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Managed Care Public Policy

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III. MANAGED CARE PUBLIC POLICY

TIM RAVICH: I am extraordinarily pleased to introduce you to **STEPHEN J. DEMONTMOLLIN**. He is General Counsel, Vice President of Legal Affairs for Av-Med Health Plan, Florida's oldest and largest not-for-profit health maintenance organization. He is responsible for corporate legal affairs, regulatory compliance, corporate risk management, public policy, and is the Corporate Compliance Officer. He is licensed as an attorney in Florida and the District of Columbia, and is a Florida Board-Certified Health Law attorney. Steve received his law degree from Georgetown University in Washington, D.C. He served as Legislative Assistant to U.S. Representative Don Fuquay from 1969-1975 before becoming an Assistant U.S. Attorney for the Southern District of Florida. After fifteen years in private practice in Miami and Gainesville, Steve was appointed by Governor Lawton Chiles as Florida's first Chief Inspector General to combat fraud, waste and mismanagement in state government. In 1995 he completed the program for management development at the Harvard Business School. He holds the designation of Professional Academy of Health Care Management (PAHM). Since November 1998, Steve has also served as Interim CEO of St. Augustine Health Care Inc., headquartered in Tampa, Florida. Steve, thank you for being here, the forum is yours.

STEPHEN J. DEMONTMOLLIN: Good morning and welcome. (*Applause*).

My compliments on your Symposium and you are off to an excellent start with the presentation of the provider perspective of the health care system. I want to associate myself with their comments as there must be close cooperation between health plans and providers if patients are to benefit. Furthermore, provider-friendly health plans are best able to facilitate the highest quality of care and achieve the greatest patient satisfaction. Having said that, I will spend the remainder of my time describing the unique role of the managed care company in increasing access to health care, improving its quality and moderating the rate of growth of the cost of healthcare. My company grew out of an integrated health care delivery company comprised of four general acute care hospitals, a psychiatric hospital, rehabilitation hospital, free standing outpatient surgery center, adult congregate living facility, hospice company, physician practice company, and home health company.

We sold the provider entities in order to focus on the managed care business. My main thesis is that my company now can do as much good, or more, by coordinating health care delivery and payment as it could have as an integrated healthcare provider. An HMO, as you know, combines the

financing part of healthcare with active coordination of the delivery of healthcare either through owned physician practices and facilities (a staff model HMO) or through contracts with providers (an Independent Practice Association or IPA model HMO).

But first, why managed care at all? Because *un*managed care is no longer affordable and purchasers of care, public and private, are unwilling to tolerate the growth in medical costs of the last decade or so. Purchasers also question the wide and unexplained variations in practice patterns among geographic areas and delivery systems, raising suspicions of widespread waste.

You know the numbers. Healthcare spending in the U.S. amounts to more than \$1.1 trillion annually, nearly 15% of the gross domestic product. The industrialized countries which spend the next largest percentage of gross domestic product ("GDP") on healthcare are Germany and Canada with about eight percent and this disparity raises significant issues of global competitiveness. The Health Care Financing Administration has recently estimated that this cost will escalate to \$2.1 trillion annually by the year 2007 and consume 18% of the GDP. General Motors spends more per car on employee health than on steel. In 1988, the average per-employee cost for medical benefits shot up 18.6%; in 1989, another 16.7%; in 1990, up 17.1%, and in 1991, up 12.1%. Yet everyone, the President (Bill Clinton), the Health Care Financing Administration, the American Hospital Association, the American Medical Association, and the health insurance industry agree that approximately one-third of all health care expenditures in the fee-for-service environment are inappropriate and unnecessary. Furthermore, more than 43.7 million Americans are uninsured or underinsured, up from 37 million when the President proposed his health care reforms and estimated to reach 60 million non-senior Americans by the year 2007.

However, because medical care is such a personal matter, managed care will continue to generate anxiety among some consumers and to raise issues of societal values and public policy. These issues are being played out in the media, state houses and Congress.

Dateline, *The Boston Globe*, June 12, 1997, "The managed care industry has a problem. People hate its guts. In fact, fear and loathing of health maintenance organizations has reached fever pitch. Americans consistently rank HMOs next to last among a list of industries that serve consumers, right next to tobacco companies. Trouble is, the vast majority of Americans have said that their own experiences with HMOs have not been at all negative."

This phenomenon is not unlike the vast majority of Americans who rank Members of Congress along with used car salesmen but who believe their own Congressman is just fine and, consequently, incumbents are re-elected at a rate of about 95%.

Under the headline, "Surprise! They're Happy with Their HMOs," *The Washington National Weekly Edition* reports that a recent survey by ABC News found that nearly nine out of 10 HMO and PPO members rated their coverage as "excellent" or "good". According to *The Post*, "the latest ABC poll suggests those [with managed care] may have been wildly and unfairly exaggerated."

And who can forget, Helen Hunt, playing a New York waitress in the movie "As Good as It Gets," blasting her HMO in unspeakable language because the HMO won't let her get the proper care for her severely asthmatic son? And some of you laughed and cheered along with the rest of the audience. I know who you are. The irony is, however, that many HMOs have pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce the need for emergency hospitalization. John Eisenberg, head of the U.S. Agency for Health Care Policy and Research, had this comment on the celebrated scene. "Wow! A single mother who works in a diner has health insurance. That's fabulous," he says. According to an agency survey, only 56 % of the 4.2 million unmarried women who work in establishments with fewer than 10 workers have some form of employment-related insurance.

Keep an open mind as we embark on today's discussion and in evaluating the kind of proposals you heard about earlier: 1.) you should be sure that the alleged problem or abuse actually exists in practice and is not merely hypothetical or an aberration; 2.) because workers and taxpayers and not health plans will ultimately bear the costs, the benefits of the proposed protections should outweigh the costs; and 3.) you should be sure that what is being proposed is consumer protection and not provider protection masquerading as consumer protection.

Managed care is a system of scientifically-based utilization management, where all appropriate and necessary care is delivered by the appropriate health care provider, in the appropriate setting, and is the best opportunity to control costs, increase access and improve quality. Let me illustrate the current system through the experience of one of our members. [ANECDOTE].

To put our discussion in some marketplace perspective, if you take the net asset value of all HMOs in the world — everything they own — and add it all together — it amounts to 20% of the value of Merck. That's right, the net asset value of one pharmaceutical company. The idea of the huge, powerful, monolithic managed care industry ravaging the health care system is a myth perpetuated by provider special interests committed to the *status quo*. Yet, perception is everything and organized medicine and the trial bar are attempting to exploit the so-called managed care backlash.

The history of organized medicine's antipathy toward managed care backlash is long and repetitive. In a 1985 *New England Journal of Medicine*

article, Dr. Thomas Mayer described "how managed care has survived the uncertainties of partisan politics, struggled with bureaucratic boondoggles, overcome the assaults of organized medicine, and created a small but substantial foothold in the health care system." He recounted: in 1927, Dr. Michael Shadid sold shares in the construction of Community Hospital in Elk City, Oklahoma, for \$50 each. Each share entitled the holder to medical care provided by the hospital. The consumers in Elk City responded enthusiastically, but the county medical society responded in anger and fear. Shadid lost his membership in the county medical society and, consequently, in the state and national medical societies as well. He was threatened with suspension of his license to practice medicine, and from then on, any physicians applying to the state of Oklahoma for licensure in order to work at the Community Hospital had an unusually difficult time passing the examination.

In 1929, Drs. Donald Ross and Clifford Loos began a typical fee-for-service partnership in Los Angeles. The Ross-Loos clinic served the employees of L.A. water and power departments, who convinced the two doctors to establish a prepaid program to provide medical coverage. The program was successful, and over the next two years it enrolled other groups of municipal employees. Both Ross and Loos were expelled from the L.A. Medical Society shortly thereafter for operating their prepaid clinic.

In 1937, the first urban precursor of HMOs, Group Health Association of Washington, D.C., was begun. The District of Columbia Medical Society went to work to oppose Group Health. It impeded recruitment of physicians for the Group Health staff, limited access to hospitals for physicians in Group Health, and threatened expulsion from the society for those who already belonged to hospital staffs. Group Health took the District of Columbia Medical Society to court. After four years of what has been characterized as one of the bitterest battles in the history of modern American medicine, the U.S. Supreme Court decided in favor of Group Health. The District of Columbia Medical Society was indicted by a grand jury for restraint of trade by blocking the development of Group Health, and organized medicine was once again facing charges of antitrust violations.¹

The Florida legislature is in General Session and is currently considering a measure, the passage of which would severely restrict the ability of managed care companies to control health care costs and to improve quality.

This so-called civil remedies bill would provide a statutory cause of action, to sue for compensatory, extra-contractual damages, including potentially, punitive damages as well as attorney's fees when any physician

¹ American Med. Ass'n v. United States, 317 U.S. 519 (1943).

with the HMOs panel ordered a treatment or service and the HMO declined to authorize payment for that treatment.

Now, of course, this is in addition to the common law causes of action of corporate negligence, direct negligence, negligent credentialing, vicarious liability, ostensible/apparent agency, breach of the duty of good faith and fair dealing, breach of contract, breach of non-delegable duty, breach of fiduciary duty, negligent infliction of emotional distress, intentional infliction of emotional distress, negligent utilization review, and the tort of outrage, for crying out loud!

In other words, those common law causes of action are available in virtually every jurisdiction to any HMO member who continues to feel aggrieved even after exhausting whatever administrative remedies might be available under the member's contract with the managed care plan.

The proposed Florida law would permit a civil action against an HMO for the HMOs "failure to provide a covered service when in good faith the health maintenance organization should have provided such service had it acted fairly and honestly toward its subscriber or enrollee and with due regard for his interests and, in the independent judgment of a contract treating physician the service is medically necessary."

Forget all the provider initiated measures nibbling around the periphery of managed care, like any willing provider, direct access, anti-trust exemptions and gag rule prohibitions — This measure strikes surgically right at the heart of managed care. A similar measure passed the Legislature in 1996 but it was vetoed, in part because of the apparent abuses such a measure would permit. I suggest that such an act confuses the separate and distinct legal responsibilities of IPA model health plans and physicians. The following excerpts from court decisions and Attorneys General Opinions illustrate the separate and distinct obligations to the patient:

The court in *Varol v. Blue Shield*, held that "Whether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient."²

Furthermore, the North Carolina Attorney General has opined that: "Denial of third party payment may have a direct impact upon a patient's decision of whether to undergo the treatment. However, such denial does not prohibit the patient from seeking treatment without third party benefits, and it does not prohibit the attending physician from providing the treatment."

Also, the Kansas Attorney General concluded that: "Care is not being administered or withheld by the reviewing person . . . The reviewer decision is not a gateway to treatment, it merely determines whether the insurer agrees

² 708 F. Supp. 826, 829 (E.D. Mich. 1989).

it is liable to pay for the treatment. We believe the practice of medicine statutes require licensure to practice the profession, and not to consult with insurers regarding contractual obligations.”

Accordingly, at my health plan we have encouraged our medical directors to view their role as a “science-based collaboration with the treating physician that should lead to truly informed consent on the part of the member and the doctor’s patient.” But it is the treating physician who has the “doctor-patient” relationship with the member and the medical director simply making a coverage decision.

Florida’s late-Governor Lawton Chiles, who spent 18 years as a Member of the U.S. Senate, vetoed the measure in 1996 suggesting that it would be overkill in view of the internal and external appeals mechanisms available in Florida: “The key to any dispute resolution system for health care claims is that it be fast, fair, and efficient. The tort system is often none of those. I would prefer to see a system in place which made quick and enforceable decisions as to whether a subscriber is entitled to a particular treatment so that the treatment could, if appropriate, be provided and the subscriber could be saved from further inquiry or death as opposed to a system which is designed primarily to monetarily compensate subscribers or their estates after the fact for wrongful injury or death . . . Rather than burden the courts with an abundance of managed care litigation, the Statewide Subscriber and Provider Assistance Panel, which consists of experts who are familiar with HMO contracts and medical procedures, should be strengthened to handle grievances more quickly and to directly mete out penalties to HMOs which do not provide services as ordered by the Panel . . . We should not put the entire managed care system at risk in the absence of conclusive evidence that there is a systematic problem . . . The lawsuits generated by this bill would threaten to eviscerate the concept of utilization review and cost control that are the heart of managed care . . . We have progressed too far toward our goal of assuring affordable health care insurance for all Floridians to turn our backs on it now.”

Stanford Business School Professor Alain Enthoven was appointed Chair of the California HMO Reform Task Force and explained the devastating consequences of a liability bill like that in Texas:

My concern about unlimited tort liability for HMOs is about ‘defensive utilization management.’ HMOs could make everybody happy and avoid any suits for denying or curtailing benefits by backing off from utilization management and approving everything. If they did — and this is not an unlikely consequence of the battering they are taking today — health expenditures would soar again with

very destructive consequences, including pricing coverage out of reach for even more families of moderate means.

Many people hold an illusion that the tort system 'makes HMOs pay for their mistakes.' They don't pay; workers and retirees pay in higher premiums. The costs of litigation, judgments, defensive medicine and defensive utilization management all get folded in to higher premiums which ultimately come out of the pockets of workers and retirees. So-called 'employer paid' health benefits really come out of wages. I think of the tort system applied to medical care as a costly conduit of money from workers and retirees to lawyers. Californians would be served better by a system that focused on improvement rather than punishment.

I couldn't have said it better myself.
Thank you for your attention.

(Applause)

TIM RAVICH: [. . .]