Denying medical services – who decides?

Is the country at the precipice of a major shift regarding who and how permissible health behaviors and receipt of medical services are determined? Although his reasoning is specious, columnist Dana Milbank in the June 30, 2014 *Washington Post* contends that because of a Supreme Court of the United States (SCOTUS) decision, certain citizens "can now be denied contraception…required under Obamacare." Although untrue, the phrase "required under Obamacare" piques inquiry.

The SCOTUS decision does not allow anyone to deny contraception to any citizen. It held that certain third parties could not be compelled to pay for four out of twenty types of contraception some may desire. The individual or another third party would have to pay for these relatively inexpensive (less than $40) services.

However, what if the service cost $1,000 or up? What does or will Obamacare "require" for the latest Hepatitis C treatment ($84,000), bariatric surgery for obese, hypertensive, pre-diabetic adolescents, low dose C-T lung scans for high risk smokers, virtual colonoscopy, 3-D mammography, smoking cessation products, including e-cigs, and the list goes on.

It is not the ACA law per se, but some individual(s) within the bowels of HHS who decide what services will be "required". To date this basically translates into what services must be paid for by third parties subject to ACA provisions. However, for many citizens of modest means, the HHS decisions could pragmatically dictate "de facto" receipt or denial of the service. Such "de facto" denials, i.e., "rationing" is not a new phenomenon but the major concentration of such decision making within a central, government, executive branch bureaucracy is. Who are these individuals and how will they decide?

Less than 100 years ago decisions regarding health behavior and receipt (together with responsibility for payment) of services was almost exclusively left to each individual. For public health and moral reasons, secular and religious communities placed a few restrictions upon health behaviors and assisted individuals in access to services. Charlatans roamed free and worthless and toxic remedies were unregulated. Pope Brock's book, Charlatan, vividly describes the horrible abuse and maiming that continued well into the 1900's before federal, e.g. FDA, and state agencies, laws and regulations began to provide rudimentary consumer protections regarding receipt of medical care and medical research.

Over the last 50 years, there have been far reaching, public-private, health professional, cooperative arrangements to assure medical care is competently delivered and medical products are safe and efficacious. Great care has been taken to assure such arrangements do not stifle scientific inquiry and advancements. Such deliberative bodies often include "cost-effectiveness" or "comparative effectiveness" analysis in their findings but primarily recommend whether they believe *scientifically* a health service or product is relatively safe, effective and falls within accepted professional standards. Recent Federal Trade Commission (FTC) action has challenged the legal legitimacy of some such arrangements.

These entities often recommend third party payers reimburse for certain services, especially if they believe they are superior to existing ones for certain patients. Patients' previous health behaviors and

practices, ideology, budget constraints and payment arrangements, e.g., cost-sharing, are factors that are not intended to influence such recommendations. These arrangements largely determine what products and services “de jure” will be available (that is, “not-denied) to the public. Payment is a separate issue.

What an individual must pay to have a service reimbursed through a third party arrangement is largely determined by other public and private third party entities and, more recently, central government authorities. Certain penalty practices have been curtailed, e.g., pre-existing condition denials, but other health behavior/ demographic payment penalties remain, e.g. age, smoking. Penalties related to high risk sexual behavior, drug and alcohol use/abuse, inactivity, poor dietary habits, unwed teenage pregnancies, poor immunization adherence and other costly poor health practices have largely been ignored for practical, political and other reasons.

Recently third party payers and central government authorities have hesitated to pay for certain “medical advancement” services (hepatitis C, bariatric surgery, low dose CT lung scans), avoidable if the recipients had followed good health behaviors. An example includes a June 16th Wall *Street Journal* op. ed. by several medical specialists blasting Medicare for failure to cover lung CT scans for high risk seniors, despite the recommendations of several health professional groups, including the United States Preventive Services Task Force (USPSTF). A CMS spokesperson stated Medicare would make the decision based upon whether it was “reasonable and necessary…without regard to its cost to Medicare”.

Really? What non-ideological, non-judgmental, *scientific* criteria does CMS plan to use that were not considered by these other groups of health experts? Is this how it will be determined what services are “required by Obamcare”? Is it prudent to mix service “legitimacy” with service “payment”? Will these individuals replace the arrangement we have utilized for the last 50 years? Will a “required” service morph into a “permissible” service? Who are these folks who will now decide? Is this what we want?