Oregon health care rationing plan is a dangerous precedent

by Linda Everett

Secretary of Health and Human Services Donna Shalala announced on March 19 her provisional approval of a plan of the state of Oregon to expand its Medicaid program and ration health care services to its most needy residents—the poor, uninsured, elderly, and disabled. Shalala said that since 1989, when the state initiated a process to "meet the health care needs of all its people," Oregon has significantly modified its proposal to the federal government to waive more than a dozen requirements that states typically must meet to qualify for federal Medicaid matching funds. Her decision to grant those waivers, Shalala said, "reflects a deeply held philosophy of the Clinton administration. We believe the federal government must give states the flexibility to design new approaches to their local problems, provided those initiatives observe federal standards. . . . The American people want, need, and deserve peace of mind of knowing that their health care needs will be covered."

The facts, however, both regarding the open-ended rationing of the plan itself, as well as the *known* horrors experienced by patients under a managed care system of delivery of services on which the Oregon plan depends, speak differently. It bodes ill for the future of health care reform that Shalala took lightly the concerns raised in a March 16 letter sent to the White House by a coalition of over 70 organizations, representing tens of millions of Americans including the elderly, the handicapped, unions, and civil rights advocates, all of which urged the administration to reject the rationing plan because it violates the Americans With Disabilities Act.

Shalala set certain conditions for the waiver, but no provisions can reverse the fundamental flaw in this plan, which destroys the Hippocratic ethic that has historically guided both the practice and science of medical care in this country—the safeguarding and enhancement of all human life.

Don't become seriously ill

Most media coverage of the plan focuses on how it rations health care by eliminating any services not provided for by the state's biannual budget. Bob Griss of the United Cerebral Palsy Foundation and spokesman for the coalition, points out another form of rationing, in which the state seems to force out of the plan the patient population whose needs are chronic and complicated. The list of prioritized medical services is based on the needs of the average patient—while persons with disabilities or chronic conditions often "require different health services to avoid death and maintain health."

Oregon's plan for the poor is also just a springboard for imposing top-down state controls on what medical treatments or technologies are approved, used, or denied overall in state-covered insurance programs, and economically discouraged in private ones. The Oregon Health Resources Commission is charged with making recommendations by which "the state can act to limit excessive acquisition and utilization of such medical facilities, technologies, and services as the commission determines warranted."

There are three parts to Oregon's plan, the centerpiece of which is the expansion of Medicaid coverage to about 120,000 more of the state's uninsured residents with family incomes below the federal poverty level (about $14,343 for a family of four). The state also passed "pay or play" legislation that requires all employers by 1995 to either provide a basic benefit package like the Medicaid plan to employees working at least 17.5 hours a week, or to pay into a general fund. Already in effect is a plan that provides coverage to anyone rejected by private insurers because of existing conditions. The state's general fund cannot pay the estimated $116 million needed to fund the expanded Medicaid plan, so it was designed to eliminate some life-saving services to the poor and reduce medical services overall. Gov. Barbara Roberts has also proposed a gross receipts tax on all providers. Allegedly, the federal government will pay $1.65 for every $1 paid by Oregon hospitals and physicians. *EIR* was told that providers who treat patients on the Medicaid plan will be paid back because the tax assures that they are at least paid for services rendered. Historically, doctors and hospitals were reimbursed only a small percentage of the cost of a service from Medicaid, and were not reimbursed at all for treating the uninsured poor. Those who refuse to ration services under the Medicaid program will still be taxed.

The plan ranks 688 medical conditions and the approved medical treatment for each, according to treatment cost, medical "effectiveness," and alleged "social value." For instance,

appendicitis and its treatment, appendectomy, rate high on the list as a condition-treatment pair. The state budget dictates how many services will be provided, eliminating those lower on the list. Already, about 150 medical treatments fall below the budget cutoff. The services which are funded shrink each time the state budget shrinks. Only after Governor Roberts promised not to allow any further cutback in services for the next five years of the demonstration, did a formidable critic of the plan, Rep. Henry Waxman (D-Calif.), agree not to block passage of the plan.

Rationing 'rationally'

The social "value" of a treatment, which has nothing to do with what medical science can do to save or extend life, is a formula developed after malthusian economic policy planners spent years brainwashing Oregonians in meetings and surveys debating "Who should live, who should die?" This subjective "value," heavily biased against treating older or handicapped patients in favor of preventive and primary care for the generally healthy working population, affects both the likelihood that a treatment will be funded and also the kind of treatment allowed. This more subtle rationing is harder to recognize, because conditions like birth trauma in newborns or coma appear high on the list, leading one to believe treatment for the condition is covered. But, only "medical therapy" (not medical treatment or surgery) is listed as the approved treatment. Similarly, once a diagnosis of "terminal" cancer is given, palliative care only is allowed, even though "terminal" can mean five years of life with medical intervention.

The plan says it provides "unlimited medically necessary hospitalization for any covered treatment." That sounds reasonable, except the terms "medically necessary" and "medically effective" are defined according to the latest malthusian guidelines rammed through hospitals or courts of law. One Minnesota hospital went to court to demand the end of "futile" ventilator support that kept alive a woman who asked for all life-saving treatment. Even life-sustaining treatment and basic patient feeding have been considered "futile."

The problem becomes exacerbated under managed care and health maintenance organizations (HMOs), where doctors and hospitals must provide all the medical treatment a patient needs for a flat rate, called capitation. Under such a system, there is a financial incentive to withhold treatment, so doctors become gatekeepers blocking access to specialists and testing. The well-established medical standards that define when individual patients need treatment (medical necessity) are replaced with a determination of a treatment's "medical effectiveness" based on the experience of "average patients."

Multiple or chronic problems need treatment, but doctors may not find a "medically effective" treatment on Oregon's list. Also, medical treatments that result in a residual symptom, like a disability, are ranked *lower* than treatments that eliminate all symptoms. So, even if that treatment saves your life, you could be denied treatment.

No guarantee of treatment

Addressing this bias, Shalala said Oregon must not allow its "medical effectiveness criterion" to take into account the change in a patient's functional limitation as a result of treatment. Shalala also instructed Oregon doctors to find another funded service if a person's condition is not on the list of funded treatments. But, that's no guarantee. First, doctors and hospitals are protected from liability *even if* they withhold medical services that are on the prioritized list. Besides, how much time will a doctor in managed care, who profits when limiting access to specialists, spend to learn alternatives to a prescribed treatment, let alone the treatment for any one of the 4,000 rare diseases out there, most of which are not on Oregon's list? And, is it realistic to expect primary physicians to understand the integrated needs of people suffering from any one of thousands of disabling conditions?

Take the example of Dr. Robert White of Yale-New Haven Hospital in Connecticut and one of the few specialists in the country with the expertise to treat hereditary hemorrhagic telangiectasia (HHT). He must spend hours, and sometimes entire weekends, to convince managed care or HMO programs to pay for preventive and life-saving treatment. Either the base-line medical workup is rejected repeatedly or, typically, physicians treat one symptom of the disease, not knowing it affects four organs, causes brain aneurisms and malformations, intractible bleeding in the nose, lungs, and gastrointestinal system, and could cause strokes and possible death in the third trimester of pregnancy. Another crisis arises when these managed care patients are not allowed to participate in experimental protocols at university hospital centers that could save more lives and be truly cost-effective.

Despite the fact that Shalala was a longtime board member of the Children's Defense Fund, which details the poor health care the nation's children receive, she stated that under Oregon's new Medicaid plan "no one now covered will lose coverage." She overlooked the fact that Oregon *disbanded* the federally mandated "Early and Periodic Screening and Diagnosis and Treatment Program" that guarantees low-income children access to preventive health services and diagnosis and treatment for existing conditions. Now, if the recommended treatment falls below the cutoff, the child is denied life-saving treatment.

Each type of rationing begun in the Medicaid program is likely to be replicated in private insurance plans as well as all employer "pay or play" plans which Oregon law says must provide health benefits "substanially similar" to the state's Medicaid benefit package.

Last April, Vice President Al Gore (then Senator Gore) said the Oregon plan is "seductive to policymakers but dangerous to the people who really need help." That assessment was correct then, and it's still correct now.