Debate over health care must end HMOs' murderous logic

by Linda Everett

On June 29, President Clinton unveiled his long-awaited plan to modernize the 34-year-old Federal Medicare program, the nation's second-largest health insurance plan, which provides medical care for 40 million older and disabled Americans. The centerpiece of Clinton's proposal would, for the first time, help Medicare patients pay for part of the soaring costs of their prescription medications and would eliminate their out-of-pocket costs for all Medicare-covered preventive services, such as cancer screenings and diabetes management. The plan, which calls for making Medicare "fiscally secure" with an infusion of $800 billion from a nonexistent budget surplus, offers an early Medicare buy-in option to Americans between the ages of 55-64 who are uninsured because of involuntary loss of a job or retiree benefits, and who cannot afford health insurance because this age group has the highest premiums in the nation.

These proposals, however well-intentioned, are part of a package that focusses on instituting major "market-driven" reforms in the Medicare program, modelled on those already established in the private sector under "managed care." *EIR* has demonstrated these "reforms" to be fundamentally at odds with the standards of decent health care. In 1996, the FDR-PAC, the political action committee launched by associates of Lyndon LaRouche in the Democratic Party, undertook a nationwide campaign to expose how managed care, a product of failed post-industrial policies, is a threat to the public good. Since then, we, alone, reported how managed care is simply the Wall Street and London-based financiers' vehicle to divert the trillion dollars which the nation spends annually on health care into their coffers. It constitutes a full frontal assault against every aspect of America's health care delivery infrastructure, its skilled personnel, and its patients.[1] The only way to save Medicare is to scrap both predatory market reforms and managed care altogether, and to rebuild the nation's health care infrastructure based on a revised Federal Hill-Burton Act. This must be backed by LaRouche's New Bretton Woods financial reorganization proposal to foster the infrastructure preconditions for expanded population growth.

The debate on health care in the United States is not touching the real issues, always falling short of dumping the health maintenance organization (HMO) approach, which is based on triaging, or cutting out, care for "useless eaters." But, nonetheless, with 43 million Americans uninsured, hospitals closing, and the death toll from HMOs' cost-cutting skyrocketing, patients, hospitals, and doctors alike are up in arms. The intense debate is reflected in the battle over the Patient's Bill of Rights, which the Clinton administration has championed, and which would attempt to make HMOs accountable. The bill, now under heavy attack from a media campaign by the insurance companies, is currently scheduled to come to a vote in the U.S. Senate in mid-July.

The 'market' breeds collapse

The administration's new proposal seeks to change the traditional Medicare fee-for-service plan, by using the same means that managed-care wielded to destroy our health-care infrastructure: "market-oriented" tools and "competitive" pricing, contracting with hospitals and doctors, and offering

1. See Linda Everett, " 'Managed Care' and Nursing: Back to the 19th Century," and Richard Freeman, "If You Get Sick, Will You Have a Hospital?" *EIR*, June 18, 1999.

economic incentives for physicians and hospitals to cut the costs of treating chronically ill or disabled persons. Americans who believe the lying axioms behind managed care—that we can't economically support the medical needs of the population—have adopted Wall Street's prescription: Cut health care costs by letting the free market and profit-hungry managed-care promote competition in order to close "inefficient" hospitals.

In order to be "competitive," a hospital must continually sacrifice its capacity to provide medical services—the opposite of Hill-Burton's mandate—even though managed-care plans never cover the actual costs of treating patients enrolled in their own plans. Now, a "reformed" Medicare would similarly have hospitals "compete" for its low rates.

In a single decade (1985-96), we lost more than 600 community hospitals, but not because it was some necessary shakeout of inefficient hospitals. A decades-long study shows that efficiently run hospitals, no matter how much they are needed by a community, are *more often* closed by for-profit hospital chains, because profit-driven entities are less tolerant of low financial margins.[2] For example, by all "market" standards, Columbia HCA, the largest U.S. operator of for-profit hospitals, is a Wall Street success story. Columbia, recently charged by the Federal government for defrauding the Medicare system, is known for its ruthless practice of buying up most of the hospitals within a community, closing some of them, and forcing patients into the remaining hospitals where substandard care is offered.

In 1997, the Conservative Revolution in Congress, led by Senate Majority Leader Trent Lott (R-Miss.) and House Speaker Newt Gingrich (R-Ga.), reportedly with the help of Vice President Al Gore, passed the Balanced Budget Act, which gouged $71 billion out of Medicare payments to hospitals over 1997-2002. Those cuts, the American Hospital Association says, "have shaken the foundation upon which the Medicare program is built." Independent analysis documents that Medicare pays hospitals substantially less than the costs of providing services; yet, the new Medicare plan cuts another $39 billion from hospital payments between 2002-09.

The Medicare plan would use financial inducements to get patients to join low-cost Medicare HMOs, which have a long history of cheating the elderly out of promised benefits, at the expense of their lives. About 100 of largest HMOs dumped 450,000 Medicare patients in 30 states last year—right after the U.S. Circuit Court in Arizona ruled, in a national class-action suit in August, that HMOs that deny Medicare patients needed medical treatment and their right to a timely appeals process, are violating patients' "due process," as guaranteed by the Fifth Amendment of the U.S. Constitution (*Grijalva v. Shalala*). In December 1998, the U.S. District Court in Western Texas upheld efforts by chronically disabled Medicare patients to sue their Medicare HMOs for withholding treatment for disabling heart and pulmonary diseases. The court found the HMOs' financial incentives to doctors to stay below a set number of referrals to specialists, hospitalizations, and tests, served to motivate discrimination against patients with disabilities, which constituted a violation of the Federal Americans with Disabilities Act (*Zamora-Quezada, et al. v. HealthTexas, et al.*). HMOs plan to dump 200,000 more Medicare patients this year.

Dangerous mandates

HMOs once boasted that they cut costs for medications. Now, they're hiking premiums up to 59% to cover the high cost of "new advanced medications." They don't mention that they now pay billions of dollars to middlemen, called prescription benefit managers (PBMs), who work to increase HMO profits by overruling a doctor's prescription orders. This is done by forcing pharmacists to unilaterally substitute, for example, a different, cheaper cardiac drug each time a more costly drug is prescribed, without the prescribing physician's knowledge. The drug is not a generic brand of the prescribed medication: It is a different medication, and the practice is potentially life threatening. While PBMs use financial incentives to steer doctors and pharmacists to an HMO's cheaper list of drugs (called a formulary), they are also paid by drug companies to substitute their more expensive drugs. Between 1994 and 1996, some 80% of PBM businesses were owned by major drug companies, covering 107 million patients. Yet, Medicare says the "market" and PBMs will now give the elderly discounted drug rates!

The system of managed care is as powerful as the government in setting health care policy today: State legislatures spend billions on new bills and creating new new agencies to protect patients—often unsuccessfully—from noncompliant managed-care plans whose illegal scams bankrupt the plan and leave the state with the tab. After New York passed groundbreaking HMO reforms, it found that its largest HMOs failed to comply with the law 83% of the time. This is hardly an anomaly. States are powerless to enforce regulations: In California, HMOs simply ignore the majority of bills from emergency room doctors for treating their members. Managed-care plans calculate when, if, or how you get treatment.

But, why continue down this disastrous managed-care road at all? To date, several agencies within the U.S. Departments of Labor, Commerce, Health and Human Services, the Health Care Financing Administration, the U.S. Census Bureau, and the Bureau of Labor Statistics, along with several national health-care policy and advocacy groups, have no idea what the impact of managed-care policy on the U.S. workforce and productivity has been. This writer posed this simple question, asking how many days, weeks, or months of work are lost annually due to HMO policies that delay or deny needed medical treatment or referrals to specialists. No one had any data, or any intention to obtain it.

2. Alan Sager, Ph.D. et al., "Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution," Boston University School of Public Health, 1997.