

*Testimony  
Of  
Linda Peeno, MD\**

**Domestic Policy Subcommittee of the  
Oversight and Government Reform Committee**

*Wednesday, September 16, 2009  
2154 Rayburn HOB  
10:00 a.m.*

***“Between You and Your Doctor: the Private Health  
Insurance Bureaucracy”***

**Oral Statement**

Mr. Chairman, members of the Committee, thank you for inviting me to this hearing today.

My name is Linda Peeno. Over three decades ago I obtained a hard-earned M.D. degree, expecting to practice medicine for the *benefit* of patients. After finishing medical school I had a series of jobs in which I functioned as a company doctor for several health plans. As I began to witness and participate in harm and death to patients, I left my lucrative corporate career and have spent the past 2 ½ decades working to educate others about the inner workings of the American health insurance industry.

I made one of my first appearances here before Congress in 1996, when I came as a former medical reviewer to talk about the way I had caused the death of a patient. I naively expected the country to be shocked into action. Little changed happened since we are here again, and clips from that testimony have re-emerged with shocking timeliness. I come back here today with 13 years of additional insider experience from work on over 150 legal cases against managed care companies, as well as extensive knowledge gained by helping thousands fight for needed care. I am here today representing no special interest group, and without any agenda except to urge you to force open the black box of corporate health insurance and to hold them accountable for the practices that destroy the lives of patients, families and communities, and the health professionals who must bear the consequences of their damaged care.

Things have never been worse for patients. The corporate machines are well-developed and expertly operational. The methods are more insidious, covert and devious. In

addition to outright denials of care, new tactics proliferate to avoid, delay, limit, substitute, and manipulate care for the maximization of profits. The difference between the kinds of denials I testified about in 1996 and the current system is akin to the difference between surgery with a kitchen knife and a scalpel. Cost-cutting, –saving, and –making tactics have never been so expert and deadly.

I come here today with several warnings:

- **There is an abyss between what insurance companies say and what they do:** Do not be fooled when the health insurance industry claims that it has abandoned its “old” practices of managed care. Although they say they have become more efficient, this “efficiency” works can be deadly for patients. It is easier to target high costs conditions and patients, more tactics can be recruited to deny care either directly or indirectly. Methods can be more oblique and hidden. For example, I have seen a case in which an insurance company claimed to cover a certain type of transplant, but when specific patients needed that particular category of transplants, they encountered delays, obstacles, hidden policies and other strategies that prevented them from ever receiving what they needed. Companies claim to deny less, even though a recent study shows that denial rates ranged up to almost 40%. (LA Times, September 3, 2009) Even this rate does not take into account all the de facto “denials” that occur when care is altered in ways that do not leave a record to monitor, e.g. “requests” and “encounters” that never make it to a claim. Furthermore, insurers defend their reported denial rates by claiming that they are mostly “technical,” and not “medical.” This distinction is an artificial shift that companies have perfected as they have systematized medicine into something that can be codified and contractual, eliminating clinical judgment and patient particulars that are the essence of the practice of medicine. The increase in new “health information networks” that integrate administrative, financial, and clinical data and services is a troubling sign of this trend.
- **There are new “agents” of denial:** Treating doctors and other health professionals often become a company’s “agents” for limitation, avoidance, substitution, delay and denial: Over the past two decades, insurance companies have learned how to manipulate criteria, data, contracts, payment schemes, performance evaluations, profiling, marketing and other means to co-opt physicians in their profit schemes. These sophisticated forms of behavioral modification force many physicians to adjust their ethics to fit corporate economics. When treating physicians become company doctors there is no record of denials and nothing to regulate. I have recently become aware of a situation in which a treating physician not only withheld care, he actually subjected a patient to harmful care in order to ensure that she did not qualify for a more costly procedure. Even a medical director does not have that kind of denial power. Yet this pales before the best denial method of all: forcing patients to limit their own care. I know of a case in which a woman will die because she does not have the money to pay for something she needs. She has insurance but it will not cover her condition. There is little need for company doctors when patients themselves

become the agents of their own denial. More and more patients discover that the copayments, co-insurance, and other cost-shifting tactics mean that they may have “insurance” but it will be useless at a time when they most need it.

- **The dirty work of denial and other cost-cutting practices are increasingly outsourced:** Insurance companies have learned to diffuse responsibility by shifting risk to other entities. For over two decades, they have perfected the means to “carve-out” and outsource the management of diseases and other processes to subcontracted companies. This is booming business as indicated by the rise in disease management companies, evidence-based/criteria companies, and other third party management companies. I am aware of a case in which a single patient had a primary care gatekeeper with financial incentives to control access to tests, treatments and referrals to specialists, a disease management company for congestive heart failure, a case management company for another separate condition, a pharmacy benefits manager, and a managed mental health company. None of these entities communicated with the others. They were paid by “capitation” – a payment method by which the insurance company’s costs for the services was fixed and paid per member per month. Under this arrangement, the insurer fixes its costs and the outsourced company manages the costs of care within a fixed budget, making money to the extent that it spends little by developing its own definitions of medical necessity, experimental and investigation, and other methods for delay, substitution, avoidance, and denial.
- **Adverse insurance actions cause harm and death to real individuals – these are not statistics or “mere anecdotes”:** Every adverse insurance action, whether it is direct or convoluted, whether it medical or technical, involves a real patient, a real human being with family, friends and community. Insurance companies have mastered the rhetoric necessary to discount the harm and death of their practices. They keep the focus on the majority of claims that are routine and relatively low cost, failing to disclose their aggressive efforts to mitigate or eliminate the high costs of the smaller percent of patients who must be managed. Stories of suffering in this group are quickly discounted as “mere anecdotes” – an unconscionable way to disregard the value of a fellow human being
- **The terms “medical necessity” and “experimental/investigational” are proprietary business tools supported through the huge medical guideline/criteria/evidence-based medicine industry.** These are terms of art and contractual terms that are used like rapiers to limit and deny care. They have no standardized meanings. They differ not only among companies, but can vary even within the same company. I have seen cases in which the “medical necessity” definition in the insurance plan was more generous than the hidden definition used by a carve-out group, but when members needed treatment managed by the third-party company, care they should have received under their insurance contract was denied based on the more restrictive and undisclosed definition of the subcontractor. I have seen a case in which the definition of “experimental” grew more detailed and restrictive as it went through the various review processes. The definitions shift and are often adjusted to make a denial “stick.” Companies may appear to cover something generally, for example a particular kind of transplant, but when that category of transplants is needed

almost no individual patient will meet the hidden criteria that excludes their particular condition. Various companies have grown up to supply increasingly restrictive criteria for medical services, so that almost any medical treatment or service can have medical judgment systematically eliminated. The new field of “evidence based medicine” is also an area that should be examined carefully. The so-called “evidence” is by its nature, public (from academic centers, peer-reviewed journals, research supported by tax dollars, etc.) and yet it become “criteria” to be manipulated and controlled by companies for their proprietary ends.

- **Health insurance companies operate in an ethical and legal void.** Companies do not believe that the ethics of medicine apply to their business practices, yet their practices can hold greater life and death power over a patient than any other entity in the system. For-profit health insurance is a business with obligations to stockholders, not the best-interests or well-being of patients, families and communities. Even when their actions cause harm and death, legal accountability is difficult. Americans who received their insurance through an employer will find their insurers have legal immunity provided by ERISA. Even those who have some legal recourse, find that the industry is adept at using the legal system to protect itself from disclosure of practices, key documents and accountability. I initially believed that a few key lawsuits would demonstrate how insurance practices are systemic and calculated, however the past thirteen years have taught me that insurers see the few legal cases as the cost of doing business. In addition, insurance battles have become lucrative for many. Over the past decade I have seen many—even other doctors, plaintiff lawyers, legislators, and other advocates who were supposed to help people—find ways to benefit from the broken system. I too reached a point where health care battles in the press, court rooms, legislative halls, and speaking events rewarded me more than patients I tried to help, which is why I have been mostly silent thus far in the health care debate.

I could continue for hours, but our time is brief. My written testimony includes more details about these practices and others.

I would like to close with this last warning: we will have no health reform unless we change or eliminate the for-profit model of insurance with their growing sophistication in profit maximization. We will have no health reform unless we have a medical and health care ethic – from the boardrooms to the bedsides – that is patient-centered.

Thank you for the opportunity to speak to you.

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## Bio

\*Linda Peeno is a physician who has spent over two decades educating and advocated for ethical systems in health care. In the early 1980's, which the advent of "managed care," Dr. Peeno moved from clinical work to executive positions in a variety of health care corporations, including an insurance company, an HMO, and a hospital. In the early 1990's, she left this corporate work to focus on the ethical issues emerging from changes in health care organization, financing and delivery. Dr. Peeno's struggle to bring these issues to public and professional attention is the subject of a movie, *Damaged Care*, first aired in 2002 by Showtime and Paramount, and now used all over the country in medical and health care ethics classes. A clip from her 1996 Congressional testimony recently appeared in the movie, *Sicko*.

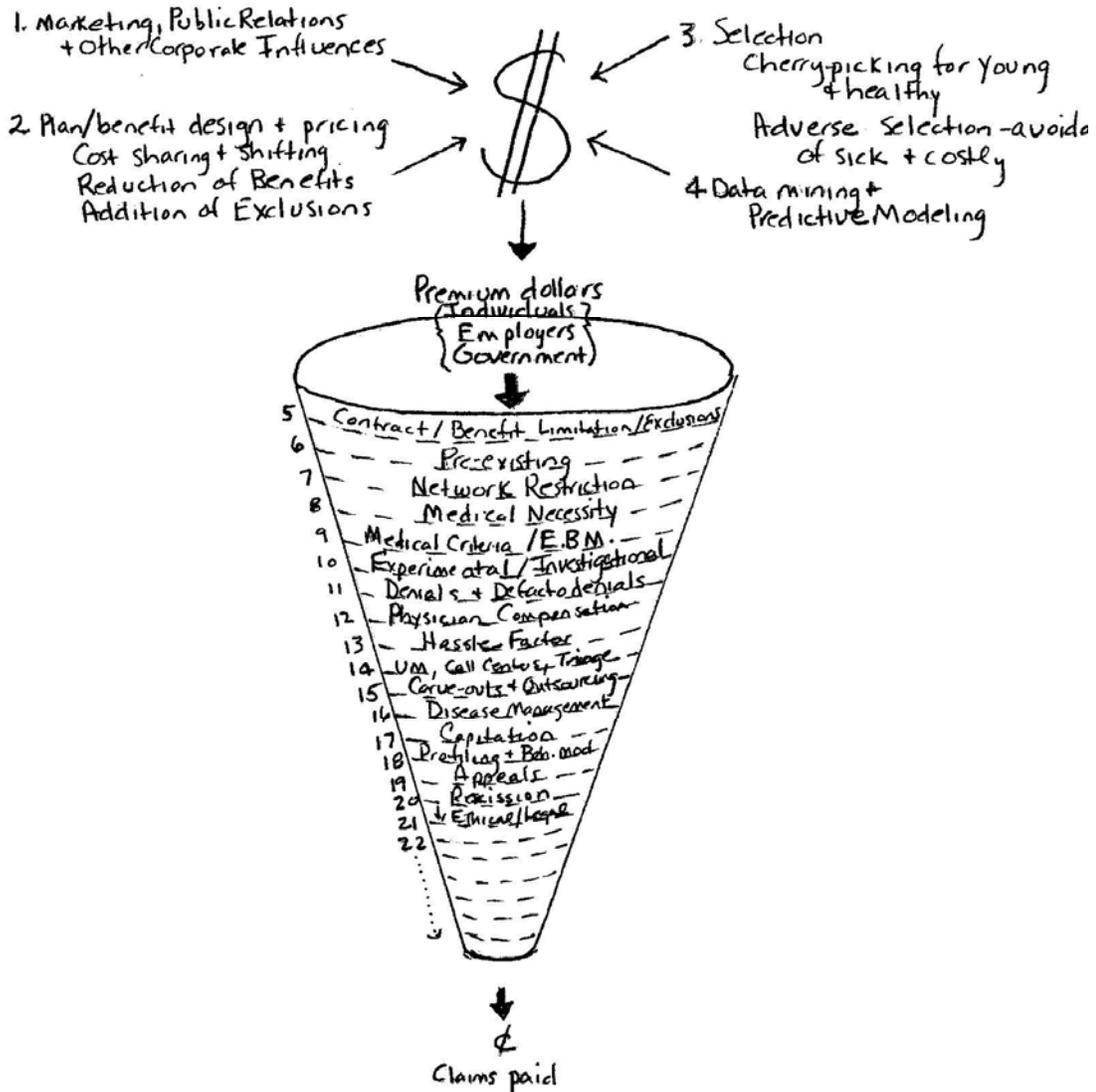
Dr. Peeno is recognized as a leading authority on the operation of health care organizations, corporate effects on medicine, and health care and medical ethics. She has testified before Congress, state legislatures, and various policy groups, and regularly provides analysis and consultation to business, medical, legal, policy and media professionals. In the past two decades, Dr. Peeno has written and spoken nationally and internationally on health care changes and reform. Her current passion, however, is teaching anatomy, physiology and pathology to students who will be entering into complex and demanding health care work.

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## Supplemental Material

### Introductory comments:

- The for-profit insurance industry is not about health care or cost control – it is about increasing the profits of the companies. Despite the existence of several major companies which appear to compete in the market place, they all engage in well-designed, resourceful methods to systematically increase their earnings and satisfaction of stockholders. Individual companies will try to claim that they are unique, that their methods are distinct and more competitive. However, the practices are the same (take in as much money as possible and limit/deny as much as possible). No health care reform can proceed without serious attention to how this system really works and the consequences for the American people. Once understood, it should be obvious to anyone that this is an industry that cannot be controlled by either competition or regulation. It is an industry that can no longer justify its existence as it now operates.
- The effects of the insurance industry spread beyond just a single denial for an individual patient. In a poignant story recently told about a “wrenching family experience,” a woman writes that “having insurance does not mean being able to afford health care when you need it the most.” (“A Wrenching” Health Care Experience,” Fonda Butler, Courier Journal, August 31, 2009) More and more Americans are discovering this.
- Over the years, multiple attempts have been made to hold insurance companies accountable with little effective change in their practices. I have participated in cases that have included negligence, bad faith, breach of contract, unfair business practices, interference with doctor/patient relationship, intentional misrepresentation, negligent misrepresentation, fraud, civil RICO, corporate practice of medicine, corporate negligence, negligent credentialing, vicarious liability, fraud, and many other causes of actions. Every case is an invaluable opportunity to gain a peephole into the inner, hidden practices. Although companies try to portray any particular case as unique and isolated, the documents and testimonies that come from these cases reveal that the practices are well-developed, systematic and calculated. These practices are little known and studied because they occur behind layers of protection and obscurity. It is even worse when we realize that the premiums of the insured are used to develop these tactics, creating conditions in which patients fund the development of the very tools that will be used against them in times of need.
- The model that I use to understand these practices and their collective effect is that of a large funnel with layers of filters. One can see the effects of the simple business model: increase premiums and decrease payments. Each of these tactics is based upon engaging in some practice that achieves this.



**THE HEALTH INSURANCE BUSINESS MODEL:**

**THE FUNNEL OF PROFIT MAXIMIZATION AND COST SAVING**

## 1. Marketing, public relations and other corporate influences:

- a. **Power of money and resources:** The power of money to influence policymakers and media (more recent details provided by Wendell Potter) and well-documented by reports about the influence of lobbyists and other means.
- b. **Mere anecdotes:** Public relations spin described by Mr. Potter, which extends to the discounting of any evidence of harm or death as a “horror story,” a “mere anecdote,” a media sensation, etc.
- c. **Censorship by prior restraint:** when the information and media are controlled to the point that “negative” (read “truthful”) stories are suppressed. This occurs in many insidious ways. I have known several journalists who were forbidden to do stories or whose stories were killed (“into the buzzsaw” – a term that describes this practice) or suppressed because they were critical of a company with power in a community. I experienced the attempts by the industry to prohibit the release of *Damaged Care*. After the film was released, the major trade group for the health insurance industry entered into a large contract with an leading agency in Hollywood (William Morris – the account of this was reported in several leading newspapers in the summer of 2002) to influence the production of any future negative accounts of the industry. Wendell Potter has detailed the organized fight against the movie *Sicko*. ([http://www.cjr.org/campaign\\_desk/excluded\\_voices\\_6.php](http://www.cjr.org/campaign_desk/excluded_voices_6.php)) I personally experienced the backlash after *Sicko* has Humana tried to discount the importance of the heart transplant story and my association with the company. (See.”Statement by Dr. Linda Peeno and Response to Attacks from Humana – July 3, 2007” available on [www.michaelmoore.com](http://www.michaelmoore.com))
- d. **Exploitation of media constraints for advantage:** Mr. Potter has mentioned the deception, misinformation, selective disclosure, and omission of facts as a way to control the message. He has also mentioned the “laziness” of many journalists, although my experience over the years has been that few journalists have the time or means to understand the industry enough to break through the rhetoric and well-financed shields. I have spent thousands of hours over the past two decades educating journalists who have worked hard to grasp the complexity of the systems of corporate health care. Even when they do grasp it, the information that is available is limited by all the corporate strategies of protection. I know from the legal cases how it is nearly impossible to acquire critical documents for evidence of practices, even with the power of courts and their orders. Nearly everything written by a journalists or an academic researcher is limited by the lack of real information about what is really going on behind the scenes.
- e. **Marketing to select and desirable populations:** There is abundant evidence about these practices over the past couple of decades. Many of the marketing practices are deceptive and some are even fraudulent. There are legal cases that address the misrepresentations, illusory promises, and

fraudulent claims regarding plans, benefits, networks, and other methods designed to acquire targeted populations who have best health and financial means.

2. **Plan/benefit design and Pricing:** We have more than enough evidence now to demonstrate that the insurance industry engages in practices that influence the products and pricing available.
  - a. **Reduction of benefits/Increase in exclusions:** Over the years, benefits have been systematically reduced. For example, I participated over 20 years ago in the change for short-term and long-term benefits. The plan for which I worked has previously defined long-term rehabilitation as medically necessary as long as an individual continued to demonstrate improvement. For those conditions in which rehabilitation can be a slow process (after some head and spinal cord injuries), months of medical rehabilitation might be required. However, these are the most expensive and undesirable patients, so plans began to put artificial and unrealistic time frames on the benefits, and we shifted our policy language to that taking hold in the industry. We restricted rehabilitation to 90 days only. In the years to follow, I was involved in many cases, trying to assist patients whose care had been worsened by this definition. In one case a plan stated that the 90 days began at the time of the injury and a young patient who had had both a head and spinal cord injury ate up the 90 days while still in a coma. By the time he recovered from the coma, he was had no benefits available to assist in his recovery of basic functions. He was left to languish in a nursing home eventually at the expense of the state in which he lived.
  - b. **Increased premiums and other pricing tricks:** Mr. Potter has provided details about how the health insurance industry has systematically gutted benefits while simultaneously raising premiums. We have abundant evidence by now of the most recent tactics to the financial costs to consumers and patients. (See the unpublished editorial included in the appendix regarding the evolution of health insurance tactics.)
  - c. **Insurance without insurance:** These tactics and others result in our current situation in which almost no one who has insurance is really protected in the event of a significant and expensive medical event. We have research that shows that nearly  $\frac{3}{4}$  of individuals bankrupted by medical bills had insurance. (See “Insured, but Bankrupted by Health Crises,” by Reed Abelson, NYT, July 1, 2009.)
3. **Selection of who gets insurance:** These tactics have been well-documented as well. The industry terms “cherry-picking” and “adverse selection” reflect the strategies to select the healthiest and avoid the sickest – two companion strategies that provide the least risk to a company. Underwriting and actuarial analysis has become sophisticated and plans can select and deselect with great precision now.
4. **Data Mining and Prospective cost management:** New resources in date acquisition and management allow companies to identify and even make predictions about the potential costs of patients. (See section on “Predictive

modeling and prospective” care” in the “Second Coming of Managed Care” in the appendix.)

**5. Contract/benefits:**

- a. **Language and importance:** Few people understand that their plan documents are contracts to which the company will refer when seeking justification for an adverse action. Often members do not even receive member handbooks and are unaware of the contents until they have to challenge a plan’s decision. Even if the documents are read, most consumers will find the documents full of fluffy promises for “best care,” “highest quality of care,” etc. – promises that are rarely fulfilled. The language is often general and vague with little to no disclosure of the company practices and organization that will be used against the patient in the event of some costly medical event.
  - b. **Exclusions:** These multiply and are rarely appreciated by someone until they discover that something they need is listed as an “exclusion.” For example in one plan I worked we specifically excluded dialysis, something a young couple did not know or understand until the husband needed dialysis to support him during an episode of acute renal failure.
  - c. **Pre-existing conditions:** We have abundant examples of the extent to which companies use this to their advantage. I have worked in the past with a team who combed through claims kicked out by the system based on cost or service triggers. Our task was to acquire and review previous medical files in order to justify a denial based on some pre-existing conditions. We also used this process to rescind policies – see below.
- 6. Pre-existing:** We have plenty of evidence that this remains an effective tool to limit liability for health insurers. Despite attempts to limit the use of this, insurance companies continue to use this abusively, often going back into medical records for years and pulling out minor complaints as justification for the denial of payment. Recent documents reveal that some insurance companies have gone so far as to claim that “domestic violence” is a pre-existing condition.
- 7. Network restriction and selective contracting:** Although most people associate this with the HMO plans that restrict panels of physician and facilities, most insurance plans have limitations on who and what is available. In my hometown of Louisville, there are two current disputes that seriously affect patient care. In one, a major hospital system and insurer could not agree on a contract and overnight the care of thousands of patients was disrupted when they were told by the insurer they could no longer use the doctors and hospitals in this system. In another dispute, several leading specialists in the community were told their contracts would not be renewed by a major insurer that seeks to narrow its network. This forced many patients with long-standing relationships with these physicians and in the midst of medical treatments to seek other physicians who would be covered by their insurers. Many consumers believe they have “choice,” only to discover that this choice is seriously restricted and can be costly, and in some instances may be so costly as to prohibit the very care they need for their condition. :

- 8. Medical Necessity:** This is addressed in the oral statement above and in the article that is appended to this list. It is the key to the goldmine for insurance profits. As the threads of this filter are tightened, fewer conditions meet proprietary definitions of “medical necessity.”
- 9. Medical criteria/evidence-based medicine:** This too is addressed above and at the end. Despite the advantages to having practice standards and guidelines, medical “guidelines” become company dictates. They are purchased from companies that make money by increasing restrictions and applications to deny care. A company adjusts criteria to their proprietary needs, negating their claims for standards. For example, criteria that determine the appropriate conditions for a hysterectomy should be the same whether it is Boston or Biloxi. It should be the same whether it is Humana or Cigna. However, I have seen a case in which an insurer subcontracted with a medical criteria/medical review company whose proprietary criteria for hysterectomies and their company doctors' reviews guaranteed at least a twenty-five percent denial rate.
- 10. Experimental/Investigational:** This is an area that has become the most devious of all the practices. Many insureds have insurance benefits that appear to cover needed procedures and even many transplants, however most patients will discover that there are hidden policies and practices that may cause their tests, procedures and treatments to be denied for this reason. Increasingly, companies will appear to cover something like stem cell transplants, but when particular patients need one, they discover that the company will claim that that the particular medical condition does not meet criteria – for example, stem cell transplants may be covered but not stem cell transplants for certain stages of certain conditions. In addition, the definition of these terms can shift around as companies attempt to justify a denial. Language in the contract may be general and leave open consideration for many treatments that will be denied by definitions behind the scenes that can go for pages. Companies also pick and choose what information and studies they use to justify their determinations, often discounting or rejecting academic studies in favor of the patients because they included a wrong group of patients, the studies were done outside of this country, or any number of other reasons.
- 11. Denials and de facto “denials” – limitation, avoidance, delay, substitution & the hidden denial record, encounter data and denial rates:** This is discussed above and at length in the attached article. However, the evolution of managed care relies upon the use of avoidance, substitution and inconvenience to shift the cost-saving actions to less obvious and less direct denial methods. In one recent case, a health plan employee discussed how physicians would call and get informal rulings on patient tests and treatments, insuring that only the “approved” were ordered and recorded. Companies understand that a “claim” represents only what has been submitted for payment after a test or treatment. All the tactics to use prospective and concurrent interference and obstruction are unrecorded and difficult to untangle.
- 12. Physician compensation, corporate incentives and other forms of behavioral modification:** Although companies claim that the more direct payment methods for treating physicians and corporate employees have diminished or changed,

bonuses and other rewards remain key methods to ensure that decisions are consistent with corporate goals. Profit-sharing and bonuses based on earnings-per-share may have replaced the more direct bonuses for denials, but the results are the same. Companies have also developed systems that will identify the physicians most compliant with their rules and financial goals. One company would “gold card” its most compliant physicians, providing quick authorizations and claims payments for their allegiance and performance. There are signs that this practice has become more sophisticated and will be part of new “health information” and claims payment systems. Financial success to the companies and their agents depends directly on decisions that increase money in and decrease money out.

- 13. Hassle factor – both patients and physicians:** Plans deliberately create complex, difficult, and inexplicable policies and procedures for navigating the managed care maze. The industry knows that only a small percentage will fight denials or other problems. They know too that even fewer of these will persevere through the labyrinth of rules and requirements. Some of this is calculated; some of it is the inevitable consequence of organization complexity and ineptitude. Either way the hassles can be great and overwhelming, serving as an advantage to the companies who make money for delays and denials in the process. The same kind of “hassle factor” works for physicians as well. Over twenty years ago I learned the term as we systematically beat down the physicians who attempted to challenge the medical decisions we were making for their patients. Eventually the sheer volume of patients affected, the resources needed, and threats about contracts and payments resulted in more compliant physicians willing to accommodate to the company’s decisions about patient care.
- 14. Utilization management, call centers, triage and other methods of prospective, concurrent and retrospective review:** These methods multiply daily and it is nearly impossible to address fully here. Patient stories are full of the obstacles and tricks. However, one method is little known but widely used. Many insureds will find that they have obtained “approvals” from their plan. In fact, an authorization number will be issued for doctors and hospitals to submit claims. Hidden within the approval letter will be a clause – “authorization does not guarantee payment” – that enables a company to review the file after the service has been received and then to refuse payment based on some technicality. In addition, sophisticated claims processing allows certain claims to be targeted as they go through the system. Claims can be suspended for review based on any type of “trigger” – from specific medical codes that may indicate conditions that are expensive to financial thresholds and other variables. These targeted claims can be used for any of the other kinds of denials that are discussed in this list.
- 15. Carve-outs and outsourcing:** This is discussed in the oral statement and the article included at the end. It is important to note that these new management companies fall outside of most regulatory and accreditation requirements, making it difficult to get to their inner workings and hold them accountable for consequences to patients.
- 16. Disease management:** This too is discussed above and in the end article.

- 17. Capitation:** In its heyday, this method was widely used to pay physicians. Despite industry claims, it is still used frequently with physicians, but more frequently for outsourced management companies. Under this form of payment, the insurers costs are fixed, and the management/cost risks are shifted to some other entity – either physicians or a company managing a condition or process. Since money is saved or made only by limiting payments, this creates incentives to withhold, delay, substitute and deny care at the level of the treating physician or the stand-alone management company that can harm patients.
- 18. Physician profiling and other methods of behavioral modification:** As the amount of data increases, physicians are subjected to more comparative evaluations. If a physician shows up as an “outlier,” which can have little to do with the actual quality of medicine practiced, then this can trigger reviews and other corrective measures to bring a physician into line with a company’s goals. The big brother effect chills professional autonomy and judgment as well, and slowly physicians can be molded into practicing the kind of medicine that is desired and dictated by health care plans.
- 19. Appeals & third party reviewers:** Although appeals are required, the process can be cumbersome and difficult for patients, especially when they are in the midst of life-threatening medical conditions. In many cases, there is a difference between the appeal policy and the actual appeal process that occurs behind the scenes. Appeals are heavily weighted in favor of the companies, and can be easily manipulated. Even outside appeal and third party reviewers have incentives that are not aligned with objective evaluation and patients find that getting a real independent consideration of an appeal is impossible.
- 20. Rescission:** This has gotten much recent attention, but as far back as the late 80’s, I participated in a group that was charged with reviewing certain claims that were submitted to us for review as possible candidates for rescission. At that time, our claims systems were set up to kick out certain codes that suggested conditions like HIV/AIDS and other expensive conditions. We would then request all prior medical records and comb these in detail in order to determine a way to claim that the individual had failed to disclose something and we could terminate their insurance. This practice has only grown in sophistication over the two decades.
- 21. Limitation of legal and ethical constraints:** I have discussed this at length in many other documents, especially the two Congressional testimonies:
- 22. Many others...** The methods continue to proliferate and are too many and too complex to list completely. In addition, new filters are added daily. Other methods include: inadequate access to specialists who are qualified for treatments; lack of physicians who will advocate for necessary treatments or do the work that is required to make an effective appeal; episodic care and single event denials that interfere with the overall plan of care for chronic, complicated conditions contributed to a downward spiral of care; illusory prevention/early intervention that is driven by short-term profit/loss concerns...

I would like to close, with the following considerations:

- **Real purpose of insurance:** What are the real purposes and effects of managed care/HMO/insurance companies? What do they really do for patients?
  - Are they insurance companies that simply pay claims, while the other aspects of the health care system (physicians, academics, etc.) determine what is medically appropriate or do they influence and direct medical care (basically practicing medicine) through their various resources? If they sell insurance plans and pay claims, then their activities should be transparent and easy to evaluate based on traditional insurance law by evaluating contracts, adherence to contracts, fair claims processing, etc.
  - If they are influencing medical care and the health of members and patients, then they should be accountable for the results, both the negative and the positive. Companies focus on the positive actions – how they are engaged in prevention, wellness, etc., but the same mechanisms that allow organizations to influence patient care in these so-called positive ways are also used negatively – by restricting, substituting, delaying and denying care. We should be able to assess the effects of this, and organizations should be accountable for the consequences of their decisions and actions on individual patients with whom they have contracted.
  - Managed care plans practice medicine. While there have always been contractual limitations to what would be covered, the claims were paid after the care was delivered. There was little to no interference in the practice of medicine. With the advent of managed care, organizations began to influence, direct and determine medical care. Marketing materials and member handbooks make claims about assuring “highest quality of care,” etc. These positive claims to make medical care better became the rationale for all of the interferences, e.g. restricting choice of doctors, controlling admissions to hospitals, denying “medically unnecessary” care. The member/insure/patient was and is led to believe that these actions are in the best interest of the patient.
  - With the managed care backlash of late 90’s, health care companies began to mask and withdraw some of these claims. Language was changed in member materials, advertisements and other documents that would be seen by the public. However, the tactics to control doctors and patients continued to evolve.
  - In addition, the rise of HSA’s and other methods to shift the financial management to consumers allowed the companies to appear to move into a type of broker role – simply managers of money. However, as many people have discovered, they may have many choices when it comes to inexpensive, low levels of medical care, but when something expensive happens, all the managed care machinery gears up and services are limited or denied as if the patient is in a HMO/managed care plan.
  
- **Where the dollars go:** In what way do the high administrative expenses contribute to better health care and patient care, either for individual members/enrollees or the health care of the country overall? Consider the

exorbitant resources that are spent on marketing and advertising, executive salaries and perks, and other areas that have come under question. The dramatic ethical epiphany I had in 1987 about the expense of the sculpture (which I later came to know cost 3.8 million dollars) juxtaposed with the money “saved” by denying the heart transplant (about half million dollars) remains. Even when there are legitimate savings by appropriate, patient-centered managed care, companies cannot demonstrate that the savings go back into health care and medical needs for the members/insurees. The “savings” convert to profit, further fueling the development of means to further “save” and make money. In this sense, patients are funding their own tools of rationing.

- **The history of managed care has been one of companies engaging in egregious practices and when backlash occurs, they “correct” them and call this reform. We are in the midst of such a cycle now and should be aware of the ways in which many so-called “new” tactics are illusory or deceptive.**

In summary, insurance companies have become ingenious machines for generating increased premium dollars and decreasing claims payments – an obscene business model supported by the life and death of real people – and anyone of us could be next.

Additional resources by Linda Peeno:

1. Managed Care Ethics, Congressional testimony, May 30, 1996.
2. The Menace of Managed Care, Congressional testimony, October 28, 1997
3. What is the Value of a Voice? US News & World Report, March 1, 1998
4. Burden of Oath, Creative Nonfiction Journal, Issue 21
5. Statement regarding heart transplant patient, July 3, 2007, [www.michaelmoore.com](http://www.michaelmoore.com)
6. The Second Coming of Managed Care, TRIAL, May 2004 (appended)

# The second coming of managed care

Linda Peeno[\*]

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*New management techniques and complex organizational structures allow the health care industry to continue placing costs above care and profits over patients.*

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On one side of my office, piles of articles tout the transformation, even death, of managed care.[1] Even the media seem to have lost interest in the tragic stories that continue to

emerge from our profit-driven health care system. According to the health industry, we have entered into a "kinder and gentler" era of health insurance, one in which health plans claim they are moving away from medical gatekeepers and denials of care.[2]

The other side of my office tells a different story. Piles of e-mail messages and letters from patients, as well as mounds of evidence on how health plans really work, bring to mind a new twist on the famous words of Mark Twain: News of managed care's death may be greatly exaggerated. In fact, evidence from my files indicates that managed care is alive and thriving, so much so that one health care executive claims we are in the middle of its "second coming." [3]

Twenty-first century managed care is best defined as the organizational practices of any health care entity using business strategies to influence or control access to and availability of medical services for economic gain. Patients can become victims of systems that lead to too much care as well as too little, and they now risk danger from corporations as much as from individual agents.

This should not surprise anyone, since the provision of health care, from for-profit insurance companies to nonprofit government organizations, still works on a simple principle: Financial success and "savings" depend on maximizing the gap between money taken in and money paid out. Its face may change, but managed care is not going away. New companies, strategies, and profits continue to mushroom, with HMOs reporting \$5.5 billion in profits for 2002, an 81 percent increase since 2001.[4] At the same time, more Americans are uninsured or underinsured, and patients face mounting bureaucratic nightmares and diminishing protections.

The Health Maintenance Organization Act of 1973 launched the explosion of new forms of health delivery and finance. HMOs began as prepaid health plans, organized to provide "basic and supplemental health services to [their] members . . . without limitation as to time and cost." [5] They were intended to reduce the spiraling costs of medical care through a focus on prevention, early intervention, and health maintenance.

However, it soon became obvious that this type of cost-control required lengthy business cycles, so insurers would not reap profits for many years. The companies began to focus on what would produce immediate profits.

The earliest forms of managed care focused on what the industry calls "low-hanging fruit," or areas that generated the quickest and highest "savings." Primitive forms of managed care relied heavily on "cherry-picking", that is, enrolling only healthy people and not accepting those with health problems, as well as network limitation, discounts, risk-sharing, and blunt utilization review that targeted-denial of expensive tests and treatments, specialty referrals, and hospitalizations.[6] Managed care represented an unprecedented opportunity for organizations to control medical care *before* it was delivered.

Physicians no longer practice medicine alone. Severe limitations, denials, and alterations of care led to great profitability in the early to mid-1990s, but these savings proved to be one-time phenomena.<sup>[7]</sup> High-profile effects, like 24-hour maternity stays and 48-hour mastectomy stays, caused a consumer "backlash."<sup>[8]</sup> By the new millennium, decreased profits, poor public relations, and demands for better "patient protection" sent the health insurance industry back to its drawing board.<sup>[9]</sup>

### **Trend toward specialization**

Although earlier forms of managed care still exist, insurers' practices are increasingly subtle, refined, and disguised. Instead of one company doctor sitting in corporate headquarters making decisions about treatments and hospitalizations, several different people in many different locations manage patient care.

In addition to health plans and insurance companies, care can be managed by external utilization-management companies; third-party administrators; benefit-management, disease-management, pharmacy-management, and mental-health-management companies; hospitals; employers; and government payers, to name just a few.

I have reviewed documents in which a single patient's care was managed through the health plan's gatekeeper, a disease-management company for congestive heart failure, a case manager for diabetes-related complications, a pharmacy-benefits manager, and a managed mental-health care company. Each of these entities had a different definition of "medical necessity" and different policies and structures, with little or no coordination among them.

"Disease management" represents the newest managed care trend, as the health industry concentrates its resources on wringing out savings from a trillion-dollar health-care coffer.<sup>[10]</sup> Also, with the current focus on drug costs and new Medicare legislation, pharmacy-management companies will have increased effects on decisions related to patient care. For example, the merger of two giant pharmaceutical-benefits managers, Caremark RX, Inc., and AdvancePCS, will give a new company the opportunity to manage prescriptions for about 70 million members.<sup>[11]</sup>

Other businesses specialize in the management of networks, doctor "scorecards,"<sup>[12]</sup> credentialing, special populations (like Medicaid recipients and prisoners), and specific care areas (such as rehabilitation, home-health care, and "complementary", or alternative, medicine).

Managed care systems depend on the manipulation of patients, physicians, benefits, and medical management to achieve cost-savings and profits. Early forms of managed care relied more on blunt denials of treatment that often harmed patients. Newer forms of managed care are marked by sophisticated systems that distribute management and change care in ways that still harm patients, but are less obvious. The emerging trends include the following.

## Benefit restrictions

Health insurance companies continue to limit benefits in ways that are rarely disclosed and are seldom understood by potential enrollees. Often patients do not understand the implications of certain restrictions until they need services that they expected their plan to cover.

In other situations, some contracts indicate that certain benefits will be available, but when patients need the specific benefit, they discover that tightened authorization procedures limit the benefit. Some health care organizations continue to use misrepresentation and deception to gain financial or market advantage, with potential serious consequences for patients.

**Medical necessity.** The term "medical necessity" can have hundreds of different meanings, interpretations, and applications, even within the same company. And as health plans fragment and outsource more of their management functions, different companies may use and apply varied definitions of "medical necessity," including some that are more restrictive than the one contractually disclosed to members.

Health plans can also delegate decision-making about medical necessity to medical groups and other vendors who are under risk-sharing arrangements, such as capitation, that is, set fees an HMO agrees to pay a physician per patient, regardless of the frequency or cost of the medical care provided. These providers have financial incentives to limit or deny care, or substitute less costly alternatives. In some cases, even reinsurance companies enter into medical decision-making prospectively, requiring health plans to seek their approval first. In these situations, the reinsurer's definition of "medical necessity" may be more restrictive than the plan's.[\[13\]](#)

Furthermore, nothing about this additional layer of medical management is ever disclosed to plan members. I have examined a case in which a health plan would have approved an expensive treatment but eventually denied it after the reinsurance company determined that the treatment did not meet its criteria for "medical necessity."

Despite claims that denials have decreased, a study of two California health plans reported that between 8 percent and 10 percent of requests for medical treatment and coverage were explicitly denied, an increase of 3 percent over previous reports.[\[14\]](#) And even though medical-necessity determinations remain critical to cost control, we know little about how they are made, and each decision must be examined carefully to determine its validity.[\[15\]](#)

**Medical guidelines.** Medical management depends on having codified criteria that provide the rules for evaluating medical necessity and making other medical determinations. For example, in the early days of managed care, authorization requests for hysterectomies were evaluated by medical directors who relied primarily on their understanding of the prevailing clinical standards of care, which would come predominantly from research and academic literature. However, when company doctors

began to review requests for medical treatment, these standards allowed too much variation in medical judgment.

Many companies sprang up to fill the gaps, so that now almost every medical treatment or service is so systematized that little independent medical judgment enters into the review for many managed care organizations. In one case, a company made the conditions for approval of a hysterectomy so narrow that they would have required conservative treatments to fail and the patient to have suffered a recurrence of invasive carcinoma before she could have the surgery. In other situations, managed care organizations applied outdated or wrong criteria and manipulated criteria inappropriately to justify a denial.

Although "evidence-based medicine" is the new buzz phrase,[\[16\]](#) there is a difference between legitimate clinical criteria that have been developed through research and peer review, and proprietary protocols developed by commercial companies using pseudo-scientific processes.[\[17\]](#)

**Exclusions for "experimental and investigational" treatments.** When managed care was first established, health plans often relied on prevailing clinical and government standards to determine whether a requested treatment was experimental. With advancements in technology and research, the exclusion grew to include investigational procedures. Now, definitions that used to be only a couple of sentences long extend for pages. Some plans try to exclude standard therapies simply because they are part of a researcher's data collection and study.

As with "medical necessity," patients may find that health plans apply different definitions of these terms. In one case I examined, a plan member's medical needs were not excluded under the contract's broad, two-line definition of "experimental." However, when the health plan sent the case to an outside consultant, it requested that he use a detailed definition and criteria that were nearly two pages long, giving the physician more technicalities on which to justify a denial.

## **New plans**

Traditional HMO membership is decreasing, and more members are choosing preferred provider organizations (PPOs) and other managed care hybrids. Although PPOs are generally viewed as less restrictive, they continue to use many of the managed care practices associated with HMOs, such as hospital precertification and authorizations for certain tests, treatments, referrals, and drugs.

Although many PPOs do not use gatekeeping, that is, they don't use physicians to control patients' access to treatments, tests, and specialists, they have other ways to control patients and their physicians. Some PPOs delegate utilization management to physician groups such as individual practice organizations, which in turn use contracts, payments, and even peer pressure to influence and control treating physicians' decisions. PPOs also

use disease management, pharmacy management, selected networks, and medical criteria in making "medical necessity" decisions that can emphasize cost rather than care.

**Managed-indemnity plans.** Many people buy "indemnity" health insurance that they believe is closer to traditional coverage, without managed care. However, these insureds often discover that when they need medical treatment, they face managed care practices that are often associated with more restrictive health plans.

For example, I reviewed a case in which a health insurance company used a medical-necessity requirement as a basis for a denial, even though the insured's contract did not contain such a provision. Further investigation revealed that the company was channeling all its medical management through a utilization-review department designed for its HMO business. Even though some consumers were paying more for a less-managed health plan, they were essentially treated as if they were HMO members.

**Tiered plans.** Health care companies continue to rely on network restrictions as a means to control costs and care, although new health plans appear to be less managed, with their various "tiers" of providers and benefits. Many patients in these tiered plans discover that to receive medically necessary, high-quality care, they must choose the most expensive tiers, if they can afford to do so.

For example, a plan's lowest tier will restrict the network of doctors and require HMO-type restrictions for referrals and specialty care. If a patient chooses this tier, out-of-pocket costs will be minimal and care might be limited. The highest tier will allow more open access to doctors and hospitals with fewer restrictions, at increased patient expense.

In tiered plans, patients assume their own health care management and might find that they will have to deny themselves quality care for financial reasons. If patients remain in the lowest-cost tier, they will be in an HMO-type plan, with most of the more restrictive managed care practices. These tiered plans have the potential to affect quality of care: "More efficient" physicians and other providers who provide the least expensive treatment are placed in lower-cost tiers, putting sicker patients and the physicians who care for them at serious economic disadvantage.[18] The physicians in the lowest tiers are the most "cost effective," so they provide the least amount of care and will not want to treat sicker patients. Patients, both well-off and poor, who need more care may need to go to other tiers.

The sheer complexity of these arrangements may result in significant savings and profits to health plans.[19] The administrative complexity makes it hard for patients and physicians to get access and payment, so delays and payment hassles multiply, and plans benefit from anything that allows them to keep the money longer.

**Illusory choice and cost-shifting.** The managed care backlash and decreasing profitability have driven insurance companies to develop new plans that capitalize on consumers' demands for choice and freedom in treatment and the doctors they can

choose. Some consumers can put together their own networks and choose levels of benefits according to how much they want to pay.

Few consumers understand the implications of these new plans, especially the amount of cost-shifting that occurs when patients require medical treatment. This shifting of the economic burden becomes the most sophisticated cost-management tool yet. In one case, a couple discovered after they had a child that they had chosen a network that did not include the specialized neonatal care their child needed. They had to assume greater out-of-pocket costs so their child could receive appropriate medical treatment.

These new arrangements also engage in their own forms of stealth managed care. Companies that offer these new plans have their own networks and even pay providers under capitation arrangements.<sup>[20]</sup> Consumers will have to be clairvoyant about which benefit levels and networks they will need to design their plans. They now design their plans by making choices about how much they want to pay in premiums, deductibles, and copayments; what type of pharmacy benefits they want; and what network they want.

Although the structures of these new plans vary widely, most arrangements have a threshold at which some care management occurs. In such situations, patients will have the illusion of choice and freedom for medical needs like acupuncture, laser eye surgery, and other discretionary medical expenses, but will be surprised to find themselves at the mercy of a company that will decide the medical necessity of critical hospitalizations, surgeries, and expensive medical treatments.<sup>[21]</sup>

## **Targeted management**

Through sophisticated information-management systems, a managed care organization can identify particular codes, patterns, profiles, cost thresholds, or other identifiers of medical conditions and treatments for focused review and adjust its management strategies to fit current trends.

For example, as more care shifts to outpatient services, utilization management can target office-based surgeries, home health care, new diagnostic tests, high-cost injectable drugs, and durable medical equipment. Specific diseases, conditions, treatments, and even particular patients can be targeted, identified, and selectively managed. I have examined documents in which cost accounts were kept for particular members, and certain levels of review kicked in at different cost thresholds or when preset cost triggers were reached.

**Disease management.** This is the most rapidly growing medical-management industry, with over 150 companies now vying for the managed care of specific patient populations and medical conditions, such as congestive heart failure and renal disease. Many of these companies enter into risk-sharing arrangements with health plans that create financial benefits from shorter hospitalizations, decreased emergency room visits, cheaper drugs, and provisions of fewer medical services.

Although new forms of managed care are often portrayed as patient-friendly, there is no clear data showing that "disease management" reduces the cost of health care while improving its quality.[22] In fact, I have reviewed many files that suggest that disease management adds to patient risk in dangerous ways. For example, in one case, a renal-care company discouraged treatment for medical complications because approving the treatment would cut into its profits.

**Pharmacy management.** Changes in Medicare drug benefits and the rising costs of pharmaceuticals suggest that prescription-drug management will be critical for the future of managed care. I receive calls frequently from patients who are unable to obtain necessary medications or who are forced to accept substitutes that are often less effective. In some cases, serious harm and death result from a managed care organization's interference with drug treatments.

Many health care plans include new "incentive-based formularies," in which patients choose among tiers of drugs grouped by cost and copayments. For example, a patient might need a specific drug that places him or her in a tier that requires higher copayments or cost-sharing, forcing him or her to use another less costly drug that might be less effective or even dangerous. Health plans reap significant savings with these arrangements,[23] but patients' lives are endangered when these plans are misrepresented or poorly disclosed. Patients, especially those with chronic illnesses, can suffer and die needlessly if they are unable to afford necessary drugs that should be covered.

Pharmacy management will continue to evolve, with new and refined attempts to increase restrictions by using pharmacy networks, limiting the availability of certain drugs, tightening precertification requirements, and expanding drug-specific utilization management.

**Hospital and other institutional management.** Precertification for facility care, including acute hospitalization, skilled nursing care, inpatient rehabilitation, psychiatric treatment, and other forms of institutional care, remains a critical focus for medical management. Controlling admissions and lengths of stays in these facilities provides immediate, lucrative economic returns for managed care organizations.

Many companies use software programs with detailed medical protocols for their assessments. The so-called guidelines used by these programs often become rigid rules that are applied without regard for a patient's age and sex or the presence of other medical problems. A "reviewer," who may not even be a nurse, can apply rules that assign the number of days that a patient with a particular medical condition will be allowed to be treated in a hospital or other facility.

In addition to tighter precertification, managed care organizations use "concurrent review", meaning health plan nurses directly monitor a patient's care in a medical facility through daily phone calls or on-site visits. This kind of micromanagement gives a managed care organization the means to control the entire course of inpatient treatment, especially decisions about transfer, discharge, and follow-up care.

**Predictive modeling and "prospective" care.** The health industry understands that a small percentage of patients incur the largest percentage of costs. Traditional managed care depends on identifying high-cost patients through diagnosis or "cost triggers," but cost management may occur too late.

New models depend on making predictions about particular patients who are likely to be costly. Through methods of data analysis, pattern recognition, and new techniques like "time-series analysis" and "neural networking," managed care organizations can target specific individuals, and even physicians, to proactively "manage" healthy patients long before they need care.[\[24\]](#) For example, a plan can use data patterns to identify patients who might be at risk for heart disease, and then it can concentrate on limiting the future costs of these patients before they have even developed any signs of the disease.

Even prevention is giving way to new strategies of "prospective" medicine, with the development of "health coaches" and earlier intrusion by health plans into lifestyle choices.[\[25\]](#)

Health plans have also discovered that scouring claims for the "worried well", patients who seek frequent health care, convinced that they are ill even though they are physically well, enables them to control the potential costs of another population of patients before the patients need care. Health plans might use this kind of data for aggressive underwriting and marketing as well as for management, providing increased opportunities to avoid patients whose care might be costly.[\[26\]](#) The next phase of this kind of management will no doubt include genetic testing.[\[27\]](#)

## **Behavior controls**

The development of ways to influence physician behavior and practice patterns continues to be critical to managed care.

**Physician profiling.** As information management and technology become more sophisticated, managed care organizations can use physician profiling to identify specific providers according to costs and quality, and use this information to influence practice patterns. This area of physician control is likely to grow more extensive and effective.[\[28\]](#)

Studies show that physicians who have been subject to profiling linked to financial incentives, meaning that managed care organizations have detailed reports on the physicians' hospital admissions, test orders, and referrals to specialists, and they link payment to those numbers, giving higher payments and bonuses to physicians who stay within those numbers and penalizing those who exceed them, reported difficulties with making appropriate medical decisions for their patients. These physicians said they were often torn about doing what is best for the patient while working under a health plan that rewards physicians who control costs by limiting treatment.[\[29\]](#)

Physician profiling has already succeeded as a means to do economic credentialing, in which plans choose physicians based on economic performance and cost-effectiveness. Plans award the most economical physicians by placing them in networks and plans that will bring the physicians the most financial return. In some cases, economic credentialing has been coupled with targeted reviews to remove noncompliant, difficult, or costly physicians.

**Expanded capitation.** Although some reports claim that capitation is waning, it still remains an effective method to control costs by shifting the financial risk of loss for medical treatments to many different providers. Initially, health plans used capitation for primary care physicians (PCPs) or physician groups in an attempt to fix the amount of money available to pay for the medical care of a panel of members.

A panel is a group of patients who use the same primary care physician. If 500 members have Dr. A as their PCP, for example, Dr. A has a panel of 500, for which he will be paid a fixed amount. The panel members do not even have to be patients that Dr. A has seen. This is the idea behind capitation: Get your panel number up as high as possible, then do as little as possible for members. The ideal would be for none of the 500 panel members ever to visit the doctor.

Now health plans have expanded capitation to specialists, especially in fields that have high frequency and costs of surgery like gynecology, orthopedics, and otolaryngology. Under these arrangements, specialists are induced to behave more like gatekeepers.

Health care companies also use capitation for outsourced management firms, such as disease-management companies. Like traditional HMOs, these companies profit to the degree that they can control the costs of medical treatments, services, hospitalizations, drugs, and equipment.

**Organizational incentives and disincentives.** In addition to financial arrangements with providers, managed care organizations set up cultural, administrative, and economic controls to influence their employees' work. Some health plans have used cash bonuses to reward doctors and nurses for decreased costs. Other incentives are less blatant. Various methods can be used, from bonuses tied to overall company profitability or performance, to cultural and employment pressures such as audits and evaluations designed to meet cost-management objectives.

I have examined many situations in which employees who work for health plans and other health care organizations were directly and indirectly influenced to make decisions that adversely affected patients' health.

For example, in one case, when a medical director told a patient that he had been hospitalized for as long as the plan would allow, the patient's treating physician released him, putting the patient's health at risk but saving him the cost of paying out-of-pocket for a hospital stay that the plan wouldn't cover. In another instance, company nurses and doctors ignored indications that a patient's condition was too serious to discharge him

from the hospital. They denied continued hospitalization, and they received bonuses for doing so.

**Payment for quality.** The newest trend in physician payment is providing incentives for quality. Under some arrangements, physicians receive additional payments or bonuses for meeting certain goals like high immunization rates or increased patient satisfaction. But several quality-based plans have significant utilization or financial incentives that result in high-quality care for some, not all, patients.

For example, physicians under plans in which quality bonuses are paid for meeting certain goals, like ordering more mammograms, may feel pressured to give special attention to patients from whom they will benefit the most, leaving other patients at risk of different standards of care. So a plan might emphasize screening for breast cancer but not treating it.

## **Appeals**

Health plans and insurance companies create streams of disputes that result in hassles, delays, and denials of care. Although many disputes involve less than life-and-death decisions, an analysis by the Center for Health and Public Policy Studies, a research and policy-analysis group at the University of California, Berkeley, revealed that significant numbers of patients whose treatment was delayed or denied reported that their health worsened and that they suffered permanent disabilities as a result.[\[30\]](#)

The appeal process serves as an effective management tool. Health care companies benefit financially from anything that produces delays or obstacles, from patients who are too ill to fight for their treatment to personnel who are too overworked to care. Often little is known about the outcome of an appeal[\[31\]](#) until a particular patient's experience unravels in litigation.

Internal correspondence, medical case files, and other documents in patients' legal cases reveal that reviews are sometimes poorly investigated and performed. I have evaluated cases in which health plans based decisions on wrong protocols, or ignored or even hid reports from outside consultants that were favorable to patients. Even external companies that consider patient appeals do not ensure accessible, unbiased, high-quality reviews.[\[32\]](#)

In addition to continued delays and denials of care, the new consumer-directed and tiered plans will introduce layers of complexity that can result in a bureaucratic nightmare of unimaginable proportions. Countless patients have faced complicated claim problems after they were treated for serious illnesses, and these problems affected their future medical care. When patients and their families exhaust their energy and finances struggling through administrative mazes, medical treatment may be compromised.

## **Patients' future**

If these new strategies do not support continued profitability, health plans may return to older, more stringent forms of managed care. Already, there is evidence that earlier forms of managed care are re-emerging, as medical directors and physician advisers report that they are pressured to review more "tightly."<sup>[33]</sup>

Medical, legal, academic, business, and political professionals have duties to ensure that individuals and organizations are accountable, not only for specific decisions but also for the systems they create and set in motion. Until we create a health care system based on effective administrative, clinical, ethical, and legal accountability, managed care will move toward its "third coming." In this phase, the privileged will experience management by excess as they seek boutique care and enhancement medicine, and the disadvantaged will suffer management by the brutal rationing that will be necessary to keep the health industry ever more profitable.

It is not enough to focus on medical errors and malpractice without a careful examination of the underlying systems in which unsafe or negligent acts occur. It is not enough to focus on institutional safety or individual professional negligence without also addressing issues of organizational and corporate responsibility. Until we have substantive ethical, legal, and political change to our health care system, managed care will continue to endanger patients.

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## Notes

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*Linda Peeno is a Louisville, Kentucky, physician and consultant on corporate health care practices, managed care, and health care ethics.*

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