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# Treatment Denied

**How State Government Health  
Care Monopolies Care for the  
Mentally Ill**

by Linda Gorman, Ph.D.

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## ***About the Author***

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## **Executive Summary**

Experiments around the world with government run health care systems demonstrate that shortages are common, costs increase, technological progress slows dramatically, and quality declines when government takes control. The data also show that Americans get more for their money in the private health care marketplace.

In fact, as the Oregon Health Plan and Colorado's Medicaid program for the mentally ill demonstrate, government control generally results in poor patient care and substantially higher costs. Both of these programs were products of extensive efforts by the Robert Wood Johnson Foundation to nationalize health care through grants to state governments willing to work on implementing its health policy initiatives. Since 1988 the Foundation has provided more than \$8.5 million in grants directly to Oregon state government agencies.

Treatment decisions in government programs are often a complex balancing act for the seriously ill. A great deal of information is required about the preferences and capabilities of individual patients. Government health care systems cannot collect and process the information that good decisions require. Such restrictions on choice make it impossible to evaluate program quality and costs. When government controls funding, patients are also at the mercy of bureaucrats who must choose between spending large sums on the small number of severely ill people, or relatively small amounts on the minor conditions afflicting large numbers of "worried well" voters.

In the early 1990s new drugs revolutionized the treatment of schizophrenia, freeing patients from drugs that cause permanent mo-

tor dysfunction. Insensitive to patient suffering due to their narrow focus on their drug budgets, many state health bureaucracies sought innovative ways to deny patients the new drugs. Under the Oregon Health Plan, patients even have difficulty finding a physician willing to treat them. The mix of services is determined by an elite group of policy makers who routinely substitute the programs they think are important for the services Plan participants say they need most. Although the Oregon Health Plan has been presented to the public as health insurance, the Oregon Health Services Commission notes, "having coverage does not always guarantee access."

The mentally ill are but the canaries in the coal mine. The reduced services and skyrocketing costs endemic in government monopoly health care should lead sensible observers to the conclusion that with government you almost always get less than you pay for.



## **Introduction**

Many of those in favor of radical health care reform in Oregon appear to believe that providing excellent health care for everyone is a simple matter of empowering the state to purchase, finance, define, regulate, and evaluate all of the health care received by its citizens. Willfully ignorant of the copious economics literature on the impossibility of managing such a system either for quality or for low cost, and inexplicably silent on the degree of harm caused by the failures of similar experiments in Great Britain, Canada, Kentucky, and Tennessee, they continue to push for the extension of state medical assistance programs and for measures that crowd out private medical care.

To understand why a policy of systematically increasing government control over health care will prove an expensive failure, one must understand that treatment decisions for those who are seriously ill can be an excruciatingly complex balancing act and that it is theoretically and practically impossible for government to gather and analyze the information required to do an even adequate job of making those decisions. Like every other human institution, government has limits. Bureaucrats run government, and as is the case in any bureaucracy, public or private, those who staff it are neither omniscient nor necessarily disinterested. The harm done by business bureaucracies is limited by the fact that consumers almost always have the ability to find other suppliers or to forgo buying entirely, and by the fact that businesses that refuse to respond to both consumers and suppliers soon go out of business. Government bureaucrats face no such limits. They can force people to buy from them regardless of cost and, as a practical matter, are limited only by the legal or regulatory restrictions that they choose to obey.

That these differences translate into enormous differences in the way private and public health systems operate has been extensively documented. In general, private systems deliver higher quality, less waste, and less fraud. When all costs are included they also tend to be less expensive. The primary arguments against them are that they promote unequal “access” to medical care, that they promote high cost interventions, and that they do not produce sufficiently integrated systems of care for truly vulnerable populations. The equal access proposition has been decisively refuted by studies of waiting lists in Britain and Canada.

Under government-controlled care, all but the wealthy and well connected must be content with the kind of care health bureaucrats see fit to deliver. In the market driven American system, consumers have the option to pay for the expensive machines and highly trained personnel that ensure short waits for expensive diagnostic and therapeutic procedures. Numerous charities exist to help those who cannot afford care. Because people who invent new procedures valued by patients are rewarded with profits, innovations continue to alter systems of care, cures are more rapid, and those with chronic conditions lead more active lives.

Market driven progress also improves health and ensures that care is delivered in a more humane manner. In the U.S., the breast cancer mortality ratio is 25 percent. In countries with government-controlled care, breast cancer mortality ratios are 28 percent (Canada), 31 percent (Germany), 35 percent (France), and 46 percent (New Zealand and the United Kingdom). The prostate cancer mortality ratio tells the same story. In the U.S. it is 19 percent. In Canada it is 25 percent, in Germany it is 44 percent, in France it is 49 percent, in New Zealand it is 30 percent,

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and in the United Kingdom it is 57 percent.<sup>1</sup> However much reformers may admire it, giving government monopoly control of health care is hazardous to people's health.

Finally, market driven systems do a better job of controlling costs. Even though Americans receive better care, U.S. health care cost growth rates are about the same as those in industrialized nations that have government controlled care. The average annual real growth in U.S. per capita health care spending was 2.6 percent from 1960 to 1998. Spending grew at the same rate in New Zealand and the Netherlands, at 2.3 percent annually in Germany, at 2.5 percent in the United Kingdom, 2.7 percent in Australia, and 3.5 percent in Japan. Canada's growth rate was just 0.8 percent, but Canadian health care is widely acknowledged to be a system in collapse and Canadians routinely come to the United States for care. In 1996 alone, Canadians spent an estimated \$1,000,000,000 on health care in the United States.<sup>2</sup>

Claims that the United States "spends too much" on health care also fail to take into account the fact that wealthier people everywhere spend more on almost everything. Americans are, by almost any measure, the wealthiest population on earth. According to the Organization for Economic Cooperation and Development, in 2000 the U.S. per capita GDP was 27 percent higher than Canada's, 37 percent higher than Germany's, and 45 percent higher than the United Kingdom's.<sup>3</sup> When Schieber and Poullier examined health spending in industrialized countries, they found that each 10 percent difference in per capita GDP increases health care spending by about 14 percent. They estimated that the large wealth differences between the United States and other countries explained all but \$400 of the \$2,051 the U.S. spent on a per-capita basis in 1987.<sup>4</sup>

## ***Ten Years of "Reform"—Fabricating a State Health Care Monopoly in Oregon***

In the early 1990s, Oregon state officials began a radical redesign of the state's medical assistance programs. Broadly speaking, reformers promised that giving the state veto power over private arrangements in the medical marketplace, and replacing private physicians with managed care, would both lower the cost of medical assistance programs and provide more services. Taxpayers were assured that costs would not increase and care would not be compromised in any way.

With the help of the Robert Wood Johnson Foundation<sup>5</sup> and others, Oregon began to create the institutional framework necessary for the replacement of private medical care with government controlled care. Steven A. Schroeder, M.D., the Foundation's president, admires European health care systems. In the Foundation's 1994 Annual Report he wrote:

"We don't know when to stop!...All along the line—from the attitudes of patients and their families about the kind of care they want to patients' decisions about which doctors to consult, to the doctors' choices about referrals, treatments, and when and where to hospitalize, to hospitals' decisions to build and fill intensive care units—in the United States the pressure to intervene aggressively is enormous and it comes from multiple directions."

"We simply have overdeveloped our medical capacity... Compare the lavish lobbies of a typical U.S. hospital with its utilitarian European counterpart and you will appreciate how much we have invested in medical care. Orange County, California has more im-

aging machines for its 2.4 million people than all of Canada for its 27 million people...we lead the world in performing expensive diagnostic and therapeutic procedures, such as magnetic resonance imaging, coronary artery bypass surgery, hemodialysis, and organ transplants. These supply factors contribute to both medical inflation and intensity of services...Our surfeit of medical technology means that insured patients in the United States seldom have to wait for care, urgent or elective.”<sup>6</sup>

Like others who wish to force the European model of government control on Americans, Dr. Schroeder evidently feels that it is good to make people who are ill wait for treatment. Most Americans disagree. Apart from the inhumanity of requiring someone who is ill and in pain to wait months or years for care, waiting for care is dangerous. In government health care systems patients have no alternative but to wait. In other countries, people who would have been saved in the United States routinely die while waiting for care. A 1997 Health Canada study indirectly acknowledged that 20 to 30 percent of the Canadians waiting for treatment would die before they got it.<sup>7</sup> Canadian health officials respond to critics of Canadian waiting lists by saying that it is good that Canada uses its health care resources to their fullest capacity. Those who defend government controlled care apparently believe that it is better to let sick people die than to let expensive machines sit idle.

In 1992 the Robert Wood Johnson Foundation awarded the first grants for its State Initiative Program. Restricted to the governors of the 50 states, the program was designed to help move state governments toward a government controlled managed care system

designed to fit into the structure developed by the Clinton health care reform “experts.” Oregon was among the first states to receive such grants.

By the middle of the 1990s, the Robert Wood Johnson Foundation had made steady progress in remodeling the way various levels of government financed and controlled state health care systems. Its grants typically required state agencies to hire one or two temporary employees to work on passing legislation. The agencies were expected to supply additional manpower as “in kind” resources. If the targeted legislation passed, the temporary hires become permanent and more grants were generally forthcoming. This provided executive branch agencies with the manpower, and the incentive, to push Foundation programs inside the government. States receiving a series of Foundation grants generally ended up with state health policy bureaucracies that were populated with hires sympathetic to the Foundation’s aims. As those who worked on Foundation projects tended to look to it for research, data, and policy advice, state health bureaucracies began to focus on an increasingly narrow range of policy alternatives.<sup>8</sup>

Oregon state government, like its counterparts in Kentucky and Colorado, has been flooded with Robert Wood Johnson Foundation grant money. Since 1988, state executive branch departments have received grants from the Foundation totaling at least \$8,875,200.<sup>9</sup> As is always the case with Robert Wood Johnson grants, the strings attached to the money encourage state governments to move towards the Foundation’s preferred form of government-controlled health care.

In 1992, the Oregon Department of Human Resources received \$636,289 to design a mandatory employment-based insurance system.

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In 1996 it received \$1,477,523 to develop school-based health care clinics that, in other states, have denied parents access to their children's health records, and encouraged students to get various forms of medical "treatment," including birth control, poorly monitored psychological counseling, and vouchers for use at Planned Parenthood. In 1997, the Office for Health Plan Policy and Research received \$705,639 to come up with "insurance market reforms, Medicaid reforms and other significant health care financing and delivery changes." In 2000, Robert Wood Johnson awarded the Department of Administrative services \$1,488,161 for the "design and implementation of a program to reduce the number of uninsured persons in Oregon."<sup>10</sup>

The Foundation broadened its base of support in Oregon by funneling grants to existing players in the Oregon health debate and, where necessary, creating new organizations to fill perceived voids. The state universities received more than \$5,500,000 in grants, the Multnomah County Health Department received more than \$1,000,000, and the Oregon based chapter of the American Heart Association received \$1,063,392 for anti-smoking "policy initiatives" in 1996. An initiative to increase the tobacco tax was presented to the voters on November 5, 1996.<sup>11</sup>

Echoing the Foundation's drive to increase the emphasis on primary and managed care in state medical schools in Kentucky, Oregon Health Sciences University received \$2,623,675 in three grants for "Preparing Physicians for the Future," a program that requires changing the medical school curriculum to "more strongly emphasize ethical and societal concerns" and medical school promotion and tenure policies to "establish equity between teaching and research and service."<sup>12</sup> In practical terms, this program

ensures that medical school faculty who do a good job of indoctrinating students about the need for health care rationing and the benefits of government monopoly health care will be as likely to get tenure as those who discover new ways to heal the sick, and that the traditional Hippocratic Oath of loyalty to one's patient will be replaced by an ethical system that preaches loyalty to the politically correct medical fashion of the moment.

The Portland-based Foundation for Accountability, FACCT, received two Robert Wood Johnson Foundation grants in 2000 and 2001 totaling almost \$800,000. Its web site bills the organization as "The Clearinghouse for Consumer-centered Health Care," one that provides "actionable and practical solutions for your use."<sup>13</sup> The site is so lopsided in its presentation of information that a keyword search in September 2002 found nothing at all explaining medical savings accounts or defined contribution health plans. This is quite an oversight given that many health policy experts think that these ideas have the brightest promise when it comes to ensuring patient centered care and controlling costs. The 2001 *Oregon State Coverage Initiative (ORSCI)* proposal submitted by John Santa, Administrator of the Office for Oregon Health Plan Policy and Research, to Vicki Gates, Deputy Director of the State Coverage Initiatives program, gives a snapshot of how intimately the Foundation is involved in state decision making.<sup>14</sup> The proposal promises, "If [the state is] funded by The Robert Wood Johnson Foundation's State Coverage Initiative Program, Oregon will be ideally suited to progress toward universal coverage by building on the work of its Health Resources and Services Administration State Planning Grant." The report also touts the fact that,

Under the State Initiatives in Health

Care Reform program, The Robert Wood Johnson Foundation provided grants for the Universal Access Planning Project and the Consolidating Gains Project. In addition, CareOregon, on behalf of the Oregon Community Health Information Network (OCHIN), received a Community Access Program (CAP) grant. This project is developing criteria for the development of a practice management system that will be used by many county health departments and safety net clinics throughout Oregon. It will provide for seamless tracking and electronic charts for all patients...<sup>15</sup>

Practice management guidelines tell physicians how to practice medicine. Most of them are formulated with payer costs in mind. Government managed care enthusiasts claim they reduce costs by eliminating unnecessary care. Once a physician has diagnosed a patient's condition, he consults a set of rules to determine how the patient will be treated. Devised by a group of experts who have never seen the patient, know nothing of his circumstances, and cannot take into account the latest technological innovations because they last met years ago, such rules are no substitute for a well-trained physician primarily interested in his patient's welfare.

Supporters of practice guidelines invariably defend them by citing the results of a 1981 RAND Corporation study that convened a panel of experts to judge the appropriateness of three procedures performed on a group of Medicare patients. In slightly more than a fifth of the cases, a majority of experts voted the procedure performed "inappropriate." Examining the data more closely makes it clear that there was, in fact, substantial disagreement about the proper treatment and that despite all of the efforts made to arrive

at a definitive judgment, seven of nine experts could "agree less than half the time that the procedures were either definitely appropriate or definitely inappropriate."<sup>16</sup>

### ***Lies, damn lies, and misleading health care claims***

To see how expert opinions operating in a political environment distort priorities one need look no farther than the Prioritized List of Health Services under the Oregon Health Plan (OHP).<sup>17</sup> Although typically presented as a rational ranking, a close examination makes it clear that a peculiar kind of utilitarianism animated the panel that created the list. A vasectomy for surgical sterilization, line 93, is deemed more worthy of public money than giving someone a kidney transplant, repairing a cleft palate with airway obstruction, surgically repairing a liver rupture, or treating skin cancer. People die of liver ruptures and skin cancers. When has being unable to get a vasectomy ever harmed anyone's health?

The experts who created the list also placed a curiously high value on psychological ailments for which people typically receive psychotherapy of unproven merit. Acute stress disorder, line 245, separation anxiety disorder, line 246, and the all-purpose adjustment disorder (a maladaptive reaction to an identifiable life event), line 267, rank ahead of the treatment of cervical, prostate, endocrine, kidney, stomach, and brain cancers, stroke, epilepsy, and food poisoning. Elective mutism, a child's persistent failure to speak in some social situations in which there is an expectation for speaking even though he talks perfectly well in others, is ailment 433. Parents may consider such behavior an example of annoyingly creative sulking. The experts at the Oregon Health Plan call it a fairly serious health condition. They rank it ahead of treatment for gallbladder cancer, tick borne diseases, joint dislocations, and immune sys-

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When government controls health care, patients have little or no influence on the kind of care they receive. The small group of people who control policy can do as it wishes, claiming that its members' expertise in the subject means that they know what is good for the average citizen even if he doesn't. This is vividly illustrated in the Health Services Commission Report: *Prioritized List of Benefits Packages for the OHP Standard*, October 2001. On page 15 the Committee notes, "In the community forums and stakeholder meetings, the public tended to rank dental services as high or higher than mental health and chemical dependency. The Commission, however, ranked it somewhat lower on the list, determining that lack of dental care was less life threatening." To which informed members of the community forums might respond, "Where is the evidence that the mental health and substance abuse treatments you are using actually work?"

Another frequent assertion that turns out to be incorrect is the claim that a government health care takeover would lower overhead costs. Though government monopoly advocates like to play fast and loose with the facts by citing a study by a national health insurance advocacy group, Citizen Fund, that claims private insurers spend 33.5 cents of every premium dollar on overhead, more balanced estimates put private insurer overheads at roughly 16 cents. The state of Washington requires that major insurers file information on overhead. Its data suggest overhead for three major health insurers of 11 to 14 percent.

Actuary Mark Litow estimated Medicare and Medicaid overhead at almost 27 cents out of every premium dollar.<sup>18</sup> Foreign government controlled systems are likely to have higher

overhead because they lack a private sector to discover and benchmark low cost ways of doing things. Wharton professor Patricia Danzon's study of the Canadian system suggests that Canadian system overhead is about 45 percent of claims.<sup>19</sup> Her estimate of overhead for U.S. private insurers, net of government cost shifting, was about 7.6 percent of claims.

Advocates of expanded government control also misstate the evidence when they claim that increased preventative care will reduce overall health care costs. In fact, with the exception of some prenatal care, some newborn tests for congenital diseases, and some childhood immunizations, preventative care nearly always increases overall health care costs. It may be humane to offer diagnostic tests like mammograms and pap smears to people who cannot afford them because it reduces their personal risk, but it is wrong to pretend that such activities will lower costs. Harvard researchers estimate that an annual pap smear for women aged 20 costs \$1,477,249 per year of life saved. Annual mammography for women age 40 to 49 costs \$186,635 per year of life saved, and pneumonia vaccinations for children aged 2-4 costs \$172,634 per year of life saved.<sup>20</sup>

Advocates also mislead when they say that tax supported government-controlled programs like the Oregon Health Plan provide insurance coverage. True insurance coverage charges premiums sufficient to cover costs and, if it accepts an individual, issues a contract that gives him certain rights to payouts by the plan. Under the Oregon Health Plan people have no right to care. As the 2001 report of the Oregon Health Services Commission put it when it was discussing increasing the plan's coverage by tens of thousands of people, "In our community meetings and stakeholder sessions, the Commission heard

repeatedly about the difficulties some OHP members have in accessing services. Having coverage does not always guarantee access.”<sup>21</sup> As the last 10 years of Robert Wood Johnson inspired reforms have all been about “expanding access,” taxpayers might legitimately wonder what they have been getting for their money.

If advocates of a government health care monopoly are correct when they say government will do a better job of allocating scarce health resources, then one would expect that health systems in countries that have government controlled care and many unmet medical needs would tend to provide only “necessary care.” This turns out not to be the case. After a study of practices in Britain’s National Health Service, RAND researcher Robert H. Brook told a U.S. Senate Committee that he was “shocked to find that half of the people who actually got cardiac revascularization did not meet criteria established by physicians in the U.K. for getting those procedures.” Overall, the RAND study of “unnecessary care” abroad concluded, “Contrary to the researchers’ expectations, habitual rationing of resources did not restrict use of these sophisticated and expensive treatments to only those who would most clearly benefit from them.”<sup>22</sup>

### ***Other reform alternatives***

Although Oregon state policy makers have concentrated on expanding Medicaid to embrace ever-larger segments of the population, there is ample evidence that other types of reform offer a greater promise of success. Eliminating the rampant cost shifting forced on the private sector by the unrealistically low reimbursement rates legislated under the Medicaid and Medicare programs would make private sector care considerably more affordable. Reducing the burden of federal and state health care regulation, deregulating

health insurance, and letting people save for their medical care in tax-free accounts would also go a long way toward reducing health care costs without reducing the quality of care. For those who still need financial assistance, it would be far easier, and less costly, to imitate the food stamp program than to give government a monopoly over any health care system.

The cost reduction that occurs when individuals must pay routine medical expenses out-of-pocket is substantial. In one of the most careful social experiments ever constructed, the U.S. federal government mounted a five-year study to see whether the amount of health care consumed varied with the level of out-of-pocket expense. Known as the RAND health care experiment, the study involved 2,000 non-elderly families who were randomly selected to represent the U.S. population and randomly assigned to insurance plans that varied by coinsurance rates and deductibles. Deductible amounts were set as percentages of family income (5, 10 or 15 percent), up to a maximum of \$1,000. Out-of-pocket expenses varied from 0 percent, essentially free care, to 95 percent. Families were tracked for three to five years. Families that paid 25 percent out-of-pocket rates incurred annual health care costs, on average, of \$826. Those receiving free care spent \$1,019. With the exception of some conditions afflicting the “sick poor,” people with low incomes who were ill at the start of the experiment and who made up just 6 percent of the study population, “free care” did not measurably improve people’s health. It did increase overall costs by about a third relative to the 95 percent out-of-pocket group. It did not measurably improve people’s health.<sup>23</sup>

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**When government controls health care, patients do not have a contractual right to receive care. Even those who survive waiting lists may fail to receive good treatment, as cancer patients in the United Kingdom have found, simply because bureaucrats decree that new forms of effective treatment are “too expensive.”**

### ***Colorado Medicaid Mental Health: How Government Monopolies Really Treat Vulnerable Populations***

Aside from its astronomical cost and shoddy service, the main problem with government health care monopolies is that removing price constraints requires rationing in other forms, and that capitated managed care—the substitute for private medicine typically proposed by reformers—poses a significant danger for patients. When government controls health care, patients do not have a contractual right to receive care. Even those who survive waiting lists may fail to receive good treatment, as cancer patients in the United Kingdom have found, simply because bureaucrats decree that new forms of effective treatment are “too expensive.” Practice guidelines may also prevent physicians from using state-of-the-art techniques. Finally, there is no guarantee that government controlled working conditions and wage rates will attract people to careers in health care. Usually the reverse is true. Current government reimbursement rates for Medicaid and Medicare care are so low that providers are leaving the programs in droves.<sup>24, 25</sup>

The original goal of Colorado reformers was the creation of ColoradoCare, a state-run health care monopoly designed under grants from the Robert Wood Johnson Foundation. When this proved too expensive, they settled on a package of incremental reforms intended to achieve the same results by gradually extending state health insurance to larger and larger fractions of the state’s population. To provide flexibility, the state sought federal waivers exempting it from the straightjacket of federal rules governing the Medicaid program. The state’s Medicaid 1915(b) waivers allowed the implementation of mandatory Medicaid managed care programs eliminat-

ing patient choice in health care. The 1915(c) waivers for home and community based services provided more flexibility in the services the state can provide, income caps, and variations in coverage.<sup>26</sup>

As in most states that applied for federal waivers under Robert Wood Johnson Foundation grants, Colorado chose to innovate by requiring its Medicaid recipients to enroll in strict managed care. Under strict managed care, patients are at the mercy of their health care provider. Patients must see the doctors their provider tells them to, follow the diagnostic procedures their provider lays out, and submit to the treatments their provider specifies. Their only alternative is to pay the entire cost out of their own pocket. With its waivers in hand, the state set up small pilot programs requiring that Medicaid recipients rely on pre-paid capitated managed care programs, promoted legislation mandating expensive private insurance policies that likely increased the number of uninsured, radically restructured the state agencies responsible for administering health care programs, and reshaped the market for “private” insurance.<sup>27</sup>

Under the assumption that strict managed care would produce great savings, the state also expanded both the populations eligible for medical assistance and the services offered under it. In 1997, Colorado authorized a buy-in program to extend Medicaid coverage indefinitely for former welfare recipients who return to work. It created the Children’s Basic Health Plan, extending state financed health care to all children from families with incomes less than 185 percent of the Federal Poverty Level, roughly \$31,000 for a family of four in 2000,<sup>28</sup> and to anyone else who would like to buy in at cost. School districts were also made eligible for reimbursement provided to Medicaid enrollees, and were authorized to keep up to 30 percent of the fed-

eral matching funds they received for their services.<sup>29</sup>

### ***Reforms instituted without proper trials, evaluation, or safeguards***

In effect, the reformers sought to create a Medicaid health care monopoly modeled after Medicare, but without Medicare's fee-for-service component. Surviving documents make it clear that those involved knew that the proposed reforms could compromise the quality of care received by those on medical assistance. Though they refused to let patients vote with their feet, they devoted a great deal of effort to creating custom designed systems to measure the quality of the programs that they would eventually run. When the state sought funding from the Robert Wood Johnson Foundation in 1996, it was for an experimental program designed to "make Medicaid managed care work for vulnerable populations covered by Medicaid."<sup>30</sup> In effect, the state was tacitly admitting that the new capitated managed care effort posed serious problems for those who were sickest and most in need of quality health care.

Long before the experimental programs could be properly evaluated, reformers had urged the state to apply them to everybody. In 1997, legislation was passed that required all managed care contracts and pilot projects be applied statewide despite evidence that similarly structured programs were failing both at home and abroad. With little comment, the ill, the poor, and the elderly were herded into experimental programs run by those who were supposed to evaluate them.

Although there is still no evidence that managed care provides either superior long-term cost control or better care than other medical delivery models, Colorado's commitment to managed care was such that the 1997 legislation required that 75 percent of those on

medical assistance be enrolled in managed care programs by July 1, 2000.<sup>31</sup> On June 30, 1999, the Health Care Financing Administration reported that 92 percent of Colorado's Medicaid enrollees received medical assistance via managed care.<sup>32</sup>

Under Colorado Medicaid, managed care takes two basic forms. In non-capitated "gatekeeper" programs case managers or primary care physicians manage patient care. The state pays providers a set fee for services delivered. Physicians in gatekeeper programs often operate under a variety of constraints, financial and otherwise, designed to control their patients' use of medical services. Under capitated care, Medicaid pays a health care organization a fixed monthly amount for all services and care. The HMO or other provider accepts responsibility for patient care and has an obligation to provide care even if its cost exceeds the amount paid. Colorado is so committed to the managed care model that rather than provide standard fee-for-service payment, it is experimenting with so-called "risk-adjusted" capitated payments in an effort to encourage HMOs to accept Medicare patients known to generate higher than average health care costs.

### ***Mentally ill denied Medicaid freedom-of-choice provision***

Though some Medicaid recipients technically have a choice between a primary care case management program, HMO, or a prepaid health plan, some of the most desperately ill have no choice at all. In July 1995, the state implemented the Medicaid Mental Health Capitation and Managed Care Program. A mental health "carve-out," meaning that mental health services are provided separately from other health services, it operates under a Section 1915(b) waiver that exempts the state from the Medicaid freedom-of-choice provision. This allows the state to require that

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**As the post office did before UPS and FedEx were allowed to compete with it, those in a protected business will always successfully argue that their costs are fair and their services excellent. Without competition, no one can prove them wrong.**

people receiving Medicaid mental health benefits receive their care from state providers. With some exceptions, this means Medicaid mental health recipients must receive care from the Mental Health Assessment and Service Agency (MHASA) that covers their geographic district.<sup>33</sup>

By 1997, 71,142 of the 130,589 people who were enrolled in Medicaid managed care were enrolled in Medicaid HMOs.<sup>34</sup> The speed with which enrollment policies changed was outlined in a 1996 draft report from the state to the Robert Wood Johnson Foundation. By 1996, it said, “Seventy-three thousand people, or thirty percent (30 percent) of all Medicaid clients in Colorado, are enrolled in HMOs. These numbers reflect a dramatic increase over 1994, when only 11,000 Medicaid clients were served by HMOs.”<sup>35</sup>

### ***Reformers planned destruction of traditional benchmarks***

When the state requires people to obtain services from a single provider, it throws away the important policing power that consumers exercise when they are free to leave a provider who delivers substandard care. It also makes it difficult or impossible to evaluate the quality and costs of existing programs. As the post office did before UPS and FedEx were allowed to compete with it, those in a protected business will always successfully argue that their costs are fair and their services excellent. Without competition, no one can prove them wrong.

Reformers in favor of universal health care run by the state knew this would be the case. A 1998 report from the state to the Robert Wood Johnson Foundation explicitly states that new benchmarks would have to be created because “Medicaid HMO capitation rates are based on historical fee-for-service expenditures. As the fee-for-service base

shrinks, it becomes less reliable as a basis for HMO rate setting. Therefore, the Department is moving toward competitive bidding of HMO contracts by January 1, 2000. Once the bidding system is implemented, managed care organizations will compete with one another to provide the best quality product at the lowest price.”<sup>36</sup>

No matter how much is spent on it, the fact remains that health care is a scarce good. Scarce goods must be rationed, and the question is how, not whether, to do it. Managed care and government monopoly reformers are generally opposed to market reforms because they reduce government power. Their preferred alternative is political rationing, which is itself no panacea.

The question is whether political or market rationing produces better outcomes for patients. Under political rationing, government officials must choose between spending large sums on the small number of people who are severely ill, or relatively small amounts to alleviate the relatively minor conditions affecting large numbers of “worried well” voters. In Colorado, the experiment with Medicaid managed care for the mentally ill puts people with schizophrenia and other disabling mental illnesses at the mercy of government bureaucrats. The choices that have been made provide an illuminating case study of the outcomes produced by political rationing. For those in favor of government run universal health care, the treatment of schizophrenics provides a cautionary tale.

### ***Clozapine—Government’s Bitter Resistance to a Major Medical Breakthrough***

#### ***Schizophrenia***

Schizophrenia is a group of conditions exhibiting similar neuropsychiatric symptoms.

The set of symptoms called schizophrenia are typically severe and disabling and often afflict physically healthy young adults. Although frequently described as a “brain disease,” schizophrenia has no known biological markers. In general, too little is known about the variance of brain structures in the normal population to determine whether the brains of people diagnosed with schizophrenia differ significantly from those in the normal population, and there are no known neurological abnormalities shared by all schizophrenics. Though researchers have examined a large number of causal candidates, including retroviruses, the Borna disease virus, and prenatal influenza infection, schizophrenia’s cause remains unknown.

Ideally, a diagnosis of schizophrenia is arrived at only after a thorough physical workup to rule out diseases, like encephalitis, known to cause similar symptoms.<sup>37</sup> In the United States, schizophrenia is diagnosed when a patient meets the criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), a classification manual for the symptoms that characterize psychological “disorders.”

DSM-IV indicators for schizophrenia include lasting episodes of persistent delusions, hallucinations, or severely disorganized speech or behavior. Afflicted people may hear voices in their heads, believe against all evidence that they are being spied upon, have racing thoughts that make thinking disorganized and fragmented, or withdraw from social interaction. Other symptoms may include impaired motor coordination, an inability to feel or show emotions, and depressions so severe that they lead to suicide. At schizophrenia’s onset, those affected typically experience declines in their ability to function in their work, in their interpersonal relationships, and in their personal care. Since schizophrenia typi-

cally manifests itself during early adulthood and often completely disrupts normal social functioning, people with the disease are often dependent on public assistance. According to the U.S. Department of Health and Human Services, approximately 90 percent of U.S. schizophrenia patients are Medicaid recipients.<sup>38</sup>

Days or years after the first symptoms appear, people afflicted with schizophrenia may endure one or more crises, psychotic episodes characterized by severe breaks with reality. When this happens, an individual may become so agitated that he poses a danger to himself or others and requires immediate hospitalization. Like its symptoms, schizophrenia’s course and ultimate outcome varies greatly across individuals. Some people have very few psychotic breaks, others have unremitting psychosis. Some people lead relatively normal lives between episodes. Others remain chronically ill for decades. Some people recover completely—German researchers in the Schizophrenia Research Unit at the Central Institute of Mental Health in Mannheim quote a 25 percent recovery rate during the first five or six years<sup>39</sup>—while others remain chronically ill fifteen or more years after their first hospital admission. Though the literature contains reports of schizophrenics recovering completely without treatment, this may be an artifact of imprecise diagnoses. Recent evidence suggests that untreated psychotic episodes are associated with a slower or less complete recovery.<sup>40</sup>

At present, standard recommendations for treatment typically include a course of drugs to control psychotic outbreaks and some form of “psychosocial” support to provide friendship, encouragement, and practical advice on handling the challenges of living with schizophrenia’s symptoms. Some reports suggest that people with schizophrenia

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are also helped by sheltered workshops. Before the development of the neuroleptic drugs in the 1950s, severely ill schizophrenic patients were often confined in mental hospitals. The neuroleptics, which include chlorpromazine (Thorazine) and haloperidol (Haldol), affect the operation of the brain's dopamine neurotransmitters. Their discovery gave hospital psychiatrists a new tool for calming agitated inmates. According to Heinz Lehmann, a pioneer in the use of chlorpromazine in treating psychiatric patients, "Our two major therapies [in the 1940s] were insulin-induced hypoglycemic coma and electroconvulsive shock therapies (EDT) for schizophrenia and affective disorders...Paraldehyde and the barbiturates were about our only means to quell agitation and violence in addition to physical seclusion and restraint ... ."41

### ***The drawbacks of conventional treatments for schizophrenia***

Early descriptions of the effects of chlorpromazine likened it to a "chemical lobotomy," highlighting its ability to make patients indifferent to their surroundings, induce lassitude, and give the appearance, at least, of passivity.<sup>42</sup> Although patients intensely disliked the side effects of the drugs, their use grew rapidly due to their unparalleled ability to reduce acute and chronic psychotic disorders and calm aggressive and impulsive outbursts. It was the ability to control psychotic symptoms, according to some observers, that made it possible to deinstitutionalize many mentally ill patients.

Neuroleptics are powerful drugs with nasty side effects. These include irreversible tremors, disfiguring muscle movements in the face, limbs or trunk, involuntary muscle spasms, and neuroleptic malignant syndrome, a rare reaction to therapeutic doses of the drugs that can be fatal.<sup>43</sup> The move-

ment disorders, which often persist even when the neuroleptics are discontinued, are also associated with deteriorations in cognitive function. In addition, patients taking the drugs report agitation, restlessness, weight changes, sleepiness, depression or lethargy, dry mouth, vertigo, and general physical weakness. Callers to SANELINE, a telephone help service operated by the British mental health charity SANE, also reported significant changes in mental outlook, saying the drugs made them feel as if their senses were numbed and their willpower was lost.

The side effects are so severe and so common—according to one estimate up to 75 percent of patients using the drugs on a long-term basis will experience motor problems<sup>44</sup>—that the term neuroleptic-induced deficit syndrome was coined to describe the drugs' adverse effects.<sup>45</sup> A small group of researchers believes that they do more harm than good and is skeptical of the benefits of any neuroleptic drug treatment.<sup>46</sup> Unsurprisingly, one of the biggest problems in treating schizophrenia on an outpatient basis is the fact that large numbers of patients simply stop taking their prescribed medications.

### ***A medical breakthrough***

In the face of such debilitating side effects, clozapine, the first entry in a new class of drugs called atypical antipsychotics, was considered a huge advance. First discovered and synthesized by Sandoz Pharmaceuticals in 1952, it was patented in Europe in the late 1950s. European clinical trials were begun in 1962. A United States patent was received in 1970, and U.S. clinical trials were begun in 1972. From 1973 to 1975 the drug was marketed as Leponex and was used to treat schizophrenia in Europe, Asia, and Africa. In 1975, 16 cases of clozapine-associated agranulocytosis, a condition that impairs the ability of

white blood cells to fight infection, caused eight deaths in Finland. The drug was taken off the market.<sup>47</sup>

From the beginning, clozapine demonstrated remarkable effectiveness in controlling psychotic symptoms. It was far better tolerated by patients, did not cause the irreversible movement disorders so commonly seen in users of conventional neuroleptics, and produced almost miraculous results in patients who had responded to nothing else. Researchers in schizophrenia treatment thought so much of clozapine's therapeutic value that they continued using it under compassionate use exemptions between 1976 and 1982.

### ***Regulatory tradeoffs stall new treatment***

Clozapine's excruciatingly slow progress in the United States market is an object lesson in how a regulatory burden intended to protect people can also harm them. In 1984, an FDA advisory committee approved further testing of clozapine in the United States. In 1988, a multi-center study designed to compare treatments in schizophrenic patients who failed to respond to treatment with conventional neuroleptics found that clozapine produced remarkable results. Researchers who saw patients regain control of their lives called the drug "a medical breakthrough." One patient helped by the drug compared herself to Rip van Winkle.<sup>48</sup>

Still, federal regulators worried about the drug's side effects. Agranulocytosis caught early enough could be reversed, but carrying out meticulous testing requires institutional arrangements focused exclusively on that. According to Sandoz, even in carefully designed clinical trials some patients inadvertently went several weeks between blood checks. FDA officials understood that approving the drug would probably result in

some deaths, but were convinced that they could be minimized with careful monitoring. Concerned that physicians and health officials might ignore label directions for burdensome testing and monitoring, and that schizophrenics could not be relied upon to ensure that they got the tests, the drug was approved for sale in 1989 with the stipulation that Sandoz develop a patient monitoring system to go with it.

In February 1990, with four years left to recoup U.S. research and development costs before the drug's patent expired, Sandoz began to sell clozapine in the U.S. under the trade name Clozaril. Worried that it might be held liable if patient monitoring was not properly done, Sandoz offered the drug only in conjunction with the Colzaril Patient Management System (CPMS) run by Caremark, a laboratory company. CPMS distributed the drug in conjunction with weekly white blood cell monitoring at a price of \$172 per week or about \$9,000 a year in 1990 dollars. According to a report from the Department of Health and Human Services, the blood monitoring made clozapine therapy eight to 15 times more expensive than current therapy with the traditional neuroleptics.

### ***State officials react hysterically to cost***

The drug's cost provoked what can only be called a hysterical reaction from officials in charge of government mental health care programs. Apparently unwilling to consider the possibility that this "medical breakthrough" might save money by reducing acute care costs, unwilling to confront the problem of legal liability for the drug's manufacturer that was created by the FDA monitoring requirement, and unwilling to admit that some improvements are worth the added cost solely because they improve patient outcomes, officials focused primarily on the damage the

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**An official for the National Association of the Mentally Ill wondered why states that routinely incurred costs of about \$66,000 a year to hospitalize schizophrenics in state institutions were so bitterly opposed to spending just \$9,000 a year for drug maintenance that could allow many schizophrenics to lead a more normal life.**

drug's immediate cost would inflict on their budgets. Only money mattered. The result, according to *The Wall Street Journal*, was that "state mental-health leaders, Medicaid officials, pharmacists, members of Congress and the secretary of veterans affairs...mounted an intense...effort to force Sandoz to uncouple the drug from the blood-testing program...and cut the price."<sup>49</sup>

The Massachusetts deputy commissioner for mental health, Mona Bennett, said "People are desperate to use this drug...We can't not use it," but treating the state's eligible patients would cost \$5 million which "we simply do not have."<sup>50</sup> In Texas, with a population just three times larger than that in Massachusetts, officials claimed a potential treatment cost of \$100 million, 20 times the Massachusetts cost estimate. California mental-health officials called Clorzaril "the most expensive treatment we've encountered." They estimated their treatment costs as \$300 million, a treatment cost 60 times higher than Massachusetts' estimate for a population only six times larger. Oklahoma simply claimed that the cost of treating eligible patients would exceed the state's total mental health budget.

The bizarre nature of these comments was pointed out by an official for the National Association of the Mentally Ill who wondered, in *The Wall Street Journal*, why states that routinely spent \$50,000 a year to keep a single Medicaid patient on dialysis and incurred costs of about \$66,000 a year to hospitalize schizophrenics in state institutions were so bitterly opposed to spending just \$9,000 a year for drug maintenance that could allow many schizophrenics to lead a more normal life.

William Reid, medical director for the Texas department of mental health and mental retardation, took the hyperbole to new heights

saying, "I feel like I'm being blackmailed by the company," and that the price amounted to "a ransom for taxpayers" while holding chronic schizophrenic patients "hostage to their illness."<sup>51</sup> In a reverse on the usual pattern of typical efficiencies of public versus private institutions, some state mental institutions even claimed that they could do the blood monitoring for less in their own labs. The executive director of the National Association of the Mentally Ill was far more realistic. Although Laurie Flynn urged Sandoz to cut the medicine's price, according to *The Wall Street Journal* "she also said her group [had] no confidence in the ability of state mental hospitals to assure the safety of patients."<sup>52</sup>

In August 1990, the FDA calmed the storm by ruling that Sandoz could use any patient monitoring system as long as it met certain standards. Sandoz was still required to be responsible for registering the alternative monitoring systems and ensuring their quality, meaning that it could still be held liable for any deaths associated with the drug. In January 1991, Sandoz separated the sale of clozapine from the CPMS. Without patient monitoring, a year's worth of clozapine treatment now cost \$4,160.

In June 1991, the Federal Trade Commission proceeded to demonstrate the remarkable elasticity of U.S. anti-trust laws by finding that Sandoz had illegally required patients to enroll in an exclusive blood monitoring program. In 1992, Sandoz settled by paying \$20 million to provider groups. By 1996, after Sandoz's patent had expired, only 11,000 patients were receiving the drug.

Years later, partially as a result of the meticulous patient monitoring generated by the reviled blood monitoring program, the FDA Psychopharmacologic Drugs Advisory Com-

mittee found that it had overestimated the dangers of agranulocytosis and concluded that the weekly blood test requirement could be relaxed. In July 1997, the committee recommended that blood tests be reduced to one every other week after six months of treatment, and that blood monitoring be made voluntary after one year.<sup>53</sup> The FDA approved these changes in March 1998.

### **States Scheme to Reduce Treatment Costs by Denying Access**

Though Clozaril was the first of the atypical antipsychotics, others were introduced in rapid succession throughout the 1990s including risperidone (Risperdal) in 1994, olanzapine (Zyprexa) in 1996, quetiapine (Seroquel) in 1997, and ziprasidone in February 2001. While all of these drugs are classified as atypical antipsychotics, and all cause far fewer side effects than the older neuroleptics, each affects slightly different receptors in the body with the result that clinical outcomes vary from patient to patient.

Risperidone, for example, is less sedating than clozapine and does not cause agranulocytosis. In some patients, however, it seems to cause “intolerable exacerbation of parkinsonism.”<sup>54</sup> Patients may find olanzapine easier to take in spite of its propensity to cause weight gains, possibly because olanzapine seems to cause fewer movement disorders than risperidone. Nor are the differences necessarily immediately obvious—one multi-center 28-week double-blind study found that patients on risperidone were more likely to attempt suicide than patients on olanzapine. Given that an estimated 30 percent of schizophrenics attempt suicide, such a difference is unquestionably a legitimate therapeutic consideration.<sup>55</sup>

Despite the fact that experts considered atypicals like clozapine and olanzapine major therapeutic advances, government health officials worried about line items in their budgets devised a number of ways to keep them from patients. Initial responses favored a direct approach in which officials simply refused to buy particular drugs for anyone. Five months after Clozaril was approved for sale in the United States, the Veteran’s Administration simply stopped providing the drug to its patients, saying that its cost was too high.<sup>56</sup> A number of states refused to add clozapine to their Medicaid formularies. In May 1991, the Health Care Financing Administration, responding to evidence that states were denying patients access to one of the largest therapeutic advances in 40 years, ordered state Medicaid programs to include clozapine.

### **Closed formularies**

This did not necessarily increase access to the drug. State legislatures have developed a variety of strategies to control drug budgets including formularies, prescription limits, generic substitution requirements, prior approval systems, and refill limits. Before 1990, many state Medicaid programs maintained closed formularies. The formularies were lists of drugs that the state would pay for. Payment was denied for all others. Concerned that restrictive state formularies denied important medicines to the poor, Congress outlawed restrictive formularies for Medicaid when it passed the Omnibus Budget Reconciliation Act of 1990. The Omnibus Budget Reconciliation Act of 1993 repealed many of the 1990 limitations. Under the 1993 revision, one way to legally maintain a closed formulary was to include all FDA approved drugs in the formulary but require prior approval before they could be dispensed. In general, there were no regulations governing prior approval criteria as long as states re-

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sponded to requests for prior approval within 24 hours and would pay for a 72-hour emergency supply of the drug under review.

### ***Prior approval***

As one would expect if one believes that doctors prescribe drugs to help individual patients, to the extent that prior approval requirements effectively restrict patient access to expensive medicines, they also increase health care costs. By delaying access to therapies known to improve health, such requirements ensure that sicker patients will visit doctors and hospitals more frequently. Prior approval systems are also expensive. Someone must pay for the additional staffing to ask for prior approvals, make, and track them.

In New York in 1991, patients approved for clozapine had to be at least 16 years old, had to have been diagnosed with schizophrenia, and to have failed treatment with other anti-psychotics. Recent research suggests that requiring treatment failure may reduce chances for recovery. The dispensing pharmacy had to have an 8-digit dispensing number in order to obtain reimbursement. Continuing clozapine required considerable additional data. These requirements were so burdensome, and made it so expensive to prescribe clozapine, that they have since been repealed. In the meantime, seriously ill patients dependent on the government were at the mercy of the whims of bureaucrats obsessed with their cost control mission.<sup>57</sup>

As late as 1999, Kentucky was still automatically entering every drug approved by the FDA on its prior approval list. In the case of olanzapine (Zyprexa), use was restricted to cases of therapeutic failure for almost two years after the drug was made available. Therapeutic failure occurs when a schizophrenic has a “break,” a bout with uncontrolled psychosis. Current research suggests

that uncontrolled psychotic breaks are associated with a poorer chance of long term recovery. Any health care system that requires a therapeutic break before prescribing a drug that is known to be more effective, and to produce fewer irreversible side effects, is cutting costs by requiring substandard medical care. According to a 1999 report for the Kentucky Legislative Research Commission, “In the case of schizophrenia, the side effects, and the personal, medical, and social costs [of therapeutic failure] can be very substantial. In such cases of therapeutic failure, medication delayed is tantamount to medication denied.”<sup>58</sup>

Kentucky’s lack of attention to proper patient care is typical of states in which government exercises control and consumers have little choice. In 1994, seduced by the false notion that a government controlled monopoly would reduce health care costs with no effect on the quality of care, Kentucky fully embraced comprehensive health care reform. It passed sweeping legislation that promised “access” to health care for all and gave the state effective control of both health insurance and medical practice.

As has been the case everywhere a government monopoly on health care has been tried, what the reformers promised never materialized. In practice, access to the latest therapies for mental illness has been degraded, and the reforms have bankrupted the state-sponsored health-insurance plan for government employees. The reforms have also destroyed the market for private health insurance.<sup>59</sup> Those who blithely assume that government will protect patients when patients have no choice should take a look at Kentucky’s prior approval system. Though federal Medicaid rules require action on prior approvals within 24 hours of making a request, Kentucky’s prior approval office was open only on week-

days between 8:00am and 6:00pm.

In spite of the evidence suggesting that state formularies increase costs and degrade quality, people who support them for state programs argue that if a state's formulary includes all FDA approved drugs it gives the state control over drug costs without denying access to new therapeutic advances. But formulary laws may also say that the state will cover drugs only if they are used for FDA approved, or "on-label," uses.

### ***Refusing to pay for "off-label" uses***

On-label uses are those for which the FDA approves a drug during the clinical trials that are a part of the new drug approval process. This process is long and famously expensive. In 1993 The Boston Consulting Group estimated that it cost \$500 million, in pretax 1990 dollars, to bring a drug to market in the United States.<sup>60</sup> Once a drug is approved, however, physicians may prescribe it for any use they feel appropriate and clinical experience often shows that a drug is effective for treating conditions other than those listed on its FDA label.

Over time, standard medical practice may include prescribing the drug for "unapproved" uses. According to the General Accounting Office, an estimated 25 percent of anti-cancer drugs are off-label. Spironolactone, a drug approved to treat water retention, is another example. Thirty years after it was approved, physicians realized it might also help people with congestive heart failure. Spending millions of dollars to conduct new clinical trials to validate this makes no sense, so its use to combat congestive heart failure will continue to be officially "unapproved" standard practice.

In practice, off-label use is of such therapeutic value that more than 35 states now have

laws protecting it. Medical experts are now trying to treat other serious mental illnesses with the atypical antipsychotics. The question for those who are severely ill and dependent on the state is whether the state's closed formulary law will be used to deny access to useful therapies when the state's health care budget comes under pressure.

### ***Unintended Consequences: State Schemes Increase Total Costs***

The poor experience with closed and heavily restricted formularies is not unique to Kentucky. A 1993 study by W. J. Moore and R. J. Newman looked at formulary restrictions in 47 Medicaid programs. They concluded,

A restricted formulary may reduce prescription drug expenditures by approximately 13 percent, on average. Because of service substitution, however, such a policy does not translate into reductions in total program expenditures. Savings in the drug budget appear to be completely offset by increased expenditures elsewhere in the system.<sup>61</sup>

In addition to increasing costs by withholding treatment, restrictive formularies are expensive to administer. Sudovar and Rein compared California's rule bound Medicaid prescription policies with the less restrictive ones in Texas in 1978. They concluded that California could have saved \$14 million by switching to the Texas system and that \$5 million of the savings would have come from reduced administrative overhead.<sup>62</sup>

### ***Delays, death, and suffering***

This estimate does not include the pain and suffering imposed by long waits for more effective medicines. Grabowski *et al.* looked at

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the experience of nine states with Medicaid formularies between 1979 and 1985. They found that during the first four years a drug was on the market, Medicaid patients had access to new drugs less than 40 percent of the time. This was true for all drugs, even those highly ranked for therapeutic importance.<sup>63</sup>

Delays cause deaths and suffering. Dr. Louis Lasagna, director of Tufts University's Center for the Study of Drug Development, estimated that 119,000 Americans died during the seven years it took to study beta blocker heart medicines. Although estimates are not available, an earlier approval of the atypical antipsychotics would almost certainly have prevented some of the suicides and deaths by misadventure that plague people tormented by schizophrenia.

Attempts to control health care expenditures by imposing brute restrictions on drugs have also had negative effects on the patients in state programs. When New Hampshire officials sought to control Medicaid costs by limiting prescriptions to three per person per month, schizophrenia patients made more visits to community mental health centers and hospitals. Soumerai *et al.* estimated that the additional service cost was 17 times higher than the reduction in drug costs.<sup>64</sup>

### ***The dangers of generic substitution***

Defenders of closed formularies often argue that offering a variety of drugs in a particular therapeutic class simply wastes money because all therapeutic substitutes are essentially the same. This is also the argument behind generic substitution, which is required in Oregon unless a provider expressly indicates no substitution.<sup>65</sup> Though Americans have been encouraged to believe that the only difference between a brand name drug and a generic one is the price, this is not always the case.

In the United States, bioequivalency is determined by statistical trials that administer a generic drug and its branded counterpart to a small group of generally healthy volunteers. Results are compared for the drug's absorption over time, its maximum concentration in the body, and the time it takes to attain maximum concentration. Products considered interchangeable can depart from the brand-name version by up to 25 percent. Given the statistical constraints, the Food and Drug Administration estimates that a "generic product that truly differs by -20%/+25% or more from the innovator product with respect to one or more pharmacokinetic parameters would actually have less than a 5% chance of being approved."<sup>66</sup>

Statistical studies measure population differences. Individual metabolisms vary widely, however, and the average results for a group can mask the fact that particular individuals may differ substantially from the average. Furthermore, generic drug bioequivalence is typically tested on groups of less than 50 generally healthy volunteers. Though most generic drugs are therapeutically equivalent and work well, individual differences, differences in drug packaging and differences in delivery systems, can substantially affect how well a drug works for a particular patient. While one patient may do just fine on cheap over-the-counter iron pills, another may be unable to tolerate them because they cause serious constipation. In the latter case, a more expensive brand name vitamin with fewer side effects might be required.

Differences in bioavailability become more important when the difference between a therapeutic and a toxic dose is small, when a particular drug has a narrow therapeutic range, or when the inability to tolerate a substitute may have serious consequences. A 1994 Veteran's Administration study found

that serum levels of phenytoin, an antiepileptic drug, were 22 to 31 percent lower when patients were on a generic phenytoin than when the same patients were given the brand-name product Dilantin.<sup>67</sup> A survey of 130 experts on cardiac arrhythmias found that a switch to generic antiarrhythmic drugs caused serious problems in over sixty cases.<sup>68</sup> At present, the therapeutic categories judged most likely to be sensitive to generic substitution are cardiovascular drugs, psychotropic agents like the atypical antipsychotics, and anticonvulsants. Other potentially sensitive categories include low-dose oral contraceptives, bronchodilating agents, oral diuretics, and oral anticoagulants. Debilitated or elderly patients with abnormal gastrointestinal, renal, or hepatic function are most likely to be at risk.<sup>69</sup>

In testimony before the Florida Commission on Mental Health and Substance Abuse, Delores Castaldo explained what can happen to patients when bureaucrats rather than doctors have the final say on the drugs administered to patients. According to Ms. Castaldo, her son, who had schizophrenia, was doing well on Clorazil. Although his prescription stated “no generics,” the pharmacist refused to comply and Florida Medicaid refused to pay for anything other than generic clozapine. When switched to generic clozapine, her son “decompensated badly.” She noted that unlike her son, many patients have no family or others to advocate for them and asked the Commission to help those with mental illnesses retain access to the most effective medications.<sup>70</sup>

### ***Variety of drugs needed because different patients react differently***

In addition to harming patients, such problems can wipe out the savings expected to occur when bureaucrats limit doctors to one or two drugs within a particular therapeutic

category. Omeprazole and lansoprazole, marketed under the brand names Prilosec and Prevacid, belong to a class of drugs called proton pump inhibitors that are commonly used to treat cases in which there is too much acid in the stomach. Initial evaluations of the pharmacology of the drugs found them similar in structure and mechanism although they were metabolized by different routes. As of July 2000, however, the average wholesale cost of a 30-day supply of a standard dosage was \$116.41 for lansoprazole and \$124.17 for omeprazole.<sup>71</sup> To save money, many managed care organizations “encouraged” a switch to lansoprazole under their therapeutic interchange programs. In clinical settings, however, patients previously stabilized on omeprazole experienced more severe symptoms when switched to lansoprazole.<sup>72</sup> Some patients did not respond to lansoprazole, and others could not tolerate its side effects. According to researchers at one Veteran’s Administration hospital, the predicted 12 percent savings from the therapeutic interchange were “quickly offset” by the associated failure rate of 28 percent.<sup>73</sup>

Despite growing evidence that patients do better when their physicians have access to a wide variety of drugs, legislation to resurrect state formularies appeared in a number of states in 2001-2002. The Oregon Health Plan Drug Formulary, which was signed into law in 2001, is typical of this kind of legislation in that it specifically exempts drugs used to treat cancer, mental illness, and AIDS.<sup>74</sup> The fact that these exemptions are allowed at all shows that those in charge of government health care are perfectly aware that limiting drug choices can compromise patient care.

Cancer, mental health, and AIDS patients are not the only people whose treatment depends heavily on being able to match individual patients to the right drug. In practice, this

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means that the formulary laws that inevitably accompany government controlled care will invariably end up adding to health care costs. People with less politically popular illnesses will also create interest groups and hire lobbyists to ensure that they can get the care that they want. But even those who pay extra to influence the political process and succeed in getting special treatment for their conditions may still find their care compromised by practice guidelines. Suggested practice guidelines for treating schizophrenics have gone so far as to ignore the side effects associated with less expensive drugs and require that patients fail on those before allowing physicians to prescribe more expensive ones.

Other studies of the effectiveness of formulary restrictions and the costs of therapeutic substitution suggest that Ms. Castaldo's experience is not unique. A 1996 survey of 200 physicians participating in Tennessee's TennCare Medicaid managed care program found that two-thirds of the physicians who were forced to switch their patients' prescriptions reported serious adverse consequences including death, strokes, and adverse drug interactions.<sup>75</sup> In Canada, The Fraser Institute reported on the success of British Columbia's drug control system and concluded,

In British Columbia, 27 percent of physicians reported that they had to admit patients to the emergency room or hospital as a result of the switching of medicines mandated by the operation of the government reference price system. Confusion or uncertainty by cardiovascular or hypertension patients due to mandated medicine switching was reported by 68 percent of doctors while 60 percent observed worsening or accelerating symptoms. British Co-

lumbia doctors for other types of patients reported similar problems with the result being an increase of patients who stop taking their medications and increased emergency room admissions. This patient confusion and uncertainty generated by government's price control system is a clear implication that the system operates for the convenience of government, not the well being of patients.<sup>76</sup>

Ironically, in the years following the hysteria over the cost of the atypical antipsychotics, it became increasingly clear that physicians and patients knew what they were about. Even if one ignores the inhumanity inherent in keeping patients on drugs known to cause permanent damage when newer ones with far fewer side effects are available, subsequent data suggests that state officials would have saved money by immediately embracing the new drugs. One startling estimate of the savings from using the new drugs came from a study by Illinois officials on the costs of treating refractory schizophrenia with clozapine. With clozapine, the state was able to discharge 243 of 518 patients. The savings from those patients alone was estimated to be "approximately \$20 million per year."<sup>77</sup>

Moderating the Illinois findings are several others that find modest savings. In a one year study of treatment refractory patients in Veterans Administration hospitals treated with clozapine and the traditional neuroleptic haloperidol, Rosenheck *et al.* concluded that clozapine treatment saved \$2,734 per patient per year.<sup>78</sup> Vaile *et al.* used data from the California's Santa Clara County Mental Health Department to measure the cost of medications and inpatient and ambulatory services to assess the difference in accumulated cost for 139 patients before and after treatment with risperidone, the least expen-

sive of the atypical antipsychotics.<sup>79</sup> They found a slight increase in expenditures with risperidone after 14 months of follow-up, although outcome measures suggested that the extra spending did make patients better off.

### ***Statistical studies no substitute for clinical judgment***

These results show the difficulties faced by those who argue that taxpayer money should not be spent on new forms of treatment until research studies demonstrating their effectiveness have been completed. In the real world, statistical study designs always have weaknesses. These range from small sample sizes with short follow-up periods to primitive outcome measures. They also include the problem of matching treatment and non-treatment groups when people have different genetic structures and different treatment histories. With a disease like schizophrenia, further complications include a disease with an unknown cause and relatively subjective measures of severity. Cost analyses are even more difficult because direct and indirect costs vary from person to person and are difficult to measure. The studies cited above, for example, need to be interpreted in light of suggestions from longer follow-ups suggesting that the major benefits from treatment with the atypical antipsychotics may not show up until a year or more after patients are stabilized on the drugs.

The problem with relying exclusively on statistical results can be summarized by the following example. Suppose that two people diagnosed with schizophrenia are discharged from the hospital on two different drugs after acute psychotic breaks. For the next six months both avoid additional hospitalization. Person number one has never been hospitalized before and is given the less expensive, less advanced drug. When he is discharged, he continues living independently

and holds down a job. Because he does not like the side effects and feels just fine, he stops taking his medication at the end of 6 months without telling anyone. The other patient, who has been in and out of the hospital and on and off various drugs for years, is discharged on a much more expensive drug. He drifts in and out of his parents' home but continues taking his medication. An inexperienced policy analyst applying simple statistics to the data contained in the medical record might well use these data to conclude that the more expensive drug is not worth its cost. Patients and clinicians familiar with the disease, who know that discontinuing medication will likely result in a future psychotic break, might legitimately come to a different conclusion.

Given that physicians act in the best interests of their patients, it comes as no surprise that attempts to second-guess their decisions often do harm. Doctors in traditional practices generally know more about their patients' lives and preferences than remote government officials. Psychiatrists who specialize in schizophrenia, for example, claim that personal familiarity with an individual patient makes them able to detect subtle changes that give them advance warning of an impending psychotic break. This means that they can take steps to prevent or manage it. Physicians this intimately involved with their patients are unlikely to prescribe a drug unless they think it will help. Given their specialist knowledge, the odds are that they will be right. In fact, the demand for atypical antipsychotics has skyrocketed precisely because clinicians observed obvious improvement in the patients who used them.

In constraining physicians' drug choices by closing formularies, limiting prescriptions, or requiring therapeutic substitutions, government officials implicitly substitute the judg-

**Suggested practice guidelines for treating schizophrenics have gone so far as to ignore the side effects associated with less expensive drugs and require that patients fail on those before allowing physicians to prescribe more expensive ones.**

**This patient confusion and uncertainty generated by government's price control system is a clear implication that the system operates for the convenience of government, not the well being of patients.**

ment of a bureaucracy for that of a physician. Lacking the information that physicians have, it is no wonder that the bureaucrats trying to substitute for them end up making costly mistakes. The problem, as researchers from the Managed Care Outcomes Project so delicately put it, is that a

causal relationship between stricter HMO cost-containment practices and increased resource use also is supported by previous studies reporting shifts to more-expensive resources when restrictions are placed on the availability of drugs in Medicaid programs. These shifts are not inconsistent with prevailing economic theory based on findings that greater choice enhances consumer satisfaction and economic efficiency. Likewise, systems theory predicts that often unforeseen effects are found when complex systems (such as the healthcare system) are perturbed.<sup>80</sup>

### ***Colorado Reforms Shortchange the Severely Ill***

Even the Robert Wood Johnson Foundation realized that state governments would have to hire others to run the health care system of their dreams. Convinced that the state's role ought to be to provide equal health care for everyone, it promoted capitated care, a system in which state policy analysts would set per capita payment levels for a year's worth of medical care and private firms would compete for the contract to carry out the work.

The dangers of this kind of arrangement have been known for years. To begin with, there is ample evidence that government agencies do a rotten job of setting prices.

### ***Projected savings never materialize***

Colorado officials, assuming that state contracted Medicaid managed care for mental health would be five percent cheaper than the fee-for-service system it replaced, constructed a mental health carve-out similar to the one in Tennessee. The basis for the five percent assumption is unclear. According to a 1998 *JAMA* article, Tennessee officials made the same assumption. Sure that savings would occur and intent on keeping them for itself, Tennessee funded its mental health managed care carve-out at 95 percent of its projections of the costs for fee-for-service care. The behavioral health organizations Tennessee contracted with then spent up to 10 percent of the capitation payments to meet their own administrative costs. Finally, the state withheld 10 percent of capitation payments for noncompliance with contractual obligations, a step that the Colorado State Auditor recommended to Colorado's Department of Human Services in 1998. The result in Tennessee, as the acting Tennessee Mental Health Commissioner acknowledged in oversight committee hearings, was that mental health and substance abuse treatments declined by 15 percent in one year.

### ***Quality declines***

Quality also declined. Many patients did not receive care or lost continuity of care when traditional referral networks were disrupted. Funds previously earmarked for severely mentally ill patients were spread across the whole Medicaid population. Providers who had specialized in treating those with severe mental illness went bankrupt. As financial stresses increased, charity care diminished. "Many CMHCs [Community Mental Health Centers] also stopped providing non-TennCare enrollees with services, especially substance abuse treatments, that had previously been subsidized by state funds."<sup>81</sup>

According to a 1998 report by Colorado's Office of the State Auditor, Colorado's capitated Medicaid mental health carve-out is exhibiting many of Tennessee's symptoms. Colorado has had no way to determine whether its per person expenditures for mental health care were reasonable because the necessary data simply do not exist. The data that did exist suggested worrisome declines in quality and service. Before capitation, the percentage of Medicaid recipients receiving mental health services was increasing. After capitation, costs per Medicaid person served increased at "a faster rate than national health care costs," the percentage of Medicaid recipients served declined, and services per person probably decreased. In 1997, the auditor estimated that the state paid \$27 million more under the capitated system than it would have under fee-for-service.<sup>82</sup>

### **Shortage of care occurs when state sets prices below costs**

Other evidence that the state does a poor job of setting prices, and when prices are politically determined program costs come first, come from Colorado's Medicaid managed care program. When Rocky Mountain HMO CEO Mike Weber criticized the state's reimbursement rates, the *Denver Post* reported that the then executive director of the Colorado Department of Health Care Policy and Finance, Jim Rizzuto, said that accountants have reviewed the state's 2000-2001 payment rates for Medicaid HMOs and he believed they were accurate. He also said he would not let the state be pressured by HMOs to overpay health-care providers. "Our responsibility is to ensure the fiscal soundness of the program," he said.<sup>83</sup>

Worried about their own fiscal soundness, Rocky Mountain HMO and the Kaiser Foundation Health Plan of Colorado have sued the state for shortchanging them. According to

Marsha Austin writing in the *Denver Post*, in May, 2000, District Court Judge Warren O. Martin found, "Richard Allen, director of Colorado's Medicaid program, underpaid HMOs beginning in 1996 and even discouraged their participation in Medicaid managed care. 'Mr. Allen undertook to achieve savings by taking them out of the hides of the HMOs,' Martin found. 'He surreptitiously, and sometimes openly hid data from the HMOs...and in essence said, 'If you don't like it, get out.''" Citing losses, Rocky Mountain reduced its service area in 1998 and the Kaiser Plan cut its Medicaid enrollment from 6,000 in 1998 to 3,000 in 1999. In 2000 it was roughly 7,200.<sup>84</sup>

An inability to keep providers also afflicts other states that have adopted capitated managed care programs incorporating new and expansive notions of treatment. In September 2002, Kaiser Permanente announced that it would stop taking Oregon Health Plan patients. This left about 12,000 people in Portland and Salem looking for a physician willing to treat them for the amount the Oregon Health Plan was willing to pay.<sup>85</sup> Rural Oregon, like rural Colorado, was already suffering. In November 1999, Curry General Hospital in Brookings closed its money-losing clinic. This left 700 Oregon Health Plan beneficiaries in the lurch at a time when the only doctor in Brookings still accepting Oregon Health Plan patients already had 300 of them.<sup>86</sup> There is also some evidence that specialist care may be more difficult to access under the Oregon Health Plan. Researchers who examined the impact of the Oregon Health Plan on children with special needs concluded, "Asthmatic children who are not SSI-eligible seemed to have particular difficulty obtaining services, like specialty care, that are available only by referral."<sup>87</sup>

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not get routine services are in essentially the same position as the uninsured. The major difference is that after a decade of reorganization, spending on the Oregon Health Plan has more than doubled. Spending on drugs has grown more rapidly than spending in other categories, from \$62,000,000 in 1993-1995 to a projected \$186,000,000 in 1999-2001. Given that the new drugs introduced in the 1990s are now first line treatment for a host of mental disorders and that Oregon lawmakers have continued to expand mental health benefits, this is unsurprising. Also unsurprising is the state's response. It is now trying to institute a drug formulary to limit the drugs that can be used to treat Oregon Health Plan patients.<sup>88</sup>

Unlike accountants and government officials, economists judge industry profits by the entry or exit of firms. Large numbers of firms exiting a particular line of business is a sign that expected profits are too low to sustain the current level of activity. Based on the number of firms and individuals that have stopped providing health care to people in government run programs in states that have adopted Robert Wood Johnson inspired "reforms," and on the number of firms that have exited the private insurance market, the evidence suggests that the true cost of the Foundation's reforms have been masked by price controls and the imposition of system-wide losses on private agents.

### ***Monopoly Capitation Dangerous for the Sick***

Even with responsible pricing, the perverse incentives of capitated care pose a real danger to patient health. Under fee-for-service arrangements, people pay for treatment received. Though proponents of health care reform in Colorado routinely claimed that fee-for-service physicians were a danger to

patients' wallets because they ordered "unnecessary" procedures, there is little hard evidence to support that claim.

### ***Providers have an incentive to spend less on treatment***

There is evidence to support the contention that capitated payment systems can endanger patients if providers seek to increase their profits by spending less on treatment. This is true even if the capitated provider is a non-profit. In that case the same behavior occurs but the spoils typically accrue to staff members in perks like better working conditions and less strict cost control rather than to stockholders in the form of cash.

Providers can control their costs by imposing costs on patients in a variety of ways that are difficult to detect. They can refuse to tell patients that more effective, but more expensive, treatments exist. Patients locked into a capitated system by government edict are singularly ill equipped to counter this behavior because they rely on providers for information about their condition. Providers can require that patients try less effective, less expensive, treatments first, with the result that they save money but patients are sick longer. They can also explicitly ration procedures. This may be done by financially penalizing physicians who refer "too many" patients for certain medical or diagnostic procedures. It can also be done explicitly by making people wait, often for years, for procedures that are readily available under fee-for-service medicine.

### ***Severely ill neglected***

Capitated health care systems around the world also systematically neglect the sickest patients. Britain has third world cancer survival rates because its bureaucrats have ruled that advanced chemotherapy drugs are "too expensive." In Canada, patients die on wait-

ing lists for heart bypasses. One estimate suggests that Canadian elderly get such poor care that at a time when years of disability-free living were rising in most of the industrialized countries, the years that elderly Canadian women could expect to enjoy free of disabilities declined by 2.3.<sup>89</sup> Even simple tests like pap smears can take seven months. In 1988, patients in Sweden's socialist paradise waited 11 months for heart x-rays and another eight months for surgery.<sup>90</sup>

In Colorado's capitated Medicaid mental health system, anecdotal reports suggest that the mentally ill wait for care, and that only those suffering acute psychosis or threatening suicide get prompt appointments. People also report that high staff turnover makes therapy less helpful. As one person with schizophrenia pointed out, when you've spent two years spilling your guts to someone and they leave because they're burned out it is really hard to just start over. According to the State Auditor's report,

Our findings support issues raised by some Medicaid recipients and mental health advocates regarding service declines. Colorado is part of a national study on managed care. The preliminary results of this study indicate that, for both years after capitation was implemented, there were increases in the number of clients who reported that they were refused service. The study also reports that there are reductions in the probability of both inpatient and outpatient use. This indicates a reduction in the number of services provided. The study also preliminarily reports that there are no negative impacts on outcomes as a result of the change in services.<sup>91</sup>

It should be noted that negative impacts on

outcomes depend on what one measures. Proponents of the British National Health System claimed good outcomes for 40 years even though a large fraction of the British population chose to avoid free national health care by paying for private care. While the National Health Service considered transportation to and from the hospital an essential service, surgical waiting lists of 800,000 out of a population of 55 million were said to have no effects on measured health. Only recently have articles detailing third world cancer survival rates and other examples of life-threatening rationing begun making British newspapers.

***Political process diverts funds from severely ill to those with less expensive complaints***

Since politicians respond to votes, the tendency to pull resources from the severely ill and spend them on providing relatively cheap care to large numbers of people with less serious complaints characterizes almost all politically controlled capitated care systems. Political control also changes effectiveness measures, typically relying more on statistically based utilization measures of easily quantified health outcomes or on the impressions collected with surveys and site visits than on informed clinical opinions. Statistics on the operation of the health system as a whole are of limited value. The statistical studies that have made great contributions to better and less expensive patient care are often those that focus on how individual doctors or clinics treat individual conditions.

Even with spending cuts of five percent, Colorado's mental health carve-out required that providers continue treating the severely mentally ill while adding broad, untested, new services like peer counseling and support services, family preservation services, consumer drop-in centers, and early intervention.<sup>92</sup>

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Under existing rules, a teenager eligible for Medicaid who is feeling depressed because she broke up with her boyfriend has as much claim on state health care spending through her school-based health care center as a chronic schizophrenic who needs atypical antipsychotics simply to maintain a semblance of normal functioning.

Although capitation did give the plans unprecedented flexibility in determining how to spend the state's money to improve individual functioning, the question is whether the expected gain in efficiency was enough to fund the additional services without negatively affecting those who were seriously ill.

Evidence from Utah suggests that the expected gains from capitated systems may never materialize. In the early 1990s, some Utah counties had fee-for-service Medicaid mental health and some had capitated plans. Popkin *et al.* examined the medical records of 200 Medicaid beneficiaries in the state's capitated plans and compared them with those of 200 beneficiaries who remained in the fee-for-service system. Records were examined before the adoption of the prepaid plan in 1990 and followed for three years after it was instituted.

The authors found traditional therapeutic encounters were de-emphasized under capitation. They also found, "the probability of a patient's terminating treatment or being lost to follow-up increased, the probability of having a case manager increased, the probability of a crisis visit decreased (but still exceeded that at the nonplan sites), and the probability of treatment for a month or longer with a suboptimal dosage of antipsychotic medication increased."<sup>93</sup>

Mannin *et al.* compared outcomes for Utah Medicare beneficiaries with schizophrenia

under the two systems of care. Between 1991 and 1994, they found that the average beneficiary's mental health status improved, but that the improvement was less under the carve-out program. No doubt some of the improvement was due to the fact that atypical antipsychotics were just coming onto the market during this period. Still, schizophrenia patients improved less under the capitated carve-out than under fee-for-service, and the difference was greatest for those who were sickest when the comparison began.<sup>94</sup>

### ***State and contractor to split money not spent on treatment***

Pharmaceuticals are not now included in capitation rates for Colorado's Medicaid mental health program. But a pilot program to include them was proposed during the October 2000 budget process. According to the description of the proposed pilot mental health pharmacy program circulating at that time, "the pilot program promotes this goal [of capitating prescription drug spending] by creating a financing model whereby Mental Health Assessment and Services Agencies (MHASAs) are given a financial incentive to properly manage utilization of the target medications while avoiding financial harm if the calculated rate is insufficient to meet the needs of consumers."<sup>95</sup> It goes on to say that the purpose of the pilot program is to give the Department of Health Care Policy and Financing "time to develop a rate development model that is financially viable for full-risk capitation." The Department, in other words, was to be encouraged to extend its failed price control activities to another segment of the health care market.

Given what is known about the operation of monopoly capitated systems in Colorado and elsewhere, one aspect of the proposed pilot program was particularly revealing. The contract discussed in the report would require

that the MHASA contractors and the state share in the savings that were expected to materialize when the state's \$16 million in spending on antipsychotic medications was subjected to mental health plan capitation rates. The contractor would get to keep the first five percent of any savings generated. The second five percent would be shared, with 85 percent going to the contractor and 15 percent going to the state. The third five percent would be split with 60 percent going to the contractor and 40 percent going to the state. Anything above that would be evenly divided.

With this reform, Colorado's Medicaid mental health care reform would have boiled down to a government program in which the government and its contractors conspired to split the profits that come from reducing treatment for desperately ill people who had no other choice.

### ***Oregon follows in Colorado's footsteps***

Putting government in control of mental health care has not worked in Oregon, either. The original Oregon Health Plan did not include mental health or chemical dependency benefits. In 1993, after Robert Wood Johnson Foundation money for health system reform had begun to flow, Senate Bill 5530 was amended in a conference committee at the very end of the legislative session to create "demonstration projects" for Oregon Health Plan mental health services. Statewide implementation of Oregon Health Plan mental health services was to occur by July 1, 1996. As in Colorado, the programs were to be implemented long before the demonstration projects could be effectively evaluated, and state officials preferred a set-up using "full service managed care health service providers" to provide mental health care. Oregon counties feared that the proposed system would compromise their ability to continue

caring for the seriously and persistently mentally ill.

In 1997, the state solicited proposals to provide coverage for the mental health benefits included in the Oregon Health Plan. The process was not smooth. In September, after an appeal to Governor Kitzhaber, the Mental Health and Developmental Disability Services Division announced that most Medicaid enrollees would be awarded to county mental health facilities. By January 1998, most mental health managed care contracts were in place.

In February 2001, the Oregon Association of Hospitals and Health Systems issued a report by Michael McCracken Consulting that examined the performance of mental health services under the Oregon Health Plan. As in Colorado, McCracken found that costs increased far faster than the number of clients served. Although poor data preclude an accurate count, McCracken concluded that although the number of Oregon clients served likely increased by about nine percent from 1997 to 1999, the cost of serving them went up 31 percent. Mental health costs as a whole increased 42 percent. Physician costs increased only 21 percent over the same period, while hospital costs declined by six percent.

After discussing the fact that the state's data systems are in such disarray that "administrative costs cannot be determined," the report notes that "the cost increases of OHP mental health services cannot be explained by a concurrent increase in numbers of people receiving services." It concludes, "mental health cost increases are likely due to the creation of new entities, Mental Health Organizations (MHOs), and the complexities of multiple subcontracts, each with added administrative expenses," that "unexplained

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**The mentally ill are but the canaries in the coal mine.**

cost increases are growing rapidly as compared to costs that are adjusted for medical inflation,” and “contrary to the goal of containing growth in costs, the new system appears to have resulted in substantial cost increases beyond what can be accounted for by medical inflation.”<sup>96</sup>

Oregon Public Broadcasting reported in August 2001 that after three years of reorganization the Multnomah County mental health system had yet another reorganization plan and it was closing its Crisis Triage Center because the hospital operating it was losing too much money. Dr. Maggie Benington-Davis, the Medical Director of Psychiatry for Salem Hospital, said that there was a shortage of psychiatric beds in Oregon and that even before the Crisis Triage Center was closed, about 20 percent of Salem Hospital’s psychiatric beds were being filled with Multnomah County patients.<sup>97</sup>

***Conclusion***

The mentally ill are but the canaries in the coal mine. Although giving governments a monopoly over mental health care has resulted in reduced services and skyrocketing costs everywhere it has been tried, this is the reform model that proponents of a government monopoly on health care want to extend to every form of medical care in the United States. Sensible people should consider how well government health care monopolies have cared for the mentally ill. Then they should call for real reforms, reforms that put patients in charge of spending their own money, reduce regulatory costs, and get government out of the health care business.

## Notes

<sup>1</sup>The mortality ratio is the death rate from a disease divided by the disease incidence. Source: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000 as cited in John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf> as of September 15, 2002.

<sup>2</sup>John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf> as of September 15, 2002, p. 22.

<sup>3</sup>Organization for Economic Cooperation and Development, July 2002. GDP Per Capita, 2000. Online version at <http://www.oecd.org/pdf/M00018000/M00018518.pdf> as of October 2, 2002.

<sup>4</sup>George J. Schieber and Jean-Pierre Poullier. 1989. "Overview of International Comparisons of Health Care Expenditures," *Health Care Financing Review*, Annual Supplement, page 172. Cited in Joseph L. Bast, Richard C. Rue, and Stuart A. Esebury, Jr. 1992. *Why We Spend Too Much on Health Care*. Chicago: The Heartland Institute, p. 29.

<sup>5</sup> [www.rwjf.org](http://www.rwjf.org).

<sup>6</sup> Steven A. Schroeder, M.D. "Cost Containment," The President's Message, *Robert Wood Johnson Foundation 1994 Annual Report*, p. 1-4. As posted on the Internet on September 28, 1998. [www.rwjf.org/library/annl94/p6.htm](http://www.rwjf.org/library/annl94/p6.htm).

<sup>7</sup>Michael Hoel and Erik Magnus Saether, "Private Health Care as a Supplement to a Public Health System with Waiting Time for Treatment," Frisch Center for Economic Research, Oslo, 2000, p. 25. Cited in footnote 22, John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf>, online edition, September 15, 2002.

<sup>8</sup> See, for example, Brigid McMenemy. December 16, 1996. "Trojan Horse Money," *Forbes*, p. 123-128; John Hood. November 1997. "Foundations and Public Policy: A View From the States," *Foundation Watch*, Capital Research Center, Washington D.C. pp. 1-7; Capital Research Center. January 1997. *Organization Trends*, "Pennsylvania Legislative Report Demands Restrictions on Private Foundation Influence Over State Government," Washington, D.C., p. 1-5; Patrick Reilly, February 1999. "A Cure Worse than the Disease: Foundations' Health Policy Funding Increase 1990s," *Foundation Watch*. Capital Research Center, Washington, D.C.; Linda Gorman. November, 2000. "Robert Wood Johnson Foundation: How Its Grants Influence Colorado's State Health Policy." *Foundation Watch*, Capital Research Center, Washington, D.C. Available on the web at <http://www.capitalresearch.org/>

publications/foundation\_watch/fw-1100.htm as of October 15, 2002.

<sup>9</sup>Author's calculations based on data from Dialog File #27, Foundation Grants Index, September 26, 2002.

<sup>10</sup> Dialog File #27, Foundation Grants Index, September 26, 2002. In a 1992 grant to the Oregon Department of Human Resources the strings were clear even in the reported purpose of the grant—"designing mandatory employment-based insurance system." For a case study of how Robert Wood Johnson Foundation grants typically operate see Linda Gorman. November 2000. "Robert Wood Johnson Foundation: How Its Grants Influence Colorado's State Health Policy." *Foundation Watch*, Capital Research Center, Washington, D.C. Available on the web at [http://www.capitalresearch.org/publications/foundation\\_watch/fw-1100.htm](http://www.capitalresearch.org/publications/foundation_watch/fw-1100.htm) as of October 15, 2002. "

<sup>11</sup> The timing of this grant suggests that it was for use in support of passing the tobacco tax. In Colorado, the Robert Wood Johnson Foundation's SmokeLess States program awarded the Coalition for a Tobacco-Free Colorado a \$1,000,000 grant for voter "education." The funds were used to collect the signatures needed to put a tobacco tax increase on the ballot through the initiative process. A state employee from an executive branch department receiving Robert Wood Johnson funding apparently helped run the campaign. For more on the Smokeless States program see Patrick Reilly, August 1998. "Not a Grassroots Campaign: Foundations, Government Bankroll Anti-Tobacco Crusade, *Foundation Watch*, Capital Research Center, Washington, D.C. Online

copy available at <http://www.heartland.org/pdf/23804z.pdf>.

<sup>12</sup>The Robert Wood Johnson Foundation, "National Program Progress Report," May 2002. "Preparing Physicians for the Future," Oregon Health Sciences University, <http://www.rwjf.org/reports/grr/020472.htm>, October 1, 2002.

<sup>13</sup> <http://www.facct.org/facct/site>

<sup>14</sup>John Santa, Susan Prows, and Bob DiPrete. June 1, 2001. Oregon State Coverage Initiative (ORSCI). Office for Oregon Health Plan Policy and Research, Salem, Oregon. p. 5.

<sup>15</sup>John Santa, Susan Prows, and Bob DiPrete. June 1, 2001. Oregon State Coverage Initiative (ORSCI). Office for Oregon Health Plan Policy and Research, Salem, Oregon. p. 7.

<sup>16</sup> John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf>, online edition, September 15, 2002, p. 45.

<sup>17</sup> The list, as of May 1, 2002 is available on the web at [http://www.ohppr.state.or.us/hsc/PDF\\_hsc/May%201,%202002%20Prioritized%20List%20with%20Guidelines.pdf](http://www.ohppr.state.or.us/hsc/PDF_hsc/May%201,%202002%20Prioritized%20List%20with%20Guidelines.pdf).

<sup>18</sup> Mark Litow and the Technical Committee, "Rhetoric vs. Reality" Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994.

<sup>19</sup>Patricia Danzon. Spring 1992. "Hidden Overhead Costs: Is Canada's System Really Less Costly?" *Health Affairs*.

<sup>20</sup> John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf>, online edition, September 15, 2002, p. 21 and Table V.

<sup>21</sup> Oregon Health Services Commission Report: *Prioritized List of Benefit Packages for OHP Standard*. October 2001. The Office of Oregon Health Policy and Research, Salem, Oregon. pp. 28 and 32.

<sup>22</sup> John C. Goodman and Devon M. Herrick, 2002. *Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World*, National Center for Policy Analysis, Dallas, Texas. <http://www.debate-central.org/topics/2002/book2.pdf>, online edition, September 15, 2002, pp. 49-50.

<sup>23</sup> Martin Zelder. 2000. *Canadian Health Reformers Should Understand RAND*. Fraser Forum, online edition. Fraser Institute, Vancouver. [http://oldfraser.lexi.net/publications/forum/2000/02/section\\_01.html](http://oldfraser.lexi.net/publications/forum/2000/02/section_01.html)

<sup>24</sup> Note that the more recent health care "reforms," in Canada and in Medicare, have been laws making it illegal for people to buy health care with their own money. Although Britain allows private medical care to coexist with the National Health Service, Canadian reformers seeking to improve on the British system made it

illegal to buy medical care outside the government system. Medicare has made it illegal for Medicare recipients to add their own money to Medicare reimbursements in hopes of obtaining a higher standard of care. Due to low pay for their work, doctors are migrating out of Canada, and U.S. physicians are refusing to accept both Medicaid and Medicare patients. The Oregon Comprehensive Health Care Finance Plan as embodied in Measure 23 on the November, 2002 ballot, continues this program by requiring that "a health service provider that accepts payment for health services from the Oregon Comprehensive HealthCare Finance Plan may not bill participants for those services. The provider must accept as payment in full amounts received from the Plan."

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<sup>26</sup> State of Colorado, Department of Health Care Policy and Financing, Advisory Committee Handout, January 13, 2000. *Waiver Comparison Chart*. As published on the web as of 5 February 2001, <http://>

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