**Michigan House Bill 4936 – Is It Genocide?**

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Today, I spoke with Mr. Jeffrey Robinson, a senior manager at the State of Michigan Family Independence Agency in Pontiac, MI. Mr. Robinson has spent most of his career in state Medicaid. He is an endearing family man who cared for his dying father. As his story unfolded, he explained that up until that point, he had never seen the care of debilitated, incapacitated patient firsthand, had never been inside a nursing home. His eyes widened as he talked about his father in the latter stages of his life, when he and his aging mother could no longer care for the man who had once been their Rock of Gibraltar, and brought him to the nursing home for care. Mr. Robinson is a man of integrity and compassion, and has spent the major portion of his life in this state funded system supervising and implementing teams of tireless field workers to care for the vulnerable, poverty stricken, ill and elderly population in Michigan. He was just the kind of man I wanted to talk with today.

I introduced myself as a registered nurse and case manager with a background in trauma and intensive care nursing in Detroit, now managing catastrophic injury patients within the Michigan No-Fault medical insurance system. My concern is house bill 4936, introduced by Representative Peter Lund, a Republican, who, at one time, worked in the Michigan insurance industry.

The Michigan Insurance Commission has attempted to do away with the No-fault system twice, and each time, the people of Michigan voted to maintain its No-Fault care. Representative Lund’s bill is strongly backed by the Michigan Insurance Commission. It is a strategically crafted document, with appropriation for no referendum, so the people of Michigan do not have the opportunity to vote on the bill. It will cap patient medical care and cost for auto injury at $250,000.00. There are no provisions written into the bill once the cap is reached, other than sending the patients into the state Medicaid system.

Representative Lund and Insurance Commissioner Kevin Clinton state their case for the bill is that the Michigan Catastrophic Claims Association (MCCA), the mechanism that funds the motor vehicle accident catastrophic injury patients that exceed $500,000 in existence since 1978, with $11 billion in the fund, is going to run out of money, so, they want to send the patients to the state Medicaid system, that is already a cash poor fund, sustained by Michigan taxpayers.

As we talked, I described my patients; the 1%-2% of the patient population that Commissioner Clinton complained was spending all the MCCA money, during his testimony at the House of Representative hearings in Lansing on October 13, 2011.

I told Mr. Robinson about Mr. R, a traumatic brain injury and spinal cord injury patient who is paralyzed from the chest down from a car accident. He has some short term memory loss and intermittent mild confusion that worsens with increased fatigue, pain or infection. He cannot turn his body over in bed, and requires hands on assistance to reposition his body every hour to avoid decubitus ulcers, and must be exercised two to three times a day to avoid contractures. He cannot eliminate waste products normally because the nerves in his colon and bladder no longer work. His bladder must be catheterized by an assistant every 2 to 3 hours so it does not get overfilled, triggering autonomic dysreflexia (AD), a spinal cord condition that increases heart rate, blood pressure and can cause stroke, heart attack and seizures. He has already had one heart attack in an AD event. He is unable to maintain an indwelling bladder catheter due to his high frequency of urinary tract infections that advance to sepsis and require hospitalizations. He has had two hospitalizations already this year. He requires assistance with a bowel program with enemas every morning to evacuate. He requires hygiene care throughout the day, as his small and intermittent bowel movements continue after each meal, further putting him at risk for skin breakdown and ulceration. Mr. R lives alone. He is divorced. His children do not visit him very often. His relatives live out of state and are not involved with him other than on holidays. Under the Michigan No-Fault law, Mr. R. receives the following care: He has 24 hour nursing care with an RN supervisor and nursing assistants highly trained in the care of spinal cord injury patients. The nursing assistants perform daily hygiene and personal care and dressing, and exercise. They assist in feeding, meal preparation, housekeeping and laundry. Mr. R participates in a highly specialized spinal cord injury therapy program three times a week at a federally funded research based university hospital rehabilitation center, and his Physical therapists train his nursing assistants in his ever evolving home exercise program as he continues to build muscle. He has a highly skilled team of teaching and research physicians overseeing his care in the specialties of Rehabilitation, Neuropsychiatry, Urology, Gastrointestinal and Pain management. Mr. R experiences pain and muscle spasms that are so disabling, he becomes non-functional, with pain ratings at 9-10 out of 10 on an analog pain scale. He screams and cries in agony. This is because his trauma injured the pain receptor sites in the white matter of his brain and spinal cord. Those receptor sites don’t work normally anymore to process pain medications effectively and he is unresponsive to safe oral amounts of medications. Mr. R has an intrathecal pump, about the size of a hockey puck, implanted just above his left hip. There is a catheter that runs from the pump to the spinal cord and is held in place with sutures just at the cord space. The catheter delivers small amount of medication into the intrathecal space, the area surrounding the spinal cord, and into the cerebral spinal fluid where it is then circulated throughout the brain. The pump was surgically implanted by Neurosurgery and requires monthly syringe refills and regular maintenance for safety by a Pain Anesthesia specialist. This pump keeps his pain levels down to 2 to 3 out of 10 on the pain scale.

Mr. R has a cognitive retraining and computer specialist who comes to his home once a week to help him learn how to use adaptive and computer equipment with a sip and puff device that he wears around his shoulder and operates with his teeth and tongue. He also has “as needed” sessions by Skype with his therapist when he runs into an electronic glitch. He is able to use a PC to surf the internet and make telephone calls from his cell phone. He has daily homework on a computer-based program to exercise his mind to sharpen his thinking and memory skills. He is now learning how to use a computer based program that is being installed in his home that will allow him to turn the lights on and off, open and close and lock and unlock doors and windows, and access every electrical device in his home with his sip and puff device. His home was remodeled to wheelchair level with a roll in shower, exit/entry ramps at 2 egresses. A hydraulic elevator lift in the garage to get him to his mini-van that has a wheelchair lift and lockdown ties to keep his wheelchair from being displaced during transit. He has a specialized power wheelchair that operates with the sip and puff device, and it has a tilt space seat that Mr. R can reposition every 15 minutes to avoid skin breakdown on his hips and buttocks while he is seated. Mr. R has goals. He wants to return to being an independent businessman, and he wants privacy again.

Then, I told Mr. Robinson about another patient. A young woman with a spinal cord injury, paralyzed from the chest down. Ms. J’s needs are very similar to Mr. R. The only difference is, Ms J does not have Michigan No-Fault auto insurance coverage. Ms J is the recipient of Medicare and Medicaid. She lives with her mother, who works 40 to 50 hours week as a waitress in two establishments to keep their home and the bills paid. She cannot get health insurance from her employers, as she works part-time, and she does not make enough money to buy her own or to cover her disabled daughter. Ms J is left alone most of the day while her mother is at work. The wheelchair ramp that her mother fundraised for at her workplace is broken from the ice and snow last winter and she can’t afford the repairs. She worries how they would get her daughter out of the house if there was a fire. She is fundraising again. Her dream is to be able to afford a tilt space power wheelchair for her daughter and a minivan with a lift to take her daughter on a road trip. While her mother is working, or fundraising, Ms J is either in her bed, or in her wheelchair. Sometimes, the television is on. Other days, she asks her mother to leave the radio on instead. She sleeps to escape the boredom. Once a day, a neighbor will come in to check on her, feed her and change her body position to alleviate the pressure on her skin. When her mother comes home, she bathes her and cleans her diaper from the days waste adhered to her skin, and cares for her wounds. Because Ms J is not repositioned regularly, she has developed decubitus ulcers. The wounds are so deep, her pelvic bones are infected. Her Medicaid doctors have provided her with oral antibiotics without success. She has had numerous hospital admissions for sepsis over the past year with intravenous antibiotic therapy, and the wounds begin to heal until she is discharged home again. Medicare coverage provides skilled nursing for wound care once a day, but only for 6 weeks, unless she has another hospital admission to recertify her care for another 60 days. The wounds continue to increase in depth. Her mother has tried to get her into a Medicaid nursing home, but there are no openings in any of the more updated, modernized facilities, and Ms J tells her mother that she would rather die at home than in one of “those places”. The wounds and infection have become so severe, the doctors are telling Ms J and her mother that she will need a hemi-pelvectomy, which is a lower body amputation from the hips down. Ms J says that if she has to do that, she would rather be dead. She feels she is dying already. She is suffering from severe Depression. Her doctor gives her an anti-depressant and prescribes counseling, but she can’t get to the counseling office during business hours because there is no one to take her while her mother is at work.

Mr. Robinson and I talked at length about the HB4936 plan to transfer No-Fault auto patients into Medicaid. He told me that there is no way that Michigan’s Medicaid system can care for these patients the way No-Fault does. It can’t provide 24 hour in-home nursing care, specialized Physical, Occupational and Cognitive therapy programs, adaptive equipment, power wheelchairs with tilt spacing, wheelchair ramps, power beds, computers, home modifications, or modified vans with lifts. It cannot provide specialized pain medications, non-generic medications, intrathecal pumps and syringe medications.

He also explained that not all physicians will participate in the Medicaid program, because it pays at such a lower rate, the physicians can’t pay their overhead and staff salary on Medicaid, and give themselves a decent salary to care for their families and pay off their loans. I told Mr. Robinson about the billboards on Interstate 96 on the way to Lansing that advertise MRI’s with No-fault at about $800 and without No-fault at about $200. He told me that Medicaid pays the lowest for MRI’s.

Mr. Robinson also explained that Medicaid is based on income and sliding scale benefits. Patients who have monthly Medicare Social Security Disability Payments can only be immediately Medicaid eligible at or below approximately $700 payments. If they are above that level, they will have a Medicaid spend down – an out-of-pocket deductible to meet, usually $1000.00 or more, before Medicaid coverage pays. Patients also have to have medical bills every three months to continue qualification for Medicaid, or they have to re-apply. Patients have to reach poverty level to qualify, and, although they are allowed to own a home and a car, they cannot have more than a specific amount of money in the bank. If they go into a nursing home, the Medicaid system will confiscate all their assets to pay for the nursing home costs, unless there is specific legal work done to bypass this recovery. Together, we identified a “Gap Patient” – one that does not yet qualify for Medicaid because they have not reached poverty level, yet will not have enough income to cover the costs of private medical insurance or medical care and treatment

We also talked about tax based state funding for the Michigan Medicaid program. Recent studies note there will be an immediate $30 million expense shift into Medicaid if No-Fault coverage ends. Mr. Robinson advised that taking into consideration that Michigan has the highest unemployment rate and foreclosures in the country since the fall of the auto industry, and that the end of No-fault auto medical coverage will eliminate an entire medical care industry serving the No-Fault catastrophic injury patients, he anticipates millions of tax dollars lost to the state revenue for Medicaid funding due to loss of yet more corporate and employee taxes.

Then, the hardest question came up. Will patients suffer medical complications and die from lack of care?

Mr. Robinson’s answers were stark.

The patients that need 24 hour care qualify as nursing home patients in the Medicaid system. There are just not enough Medicaid nursing homes in Michigan to accommodate the transfer of No-fault auto catastrophic injury patients for that kind of care. The Medicaid program can’t give the specialized care this patient population needs to overcome their injuries in a medically safe manner. There are too many barriers to care and not enough funds, and the funds will get leaner with the loss of tax based funding and business closures. Which means, medically high-risk patients with lack of care will endure medical complications leading to multi-system failures, depression and suicide.

Then, Mr. Robinson asked me a question. “Why are we doing away with a system that works? If it’s not broken, don’t fix it!” We talked about the MCCA funds and how the system was designed and developed by the people of Michigan and has never suffered financial difficulty in its existence. Presently, it costs drivers .40 cents per day for a lifetime medical benefit with world class care. We both felt that was a good return! Michigan has become a national leader in the research and development of brain and spine injury treatment, with federal grants for research at Detroit Medical Center and University of Michigan hospitals. The United States Military looks to Michigan for trauma care and training of their physicians. We have trauma physicians right here in Michigan who have traveled to Afghanistan to teach in the Doctors Without Borders program.

What about other states? We pondered. We know that Florida and West Virginia are studying Michigan’s No-Fault system as a model for their own patient care and coverage. A review of the 49 states shows a pattern of excessive litigation going on for years with patients and families holding fundraisers to meet care needs and medical expenses, forced to sell their family homes and using all their assets.

I reminded him that Insurance Commissioner Clinton says the MCCA fund is non-sustainable. He’s afraid it will run out of money. A 2010 report was located recently. It stated the MCCA paid out a little over $700 million last year, and there’s $11 billion in the fund and growing, but he’s afraid it will run out of money.

It’s what he says, but we really don’t know, because the MCCA won’t release their financial records to the public. It’s listed as a private fund, however, it is answerable to the Insurance Commission. He also won’t say where the $11 billion is going to go, if he gets it. Will it go to Medicaid to take care of the patients? No one knows.

What we do know, is that the Michigan Insurance industry stands to make more profits with HB4936. It will cap medical payouts, and charge more for premiums if drivers want to buy more insurance over the $250,000 cap. It will require drivers to pay higher liability insurance premiums because they will be personally liable for litigation to cover medical costs for victims that supercede the cap they purchased, if that driver caused the accident. It will drive the cost of health insurance premiums higher because people will need to purchase more health care coverage and long term care insurance.

We know for a fact that the Michigan Insurance Commission stands to make high profits.

We also know for a fact that the medically high risk No-fault patients, that 1% to 2% of the auto injury population, stand to go without necessary medical and nursing care and face medical complications, suffering and death.

This posed a serious ethical question for us:

Is it morally and ethically correct for a government to deliberately set up a chosen group of vulnerable, high risk people to receive significantly less medical care, putting them at credible risk for medical complications and death to gain significant amounts of money at that group of people’s demise?

Isn’t that genocide?

So, I googled:

Genocide is…

.”**Deliberately inflicting conditions of life calculated to destroy a group includes the deliberate deprivation of resources needed for the group’s physical survival, such as clean water, food, clothing, shelter or medical services.”**

Yes – it’s a fact. Michigan house bill 4936 is Genocide.

References:

**The legal definition of genocide** (Including Discussion and Key terms)

The international legal definition of the crime of genocide is found in Articles II and III of the 1948 Convention on the Prevention and Punishment of Genocide.

Article II describes two elements of the crime of genocide:

1) the ***mental element****,* meaning the"intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such", and

2) the***physical element***which includes five acts described in sections a, b, c, d and e. A crime must include *both elements* to be called "genocide."

Article III described five punishable forms of the crime of genocide: genocide; conspiracy, incitement, attempt and complicity.

**Excerpt from the *Convention on the Prevention and Punishment of Genocide*** *(*[*For full text click here*](http://www.preventgenocide.org/law/convention/index.htm#text)*)*

**"Article II:  In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:**

**(a) Killing members of the group;  (b) Causing serious bodily or mental harm to members of the group;  (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;  (d) Imposing measures intended to prevent births within the group;  (e) Forcibly transferring children of the group to another group.**

**Article III:  The following acts shall be punishable:**

**(a) Genocide;  (b) Conspiracy to commit genocide;  (c) Direct and public incitement to commit genocide; (d) Attempt to commit genocide;  (e) Complicity in genocide. "**

***Discussion:***

**It is a crime to plan or incite genocide, even before killing starts, and to aid or abet genocide**: Criminal acts include conspiracy, direct and public incitement, attempts to commit genocide, and complicity in genocide.

***Punishable Acts*** *The following are genocidal acts when committed as part of a policy to destroy a group’s existence:*

**Killing members of the group** includes direct killing and actions causing death.

**Causing serious bodily or mental harm** includes inflicting trauma on members of the group through widespread torture, rape, sexual violence, forced or coerced use of drugs, and mutilation.

**Deliberately inflicting conditions of life calculated to destroy a group** includes the deliberate deprivation of resources needed for the group’s physical survival, such as clean water, food, clothing, shelter or medical services. Deprivation of the means to sustain life can be imposed through confiscation of harvests, blockade of foodstuffs, detention in camps, forcible relocation or expulsion into deserts.  **Prevention of births** includes involuntary sterilization, forced abortion, prohibition of marriage, and long-term separation of men and women intended to prevent procreation.  **Forcible transfer of children** may be imposed by direct force or by fear of violence, duress, detention, psychological oppression or other methods of coercion. The Convention on the Rights of the Child defines children as persons under the age of 18 years.

**Genocidal acts need not kill or cause the death** of members of a group. Causing serious bodily or mental harm, prevention of births and transfer of children are acts of genocide when committed as part of a policy to destroy a group’s existence.

***Protected Groups:***

***The law protects four groups - national, ethnical, racial or religious groups.***

A **national group** means a set of individuals whose identity is defined by a common country of nationality or national origin.

An **ethnical group** is a set of individuals whose identity is defined by common cultural traditions, language or heritage.

A **racial group** means a set of individuals whose identity is defined by physical characteristics.

A **religious group** is a set of individuals whose identity is defined by common religious creeds, beliefs, doctrines, practices, or rituals.

**Usually people are born into these four groups.** These four groups share the common characteristic that individuals are most often born into the group. While some individuals may change nationality or religion - or even adopt a new cultural, ethnic or racial identity - usually people do not choose their group identity. In genocide people are targeted for destruction not because anything they have done, but because of who they are.

**Group idenity is often imposed by the perpetrators.** Perpetrators of genocide frequently make group categories more rigid or create new definintions which impose group identity on individuals, without regard to peoples individual choices.

***Key Terms:***

**The crime of genocide has two elements: intent and action.** “Intentional” means purposeful. Intent can be proven directly from statements or orders. But more often, it must be inferred from a systematic pattern of coordinated acts.

**Intent is different from motive.** Whatever may be the motive for the crime (land expropriation, national security, territorial integrity, etc.), if the perpetrators commit acts intended to destroy a group, even part of a group, it is genocide.

**The phrase "in whole or in part" is important.** Perpetrators need not intend to destroy the entire group. Destruction of only part of a group (such as its educated members, or members living in one region) is also genocide. Most authorities require intent to destroy a substantial number of group members – mass murder. But an individual criminal may be guilty of genocide even if he kills only one person, so long as he knew he was participating in a larger plan to destroy the group.

***Other Information:***

[**Kofi Annan's Stockholm Genocide Prevention Proposals, January 26, 2004**](http://www.preventgenocide.org/prevent/UNdocs/KofiAnnanStockholmGenocideProposals26Jan2004.htm)In Stockholm, Sweden on January 26, 2004 UN Secretary-General Kofi Annan calls for parties to the [Genocide Convention](http://www.preventgenocide.org/law/convention/text.htm) to establish a Genocide Prevention Committee and a UN Special Rapporteur on Genocide Prevention.

[**Ratification Status:**](http://www.preventgenocide.org/law/convention/index.htm#ratifications)135 Nations are parties to the Genocide Convention, but 52 Nations are NOT, including Indonesia, Japan and Nigeria.

Article II was included without change in the [**Rome Statute of the International Criminal Court**](http://www.preventgenocide.org/law/icc/statute/languages.htm) as [**Article 6**](http://www.preventgenocide.org/law/icc/statute/part-a.htm#a6) and also in the the Statutes of the International Criminal Tribunals for Rwanda and former Yugoslavia. For a more detailed description of the crimes described in Article II (Rome Statute Article 6) see the [**Elements of the Crime of Genocide**](http://www.preventgenocide.org/genocide/elements.htm) agreed upon by the International Criminal Court Preparatory Commission in June 2000.

Over 80 nations have made provisions for the punishment of genocide in [**domestic criminal law**](http://preventgenocide.org/law/domestic/), sometimes modifying the legal definition. [**Prosecution of genocide in domestic courts**](http://preventgenocide.org/punish/domestic/index.htm#russia) is becoming more frequent.

The legal definition of genocide can be compared to [**five alternative definitions of genocide**](http://www.isg-iags.org/definitions/def_genocide.html) proposed by researchers and scholars Frank Chalk & Kurt Jonassohn, Israel Charny, Helen Fein, Barbara Harff & Ted Gurr and Steven Katz.

**U.S. Code; Chapter 50A;**

**Section § 1091. Genocide**

  **(a) Basic Offense.** - Whoever, whether in time of peace or in time of war, in a circumstance described in subsection (d) and with the specific intent to destroy, in whole or in substantial part, a national, ethnic, racial, or religious group as such.

(1) kills members of that group;

(2) causes serious bodily injury to members of that group;

(3) causes the permanent impairment of the mental faculties of members of the group through drugs, torture, or similar techniques;

(4) subjects the group to conditions of life that are intended to cause the physical destruction of the group in whole or in part;

(5) imposes measures intended to prevent births within the group; or

(6) transfers by force children of the group to another group; or attempts to do so,

shall be punished as provided in subsection (b).

**(b) Punishment for Basic Offense.** - The punishment for an offense under subsection (a) is -

(1) in the case of an offense under subsection (a)(1), where death results, by death or imprisonment for life and a fine of not more than $1,000,000, or both; and

(2) a fine of not more than $1,000,000 or imprisonment for not more than twenty years, or both, in any other case.

**(c) Incitement Offense.** - Whoever in a circumstance described in subsection (d) directly and publicly incites another to violate subsection (a) shall be fined not more than $500,000 or imprisoned not more than five years, or both.

**(d) Required Circumstance for Offenses.** - The circumstance referred to in subsections (a) and (c) is that -

(1) the offense is committed within the United States; or

(2) the alleged offender is a national of the United States (as defined in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101).

**(e) Nonapplicability of Certain Limitations**. - Notwithstanding section 3282 of this title, in the case of an offense under subsection (a)(1) an indictment may be found, or information instituted, at any time without limitation.

**Section §1092. Exclusive remedies**

Nothing in this chapter shall be construed as precluding the application of State or local laws to the conduct proscribed by this chapter, nor shall anything in this chapter be construed as creating any substantive or procedural right enforceable by law by any party in any proceeding.

**Sec. 1093. Definitions**

As used in this chapter -

(1) the term **''children''** means the plural and means individuals who have not attained the age of eighteen years;

(2) the term **''ethnic group''** means a set of individuals whose identity as such is distinctive in terms of common cultural traditions or heritage;

(3) the term **''incites''** means urges another to engage imminently in conduct in circumstances under which there is a substantial likelihood of imminently causing such conduct;

(4) the term **''members''** means the plural;

(5) the term **''national group''** means a set of individuals whose identity as such is distinctive in terms of nationality or national origins;

(6) the term **''racial group''** means a set of individuals whose identity as such is distinctive in terms of physical characteristics or biological descent;

(7) the term **''religious group''** means a set of individuals whose identity as such is distinctive in terms of common religious creed, beliefs, doctrines, practices, or rituals; and

(8) the term **''substantial part''** means a part of a group of such numerical significance that the destruction or loss of that part would cause the destruction of the group as a viable entity within the nation of which such group is a part.

* *Source:* [**United States Code (Cornell University)**](http://www.law.cornell.edu/uscode/18/1091.html)

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