PDMPs from reaching their full potential.¹⁶¹ For example, some states’ PDMPs do not authorize Medicare or Medicaid to access the information gathered.¹⁶² A fully functioning and effective PDMP should be a resource for a substantial body of accurate information.¹⁶³ This means that these databases could be just what Medicaid and Medicare reform needs in order to work towards eliminating elderly drug dealing and prescription drug abuse.

While there are doctor shopping laws in every state, these laws leave the responsibility on the patient to report to their providers the medications they are being prescribed.¹⁶⁴ This means patients are essentially required to report their own doctor shopping. The laws that are in place are great in theory, but not effective. Medicare and Medicaid need to rely on something else. This is why other means of identification and reporting are essential to future reform.

As doctor shopping has increased in recent years, there has been a shift to a greater reliance on electronic health records included in recent federal reforms.¹⁶⁵ These databases may provide an alternative means of tracking who is getting pain medication, but that is not

157. *Id.*

158. U.S. GOV’T ACCOUNTABILITY OFF. GAO-02-634, PRESCRIPTION DRUGS: STATE MONITORING PROGRAMS PROVIDE USEFUL TOOL TO REDUCE DIVERSION (2002); *see also Epidemic, supra* note 12.

159. NCOIL, *supra* note 156, at 2.

160. *Epidemic, supra* note 12, at 5.

161. NCOIL, *supra* note 156, at 2.

162. *Id.*

163. *Id.*

164. *Id.* at 1.

165. McQuerrey, *supra* note 57.

enough.¹⁶⁶ The reforms have already spurred the creation of a medical database to which pharmacies have access.¹⁶⁷

Shockingly, up until one year ago, in California, pharmacists and physicians had no way of knowing how recently a patient had filled a prescription.¹⁶⁸ California created a statewide database that allows pharmacists to look up that information.¹⁶⁹ States are not the only entities in that predicament. In fact, Medicare and Medicaid leave pharmacists and physicians in the dark as well. When state officials, or officials at Medicare and Medicaid, appear to be unconcerned with problematic prescribing practices, it allows for patients and prescribers alike to abuse the system.

Although pharmacists are not required to access it,¹⁷⁰ the database is an excellent tool to use hand-in-hand with more substantive reform. If more states adopted this method for keeping records, it would create a better way to monitor which individuals are obtaining multiple prescriptions for control substances. This is especially true because unlike doctor shopping laws, the database is independent of the patient reporting to providers their prescription history. It would also lend itself to determining which individuals should be on the receiving end of multiple prescriptions. While state and federal government access to these databases is a wonderful development, there is still a piece of the puzzle missing. If Medicare and Medicaid had access to these types of databases, then there is a major possibility of reform that these entities so desperately need.

Fortunately, databases are not the only way to curtail abuse by Medicaid patients. According to the National Conference of State Legislatures, several states, including Alaska, Florida, Maine, Ohio, South Carolina, and West Virginia, require state approval before OxyContin prescriptions are filled.¹⁷¹ Procedures like state approval, coupled with the database system or other safeguards, would ensure that no individual slips through the cracks. If Medicare and Medicaid follow suit, they could require approval for these prescriptions and cross-reference patients with PDMPs.

166. *Id.*

167. *Id.*

168. Shoshana Walter, *In Tough Times, Grandpa Pushes Pills*, BAY CITIZEN (Sept. 18, 2010), <https://www.baycitizen.org/news/crime/tough-times-grandpa-pushes-pills/>.

169. *Id.*

170. *Id.*

171. Thompson, *supra* note 8.

Unfortunately, states without that safeguard in place leave more opportunities for Medicare and Medicaid users to abuse the system. Nearly ten thousand New York Medicare recipients were placed on restricted status, by the program, for suspected doctor shopping.¹⁷² This is merely an example from a single state, but it depicts a larger, more serious problem. Placing individuals identified as doctor shoppers on restricted status limits them to one prescriber, one pharmacy, or both for receiving prescriptions.¹⁷³ While Medicare is able to put patients on restricted status for suspected illicit activity, dropping them from Medicaid is not allowed unless it can be proven that a crime occurred.¹⁷⁴ Unfortunately, putting abusers on restricted status seems to be a rarity with Medicaid.¹⁷⁵

In 2013, Medicare did not proactively analyze its prescribing data or take action against providers whose patterns were troubling, even if they had been charged with Medicare fraud or kicked out of state Medicaid programs.¹⁷⁶ Most of Medicare's top prescribers of OxyContin in 2010 had legal or disciplinary actions filed against them; nonetheless, many retained the ability to prescribe in Part D.¹⁷⁷ This is a strong indicator that Medicare is allowing doctor shopping and prescription abuse to continue with little to no ramifications. There can be no expectation of reform without the support of the programs being abused.

Doctor shopping is a growing issue, as evidenced by all fifty states, as well as the District of Columbia, enacting laws defining and addressing doctor shopping. While these specific and general laws make it clear when an individual is overstepping, Medicare and Medicaid have not adopted these laws, meaning it is unclear when a Medicare or Medicaid beneficiary is crossing the line. Furthermore, there are very few safeguards in place to ensure that people who are doctor shopping on Medicare or Medicaid's dime will be caught.

Doctor shopping for addicts is a well known phenomenon,¹⁷⁸ but doctor shopping is often overlooked for the elderly,¹⁷⁹ and societal stereotypes are hindering reformation. Medicaid and Medicare patients,

172. *Id.*

173. MEDICARE PART D, *supra* note 141.

174. Thompson, *supra* note 8.

175. *See generally* Ornstein, *supra* note 65.

176. *Id.*

177. *Id.*

178. Fauber, *supra* note 149.

179. *Id.*

who are doctor shopping, end up getting large quantities of medicine that they do not need, and plan to sell, at the expense of these programs. Programs like Extra Help from Medicaid can reduce the cost of a prescription to between two and six dollars, meaning the program is absorbing a fairly large cost.¹⁸⁰ Because most people, including doctors, are not suspicious of the elderly, they can go to multiple doctors for the same ailment and get multiple prescriptions. Then, when the elderly only have to pay a small portion of the prescription, through programs like Extra Help, they are incentivized by the possibility of reaping larger profits.¹⁸¹

Medicare and Medicaid are paying for this illicit behavior in more ways than one by not taking advantage of the doctor shopping laws present in each state and access to PDMPs. These laws and databases are an essential part of reform. It is crucial that Medicare and Medicaid utilize these safeguards to curb future abuse.

IV. Recommendations

The repercussion of not recognizing the severity of the elderly selling their Medicaid and Medicare prescriptions for profit is a waste of social resources. Medicare and Medicaid are in place to make health care more affordable, especially for those living at or below the poverty line.¹⁸² The elderly make up a large portion of that population, with 3.4 million over the age of sixty-five living in poverty.¹⁸³ It is important for the individuals running those programs to take a special and vested interest in how the elderly are using the aid that they are receiving.

Medicare and Medicaid are allowing for the abuse of the programs by the people the programs are meant to help the most. The programs are turning a blind eye to the misuse of medication and abuse of the system. The abuse of the system is only going to increase the severity of the growing drug epidemic that Americans are facing. Because resources are diminishing, it is critical that agents of Medicare and Medicaid assess program spending and ensure that the programs are not being financially wasteful. The fact that Medicare and Medi-

180. MEDICARE, *supra* note 89.

181. *Id.*

182. See generally Diane Rowland & Barbara Lyons, *Medicare, Medicaid, and the Elderly Poor*, 18 HEALTH CARE FIN. REV. 2 (1996).

183. Cawthorne, *supra* note 2.

caid are spending millions of dollars to cover prescriptions that end up on the black market is a completely inefficient use of resources. Creating a committee or position within the program to establish clear doctor shopping and drug misuse rules along with their repercussions, work with states, and monitor PDMPs is the best way to create change and spark reform.

Problematic prescribing practices are a leading contributor to the current drug epidemic¹⁸⁴ and one of the ways the elderly get large quantities of these drugs. Because of this widespread and complex issue, cities and states across the country have taken steps to improve painkiller prescribing and prevent prescription misuse, abuse, and overdose;¹⁸⁵ however, more needs to be done in conjunction with the elderly's role in this epidemic. Committees or agents should be in place to monitor databases, enforce doctor shopping laws, and ensure that progress is being made by Medicare and Medicaid.

States can take steps to improve prescribing practices in public insurance programs like Medicaid through the use of committees or specialized agents.¹⁸⁶ The use of state PDMPs gives healthcare providers information to improve patient safety and protect patients, while still preserving patient access to safe and effective pain treatment.¹⁸⁷ The implication of a program like that could be absolutely essential to the reform of programs like Medicare and Medicaid and limiting the over-accessibility to prescription drugs by the elderly.

PDMPs monitor patient information to assess suspected abuse or channeling of drugs into illegal use.¹⁸⁸ The information is then made accessible to prescribers or pharmacists so that they are aware of a patient's controlled substance prescription history.¹⁸⁹ Furthermore, this type of database would allow for the identification of high-risk patients.¹⁹⁰ PDMPs are considered to be on the level of some of the most promising state-level interventions to improve painkiller prescribing.¹⁹¹

As these types of programs continue to develop, they could be a game changer in future Medicare and Medicaid reform, particularly if

184. *Understanding the Epidemic*, *supra* note 47.

185. *Id.*

186. *Id.*

187. *Id.*

188. *PDMPs*, *supra* note 150.

189. *Id.*

190. *Id.*

191. *Id.*

they are implemented correctly. Having a person, or group of people, in place to monitor the database and enforce the rules will be equally important in reform. A committee, or agent, in place for the sole purpose of monitoring this system, enforcing doctor shopping laws, giving patient approval for prescriptions, or a combination of the three, will ensure elderly abusers do not slip through the cracks.

The implementation of a federal or state database, let alone both, could be a driving force in the elimination of Medicare and Medicaid abuse by elderly drug dealers, especially if monitored by an agent or group specially trained in this area. If the elderly are unable to doctor shop, it eliminates multiple prescriptions that they would be able to sell for a profit at the expense of one of these programs. While it might not seem apparent, PDMPs support access to legitimate medical use of controlled substances.¹⁹² PDMPs also identify and prevent, or at least deter, drug abuse and diversion.¹⁹³ Furthermore, PDMPs also inform public health initiatives through outlining of use and abuse trends.¹⁹⁴

Per state law, PDMPs monitor controlled substances as defined by federal and state-controlled substances laws.¹⁹⁵ Most PDMPs collect data on federal schedules II-IV, which includes narcotics like hydrocodone.¹⁹⁶ If Medicare and Medicaid subscribed to the doctor shopping laws that states have enacted and coupled that with more diligent and unlimited access to the PDMP system, there is a possibility of greatly reducing the amount of elderly individuals abusing the system to make ends meet. This is particularly true if an agent or committee is in place to monitor and enforce the breaking of state doctor shopping systems by way of a PDMP system.

The White House has listed actions that will be taken to assist states in addressing doctor shopping and pill mills.¹⁹⁷ The solutions include: an increase of intelligence-gathering and investigation of prescription drug trafficking, including increases in joint investigations by federal, state, and local agencies (such as Medicare and Medi-

192. U.S. DEP'T OF JUSTICE, DRUG ENF'T ADMIN., OFF. OF DIVERSION CONTROL, *State Prescription Drug Monitoring Programs* (June 2016), http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm.

193. *Id.*

194. *Id.*

195. *Prescription Drug Monitoring Frequently Asked Questions*, PRESCRIPTION DRUG MONITORING PROGRAM: TRAINING & TECH. ASSISTANCE CTR., <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq> (last visited Nov. 9, 2016).

196. *Id.*

197. *Epidemic*, *supra* note 12.

caid);¹⁹⁸ identifying and seeking to remove administrative and regulatory barriers to “pill mill” and prescriber investigations that impair investigations while not serving another public policy goal;¹⁹⁹ expanding the use of PDMP data to identify criminal prescribers and clinics by the volume of selected drugs prescribed;²⁰⁰ using PDMP data to identify “doctor shoppers” by their numbers of prescribers or pharmacies.²⁰¹ If programs like Medicare or Medicaid implement even just a few of those strategies to try to eliminate elderly drug abuse and dealing, then they would be taking a step in the right direction, towards reform. In fact, forward momentum could be obtained through a committee monitoring PDMPs and interpreting the data. This is the best time to create a committee or place an official in charge of reform and by training them on the information listed above and allowing them access to PDMPs.

The rise in opioids prescribed to elderly individuals should show a corresponding increase in the time that Medicaid and Medicare are spending to ensure that money, and other resources, are not being wasted to help elderly individuals purchase prescription opioids and sell them at a profit.²⁰² Unfortunately, we are not seeing this corresponding increase, which is something a committee could help combat. Because healthcare is so expensive, and Medicare and Medicaid are absorbing these costs, having safe guards in place to ensure that money is not being wasted is essential. For a fraction of the amount of money wasted, Medicare and Medicaid could create specialized committees to monitor and enforce laws regarding the beneficiaries of the programs. It seems unreasonable to take on the financial burden of paying for prescription painkillers that will eventually make it out onto the black market. If programs like Medicare and Medicaid cracked down on the abuse at their expense, they would be able to apply those resources to other more valuable causes.

If these programs keep paying for people who abuse the system, then there could be major financial, or even liability, issues arising in the future. Medicare and Medicaid should create committees who are trained on state doctor shopping laws, know how to monitor PDMPs,

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.*

202. Julia Medew, *Seniors Selling off Their Drugs*, SYDNEY MORNING HERALD (Nov. 18, 2012), <http://www.smh.com.au/national/seniors-selling-off-their-drugs-20121117-29jb1.html>.

and have the tools to enforce these policies. Thus, if Medicare and Medicaid do not want to be servicing drug dealing at the programs' expense, then there should be a focus on gaining a thorough understanding of the problem and implementing a solidified plan that is working towards future reform.

V. CONCLUSION

Medicaid and Medicare need to be more aware of the prevalent use of the black market for the elderly to sell their prescription pills. Elderly individuals struggling to pay their bills may view this as a relatively easy and harmless way to make extra cash. If Medicaid and Medicare agents were more cognizant of this growing problem, then there would likely be less money wasted on prescriptions that will ultimately be sold to a dealer or an addict. It is important to eliminate these programs' contribution to the growing prescription painkiller abuse epidemic.

There is very little public awareness on such a rapidly growing issue. While prescription drug abuse is gaining widespread publicity, the role that the elderly play in the epidemic still goes relatively unnoticed. It is unacceptable that more is not being done to create boundaries to preclude the elderly from using their healthcare aid through Medicare and Medicaid to purchase large quantities of prescription painkillers and then sell them at a profit. Awareness will in turn lead to future reform which is necessary to ensure that the financial losses from this illicit activity cease. A committee in charge of using the PDMPs, enforcing doctor shopping laws, implementing an approval process for painkillers, or a combination of the above will prevent Medicare and Medicaid from continuing to enable elderly drug dealers.