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**The Health Care Debate in Washington:
Focused on the Wrong Health Crisis**

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by *Richard L. Huber*



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The debate in Congress over health care reform carries two great risks for the American health care system. First, it threatens to result in legislation that would increase the cost of health care without improving quality. Second, it fails to address the most pressing health care issues facing our nation.

Patients Bill of Rights

The focus of the current congressional debate is a so-called Patients Bill of Rights that represents an effort to provide more regulation of managed health care.

HMOs and other forms of managed care expanded dramatically in the 1990s as the employers who fund most health coverage for their employees sought to control runaway health care costs that were increasing at double-digit rates annually.

While managed care successfully slowed the increase in costs, the methods were not without controversy. The industry focus was on encouraging quality health care—particularly preventive care—and eliminating excesses. But many resented the idea that services appeared to be constrained.

This paper attempts to put balance into the debate and counter a number of myths that have grown up around managed care—using data instead of anecdotes.

The Patients Bill of Rights is motivated in part by unrepresentative and sometimes unsubstantiated managed care “horror” stories. *Washington Post* media critic Howard Kurtz reported in August 1998 that “such stories are often more complicated than they seem at first.”¹ He quoted one journalist who had been burned by reporting a false HMO horror story: “I think the power of the anecdote, the horror story that we’ve all heard and become so tired of, is on the way out.” Yet the beat goes on daily in the news media, fed by organizations like Families USA, which

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solicits “health care hardship stories” on its website.

The managed care bashing has also become a staple of the entertainment media. Gratuitous slaps at HMOs for fictional transgressions are common on popular medical television shows like *ER* and *Chicago Hope*. And Helen Hunt and Jack Nicholson won Oscars for their performances in *As Good As It Gets*, in which Nicholson’s character helps Hunt’s deal with an HMO that has allegedly failed to help her asthmatic child.

Yet, *Washington Post* reporter Abigail Trafford wrote in an analysis of the movie’s HMO theme, “The irony is that some HMOs have been pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce the need for emergency hospitalization.”² These programs are not available to people with fee-for-service health insurance. Aetna U.S. Healthcare, for example, has an asthma disease management program for managed care members that provides nurses who regularly call asthma patients to make sure they are following their doctor’s advice as well as home medical equipment and educational materials to help patients manage their disease. As a result, the number of asthma patients’ hospital admissions are down 34 percent and emergency room visits have fallen 26 percent.³

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Interestingly, despite the media barrage, numerous polls have documented that people are generally satisfied with their own health care coverage, and that people in managed care plans are as satisfied—in some cases more so—as people with traditional fee-for-service indemnity coverage.⁴ Yet, apparently largely as a result of the daily media drumbeat, public opinion of managed care has plummeted.⁵

Polls show that people are afraid managed care is focused more on cutting costs than on increasing quality.⁶ And there is superficial evidence to suggest public support for more regulation of managed care, but that support quickly evaporates if people are informed that it will raise the cost of care.⁷

So the congressional response is to consider a slew of new “rights” for patients. But the proponents fail to mention that each of these so-called rights comes with a price tag, which is ultimately borne by all of us.

Let me be clear. Many of the proposed changes are things most of the managed care industry already does; for example, following the “prudent layperson” standard for emergency room visits and direct access to Ob/Gyns. One of the most popular proposed requirements is a ban on gag clauses in physician contracts. Yet a GAO study of 520 health plans found no so-called gag clauses among any of them,⁸ and Aetna U.S. Healthcare has specific language in its contracts that encourages physicians to discuss all treatment options with patients.

But we should be extremely wary of sweeping new requirements and mandates that add to health care costs. There are currently well over 1,000 mandates in place across the country—mostly at the state level. These include requirements for coverage of a particular service, coverage of a minimum number of hospital days following certain procedures, the nature of provider networks, and a host of other regulations.

A recent study from the Health Insurance Association of America found that state mandates have added between 4 and 13 percent to the cost of health coverage, and that this additional cost is responsible for between 20 and 25 percent of the nation’s 43 million uninsured.⁹

Malpractice Liability

The most costly new “right” under consideration in the Congress is an enhanced right to sue health plans for medical malpractice. The proposal would eliminate the ERISA provision that has the effect of prohibiting recovery of windfall punitive damages in suits over coverage decisions by employer-sponsored health plans.

Unfortunately, large punitive damage verdicts do not improve access to quality health care, but do drive up health costs and thereby make it more difficult for people to afford health coverage.

The Barents Group estimates that the proposal to increase the liability exposure of health plans could increase health insurance premiums 8.6 percent¹⁰ and the Lewin Group estimates that each 1 percent premium increase equates to 300,000 additional uninsured.¹¹ This provision alone could increase the number of Americans without health insurance by more than 2.5 million.

Setting cost considerations aside, the tort system is probably the least effective way to achieve a public good. It is slow, unpredictable, expensive, and inefficient. Perhaps for these rea-

sons, only one in eight people with legitimate medical malpractice claims against physicians actually file suit, according to a recent Harvard study.¹² So most people with legitimate claims are not helped by the right to sue.

Furthermore, people with meritless claims file two-thirds of such suits, the study found. So the court system is burdened with weeding out the undeserving claimants, some of whom wrongly prevail.

Again, from Harvard: the top 25 percent of those who won awards received 10 times as much as the bottom 25 percent with similar injuries. So the tort system's rewards are uneven, and therefore unfair.

Finally, 60 percent of litigation expenses did not go to plaintiffs, but were eaten up in court costs, legal fees, etc.

In sum, the slow, cumbersome tort process leaves legitimate claimants without justice, often rewards the unworthy, lines the pockets of trial lawyers and heaps huge costs on the health care system that are passed on to consumers, many of whom

lose their health care coverage entirely as a result. Perhaps worst of all, court verdicts that take many years to obtain do nothing to help people get the care they need when they need it.

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Consumers' primary goals are to get their health care issues resolved quickly and to have these complex medical questions decided by medical experts, not lawyers or juries who have no training in the complex medical issues facing patients. The slow and inefficient court system will not accomplish either goal.

There must be a better way, and we believe there is. It's called independent external review, which allows independent medical experts to review a case while it's still current and, if appropriate, overturn coverage determinations. That way, people can get the health care they need now, rather than expensive compensation later.

That's why Aetna U.S. Healthcare recently became the first national health benefits company to provide our managed care members with the right to appeal coverage denials based on medical necessity to neutral, independent physician reviewers—a policy applauded by consumer groups. Where permitted

by law, the fair and unbiased decision of the external reviewer will be binding. Other companies are following suit, and this procedure is quickly becoming standard practice among leading managed care companies.

Denials of Health Care

The premise for much of this debate over new mandates—and especially over the expanded liability exposure—is the notion that managed care companies are somehow engaged in a systematic effort to deny their members access to necessary medical care.

Complaints are often heard that a health plan won't cover a particular service or pharmaceutical product. In reality, health insurers will gladly issue policies covering anything a purchaser may want to pay for. But selecting a limited plan and then expecting full coverage is unreasonable. After all, if we decline

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collision coverage, we don't expect the auto insurer to pay for a crumpled fender when we hit a tree.

More troublesome to many people is the idea that the

health plan may deny coverage based on its finding that a given procedure may not be medically necessary. This perception stems from managed care's attempt to ensure that hospitalizations and services are both medically indicated and carried out appropriately.

Dr. Susan Love, the noted surgeon and author, has said that the old fee-for-service system encouraged overtreatment, discouraged preventive medicine and offered patients too little information to question high-priced and often excessive care.¹³ In the late 1980s, studies by Drs. Robert Brook and Mark Chassin of the Rand Corporation found that one-third of coronary artery bypass graft procedures were unnecessary, and another one-third were questionable.¹⁴

Instead of rewarding physicians for providing more services, managed care changed the paradigm. It began to reward the efficient provision of care and to emphasize early detection and treatment to make care less expensive.

Managed care also strengthened utilization management by

health plans, in which inappropriate treatment, or treatment judged to be not medically necessary, is not approved for coverage. It is this activity that causes the fear and many of the alleged horror stories, but in fact, the data show that denials are very few. A recent survey of 2,000 physicians found that 97 percent had experienced no denials of care.¹⁵

Michael Weinstein recently reported in *The New York Times* that, “For a variety of reasons ... managed care plans appear to be denying little care, notwithstanding all the well-publicized horror stories and growing complaints as HMOs become commonplace in American society.”¹⁶ Furthermore, the overtreatment patterns observed in an earlier era by Drs. Love, Brook and Chassin persist. Weinstein noted that a presidential commission recently found that excessive procedures account for as much as 30 percent of the nation’s medical bills. “The problem is too many medical treatments rather than too few,” he concluded.

Underutilization of desirable services, such as primary and preventive care, is just as harmful as overutilization. It can result in a more advanced illness. That, in turn, means more invasive and expensive treatments for conditions that could have been treated earlier or avoided altogether.

Managed care can help by encouraging more of the right kind of care. It does so not only by covering prevention and wellness programs, checkups and screenings not covered by traditional fee-for-service insurance, but also by proactively encouraging its members to use these services. Aetna U.S. Healthcare, for example, tracks which members haven’t had needed checkups and screenings and sends reminders to encourage them to do so. In addition, disease management programs—like the asthma programs described by Ms. Trafford—have been created by managed health care plans to encourage members to get needed care for conditions ranging from lower back pain to congestive heart failure.

There is a large and growing body of evidence suggesting that these efforts by managed care are beginning to have a substantial positive impact on the quality of health care.¹⁷ As just one example, surveys by the Centers for Disease Control and Prevention found that women in managed care programs are more likely to receive mammograms and Pap smears than women covered by traditional plans.¹⁸

The Future of Managed Care

Regional disparities in the delivery of health care are a longstanding problem. In 1993, Dr. John Wennberg of Dartmouth Medical School told a Senate committee that, “In health care, geography is destiny.”¹⁹ Hospital admission rates, he said, varied significantly across the country. Admission rates depended not on the nature of the illness or the health of the patient, but rather on the number of hospital beds in that community.

Utilization management by managed care companies is one way to address these issues. A better way may be providing physicians with reliable data on how their practices compare with accepted norms. Managed care is uniquely capable of providing this service based on the huge databases our companies are developing.

Empowered with information, physicians around the country will be encouraged to adopt best practices in ways not possible before. Here’s an example: The American College of Cardiology has established that beta-blockers are extremely beneficial in preventing second heart attacks, yet studies show that as few as 30 percent of those who could benefit from this treatment actually receive it.²⁰ The challenge is to show physicians how their own practice patterns compare to their peers’ and to accepted best practices. Aetna U.S. Healthcare is doing it already, through “report cards” provided to physicians by our U.S. Quality Algorithms affiliate.

This information revolution brought on by managed care is just beginning, and the next stages of managed care may be as controversial as the past ones. There undoubtedly will be resistance from those who prefer the autonomy doctors enjoyed under the old system. But we believe most doctors will welcome the information we give them as a tool to help them adopt practices that lead to better and more efficient health care.

The *Real* Health Care Crisis

While Congress waits for the private health care market to address these important quality issues, is there something the government can be doing that’s more productive than loading additional unnecessary costs on the system?

For a growing number of Americans, the answer is that Congress should be addressing the more pressing health care prob-

lems we face: coverage for the 43 million Americans who are uninsured and the urgent need to reform Medicare before it slides into insolvency.²¹

The uninsured problem represents an area where care truly *is* being denied. The number of uninsured has increased to 43 million Americans—the highest level ever.

The uninsured often delay seeking medical care. They neglect basic preventive care, like immunizations and cancer screenings. Consequently, they tend to get sick more frequently and for longer periods. When they do get care, it is more likely to be in an emergency room after they have dangerously delayed seeking treatment until it is sometimes too late.

Neither government nor the private sector can solve this alone. Government should provide support for market-based solutions. The private sector should develop low-cost products to allow small businesses the opportunity to purchase health benefits. Aetna U.S. Healthcare recently introduced such a product that is not perfect, but is the best we can do under current law. With changes in federal law, we could offer plans that are more comprehensive and more affordable.

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Specifically, government should provide support for the poor and near poor for basic health care coverage. Second, there is a need for tax incentives for small employers and individuals to make health benefits more affordable for currently uncovered workers. Third, lawmakers ought to limit the benefit mandates that drive up the cost of health insurance, forcing small businesses to drop coverage.

The crisis in Medicare stems from the fact that it is estimated to go bankrupt in 2008, when 77 million Baby Boomers will have hit the system. To help alleviate the cost pressures, give seniors more choices, and make the system more market-oriented, Congress created a new Medicare+Choice program that allows seniors to choose private HMO coverage. This gives them access to a richer benefits package, including prescription medications, wellness exams, preventive care screening, dental care, vision care, and hearing aids.

Unfortunately, the government's payment rates for this pro-

gram lag behind the rate of medical inflation, which has forced some HMOs to drop out of the program and limited its availability for seniors. Tragically, the presidential commission on Medicare recently failed to endorse a proposal favored by a majority of the commission that would have brought more private competition and individual choice to the Medicare market. It's still not too late, but Congress must act.

Conclusion

The problem for Congress, of course, is that it would take political courage to tackle the funding issues involved in addressing the uninsured and Medicare problems. The easier course is to load new regulations on unpopular insurance companies while hoping that no one notices when that leads to higher health care costs for everyone—and even less coverage for those who can barely afford it now.

For the rest of us, the challenge is to convince the Congress to oppose short-sighted, counterproductive measures, and instead to muster the courage to tackle the real health care crisis. ❧

Notes

1. "Some Managed-Care Sagas Need Second Exam," Howard Kurtz, *The Washington Post*, August 10, 1998.

2. "Is Movie's Slap At HMOs A Cheap Shot?" Abigail Trafford, *The Washington Post*, February 24, 1998.

3. U.S. Quality Algorithms, Inc.

4. Wirthlin Worldwide Report, *Current Trends in Public Opinion*, April 1998. 1998 satisfaction numbers: 81 percent in managed care satisfied with their current health plan; 68 percent in FFS satisfied with health plan.

5. Louis Harris and Associates, public opinion surveys from 1995 and 1997. In 1995, 59 percent said the trend from FFS to managed care was a good thing; 28 percent said it was a bad thing. In August 1997, 44 percent said trend was a good thing; 44 percent said it was a bad thing.

6. ABC News Poll, September 1997. 57 percent of people in HMOs believe insurers give precedence to cost-cutting over care.

7. Kaiser Family Foundation/Harvard University, *National Survey of Americans Views on Consumer Protections in Managed Care*, January 21, 1998. Initially, 72 percent support (17 percent oppose) Bill of Rights legislation; if they have to pay \$15-20/month more, support drops to 28 percent (57 percent oppose); if employers would drop coverage as result of this legislation, support plummets to 15 percent (72 percent oppose).

8. "Managed Care Explicit Gag Clauses Not Found in HMO Contracts but Physician Concerns Remain," GAO, August 1997.

9. Jensen, Gail and Morrissey, Michael; *Mandated Benefit Laws and Employer-Sponsored Health Insurance*, January 1999.

10. Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers: 1999-2003*, April 27, 1998.

11. The Lewin Group, letter to Richard Smith, American Association of Health Plans, February 4, 1999.

12. "Getting Litigious With HMOs," Michael Weinstein, *The New York Times*, July 19, 1998.

13. "H.M.O.'s Could Save Your Life," Susan Love, M.D., *The New York Times*, June 7, 1998.

14. R. Brook and M. Chassin, et al., "The Appropriateness of Carotid Endarterectomy," *New England Journal of Medicine*, March 24, 1988.

15. *Inquiry*, Fall 1997.

16. "In Denial: Managed Care's Other Problem—It's Not What

You Think," Michael Weinstein, *The New York Times*, February 28, 1999.

17. "Stage at Diagnosis and Treatment Patterns Among Older Women with Breast Cancer: An HMO and Fee for Service Comparison," *JAMA*, February 24, 1999. "The State of Managed Care Quality," National Committee for Quality Assurance, *Quality Compass 1997*. Nelson, et al., Physician Payment Review Commission, November 1996. Riley, et al., *The American Journal of Public Health*, October 1994. "Insurance-related Differences in the Risk of Ruptured Appendix," Braveman, et al., *The New England Journal of Medicine*, August 1994.

18. Centers for Disease Control and Prevention, *National Health Interview Survey*, 1994.

19. John Wennberg, hearing before Senate Finance Committee, October 26, 1993.

20. "National Use and Effectiveness of Beta-blockers for the Treatment of Elderly Patients After Acute Myocardial Infarction," Krumholz et al., *JAMA*, August 19, 1998.

21. "Key Voters Cite Medicare, Uninsured As Most Important Health Care Issues," findings of a national poll of 1,000 registered voters, ages 45 and older, conducted by Ayres, McHenry, & Associates, Inc. on May 16-18, 1999, commissioned by the American Association of Health Plans.

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