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I have been asked to provide testimony to the Commission as it considers changes for the Canadian health care system. It is my understanding that there are persons who believe that public funding and private delivery systems will provide improvements in access, efficiency and revenue. This belief assumes that there is a sufficient enough separation between funding and delivery of health care, and that as long as the funding remains public, then privatized delivery can occur without affecting public values, such as universality, accessibility and comprehensiveness. Privatized, market-based delivery systems and their management have been shown to result in just the opposite: fragmentation, inequity and inadequacy of care. This research is available, and, no doubt, will be addressed by other testimony. As a doctor who has worked within for-profit management organizations, and who has witnessed first hand the techniques and effects of privatized delivery systems, I intend to provide a different perspective. I know the specific ways that corporations develop increasingly sophisticated methods for the limitation and denial of care as the primary means for generating savings and/or profits.

I am a physician from Louisville, Kentucky. For the past 20 years, I have worked in the administrative side of the evolving systems of U.S. health care. I have dedicated my professional work to understanding and explicating the inner workings of American "managed care," especially when it is performed by market-based systems with adverse effects on patients. My experience derives from actual work as a physician executive inside managed health care plans, as well as recent experience as an expert in many legal cases involving the negligence, breach of contract or bad faith of some health plans. I have worked also as an auditor of health plans under consideration for managed care contracts. In these various capacities, I have read thousands of documents—business plans, board minutes, health plan contracts, policy and procedures manuals, internal memoranda, utilization and quality reports, physician profiles, financial data, testimonies from health care employees, and other evidence of internal workings of health plans.

Many of these documents are rarely, if ever, made public. This means that most of the information and analysis done at the academic or policy level in the United States comes from small peepholes into the "black box" of corporatized managed care, a box kept as tightly closed as possible by health insurance companies. American insurance companies use multiple resources to protect their actual practices from public scrutiny: federal protection from legal accountability for most members; statutory peer review protections, claims of propriety and trade secrets, confidentiality agreements and sealed court orders, contractual compliance conditions for physicians, and legal maneuvers to prevent the release of critical documents, to name just a few. Every claim made by the U.S. health industry as a whole, or any claim made by a specific health insurance company should be considered carefully—little can be verified by material open to independent, public analysis and verification.

A famous US supreme court justice once said that light is the best disinfectant, and I have committed the past decade of my professional work to the task of opening and bringing light into these black boxes of the American business of health care delivery. There is nothing more important. We have relinquished the delivery of care in this country to companies who the market model on its head: in the usual market setting, businesses succeed to the extent that they make a product available. In the managed care business, companies succeed financially to the extent that they withhold a product. I will provide some insight into how this is done.

It did not take long in my work as a medical director to understand the adverse consequences when businesses and corporations control the delivery of care for self-serving, rather than patient serving needs. I began my work enthusiastic about the social ethic encompassed with the concept of an HMO. I was attracted to the belief that pooling resources under a single umbrella of care could provide better access, comprehension, coordination and prevention. In fact, the original HMO Act of 1973 referred to the delivery of health care without regard to time or cost. If the delivery of care remains publicly controlled, managed more like a public trust with primary commitment to equity and universality for all the beneficiaries, then the social ethic of managed care retains its potential to meet its original goals.

However, the late 70's and 80's saw the rise of investor-owned, for-profit HMOs, which rushed in to take advantage of the market opportunity. The original social ethic of HMOs, which emphasized prevention, continuity of care, comprehensive benefits and long term savings, was subverted by a market ethic, which began to focus on short-term cost-cutting at the expense of care, and expedient profiteering at the expense of patients. I experienced first hand the commercialization and commoditization of medicine, as it was transformed from a profession committed to serving the best interests of patients to a series of business transitions serving the best interest of stockholders.

What began as a means to ensure appropriate care, became a means to make or save as much money as possible from some funding source for patient care. Whether the money came from premiums paid for by the public or employers, or from the government paid on behalf of certain groups, the managed care machine functioned like a huge funnel lined with increasingly sophisticated filters. Money poured in at the top from any funding source gurgled through the machine's filters until the least amount of dollars trickled out through the end. These dollars represented the amount actually spent on patient care, tellingly referred to as the "medical loss ratio," or the measure of "loss" of premium dollars to patient care. The evolution of American managed care could be told through the development of the increasing addition and sophistication of the "filters" in the funnel.

For example, 15 years ago, the "medical necessity" filter required company doctors to make assessments about medical circumstances in order to give a health plan the right to approve or deny a requested treatment or service. Initially, these company doctors used their own medical judgment, which allowed patient and condition specific flexibility. Over the years, this thread on this filter tightened, with the addition of quotas and bonuses for company nurses and doctors to encourage denials; increasing use of guidelines, with normalization of medical conditions so criteria could be applied without variation or intrusion of "subjective," patient specific effects on nurse and doctor assessments; and finally to the development of increasingly sophisticated risk, utilization compliance, and bonus/penalty contracts with treating physicians, pushing the "medical necessity" determination down to the level of the treating doctor, who in turn became a virtual medical director of the health plan. Now the new trends in American insurance, under the guise of "choice" health plans push more and more costs to the patients, putting the next phase of "medical necessity" determination into the patients themselves. A health plan medical director or capitated treating doctor will not have to limit or deny care—it will be done by the patients themselves as they face crisis of costs in the midst of medical needs. I could go through every type of "filter," from network design, contracting, benefit determination, gatekeeping, risk arrangements, utilization management tactics, appeal systems, and even the use of language—and track the transformation of managed care practices from blunt tools to refined instruments, all increasingly modified to limit and deny more and more services and treatments.

This evolution explains how the concept of HMO, defined in the original HMO act as an entity organized "to provide basic and supplemental services without limitation as to time and cost," could morph into an ideology called "managed care," now defined in a leading textbook as a system that "alters the decision-making of physicians and hospitals by interjecting a complex system of financial incentives, penalties, and administrative procedures into the doctor-patient relationship…" The managed care industry has become a methodical, systematic business engaged in the redefinition of

"what is best for the patient and how to achieve is most economically."[1] "Managed care" became an unquestioned ideology, whose values and assumptions pervade even medical education. Within this ideology, everything, even patient harm and death, becomes not only defensible but accepted as the cost of doing business.

In its ethical form, managed care would exist for the *benefit*, not detriment of patients. It would be non-profit, avoiding the commodification and commercialization of patients and medicine. A health plan would be organized and administered much like a trust, with limits on the degree to which the organization and individuals, particularly executives, could succeed financially at the expense of patient care. Furthermore, the systems of utilization and quality management would be organized for the *benefit* of existing and future patients, not for the benefit of stockholders, whose interests can often lead to detrimental effects on patients. This type of managed care would be organized on longer time frames, so that legitimate savings from the reduction of unnecessary or inappropriate care would not be dependent upon monthly, quarterly and annual profit-loss statements. These savings would go back into the system to support the addition of extended benefits, new technology, research, education and support of the medical infrastructure of professionals and facilities.

What we have developed under U.S. market conditions is a form of managed care that is fundamentally unethical in that it rations care by the very persons and organizations that financially benefit from the limitations and denials. Health insurance companies have ingeniously exploited the "managed care" concept, interjecting between funding and the receipt of care a monstrous business that is cost-effective and succeeds to the extent that it limits or denies care. It should not come as a surprise that the U.S. market and other sources of privatization looks hungrily at countries with public funding. This type of funding represents a steady, lucrative supply of dollars to go into the funnel, and to the degree that these dollars are "managed" in transit, for-profit companies stand to make the kind of windfall profits that represented the early profits obtained in this country. As U.S. companies have learned, there are huge savings in the initial management of "excesses," like hospital days, specialists' costs, provider fees, etc.—the so-called "low hanging fruit."

But every aspect of managed care relies predominantly on the reduction of treatments and services in order to achieve savings or profits, and plans have to grind through more and more labor intensive and costly processes to achieve their initial savings or profits. Whether it comes from limitation of networks, gatekeeping to limit tests and referrals, authorization (and denial) of hospitalizations and other treatments, limitation of benefits, "medical necessity" determination—there is no lower limit to the reduction. Maternity stay was pushed to 24 hour hospital stays (and in one plan got as low as 8 hours) before public outcry forced Congress to get in the business of medical

[1] Peter Boland, "Market Overview and Delivery System Dynamics," in *Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions*, 1993, p. 3.

decision-making. States have passed laws forcing health plans to pay for emergency care. There are multiple examples of how the business of management disregards the clinical consequences. The standard measure for plan performance in annual reports and Wall Street valuations includes "medical loss ratios," "days per thousand," "lengths of stay" and "per member per month" costs – all measurements of decreasing utilization, or the limitation and denial of health care services and treatments.

Although there is much about this machine I share with you, it seems most important that you understand the process of limitation and denial of care as the means to support the production of savings and profits by companies committed to their own interests and not the interests of patients. The most telling aspect of the American health care industry is the degree to which they claim they do not engage in such practices. In fact, trade and lobby material consistently state that a market-based delivery system and its management can provide greater choice, efficiency, and quality. Not only is there little evidence to support this,[2] there is enough public outcry and documentation of adverse patient events to make these claims suspect. These events are not "mere anecdotes," as the health industry would purport.

For example, in one legal case, a managed care plan was found to have negligently denied a hysterectomy. Unbeknownst to the patient or her treating doctor, the health plan had subcontracted with another for-profit company that had developed stringent criteria, hired their own reviewers, and maintained a 25% denial rate. A glossy marketing brochure by the subcontracted review company even touted to its potential clients, health plans, and its extraordinary "savings" in hysterectomy denials as a way to generate business. Reports sent from this company back to the health plan tracked the numbers of denials and the "savings" achieved. Despite references to "quality" through member material and representations to accreditation bodies that the health plan provided "quality" management, there were no quality studies done on these denials. Not only did the plan fail to monitor the outcomes of these denials (as a quality assurance process to evaluate the vendor, if nothing else), they did not even consider it important. Neither the health plan nor the subcontracted review company investigated the results of their practices to determine if criteria were too stringent, and or determine if necessary care was being denied in the zeal to keep a 25% denial rate and produce savings about which the companies could gloat. Criteria in question here involved a denial of hysterectomy in the presence of cancer. In fact, the algorithm was so restrictive and applied so automatically that the woman would have had to go through two partial, non-curative procedures for the treatment of her cancer, and her

[2] There are many articles examining the performance of for-profit and non-profit systems, as well as articles examining the performance of managed care systems, but some general references that are useful include: Robert Kuttner, *Everything for Sale: The Virtues and Limits of Markets*, pp. 110-158; Robert Kuttner, *Must Good HMOs Go Bad? – The Commercialization of Prepaid Group Health Care – First of Two Parts*, NEJM, May 21, 1998, pp. 1558-1563; Robert Kuttner, *Must Good HMOs Go Bad? – The Search for Checks and Balances – Second of Two Parts*; NEJM, May 28, 1998, 1635-1639; Robert Kuttner, *Wall Street and Health Care*, NEJM, February 25, 1999, pp. 664-668; Woolhandler and Himmelstein, *Extreme Risk – The New Corporate Proposition for Physicians*, NEJM, December 21, 1995, pp. 1706-1708; Karen Stocker, et al., *The Exportation of Managed Care to Latin America*, NEJM, April 8, 1999, pp. 1131-1136.

hysterectomy would have been approved on after a failure of the second when invasive carcinoma appeared.

This case, which resulted in a $13 million dollar punitive damage award against the health plan, represented the degree to which secret practices can have devastating effects on patient care. This case and others demonstrate how little is and can be known about the degree to which necessary care is limited or denied in the for profit health industry—unless we use inside sources. There are no statistics or independent evaluations done to determine when and where health plans cross the line between the denial of unnecessary care and the denial of necessary care. In the rapacious pursuit of profits, this line is dangerously thin, and evidence from the few legal cases that have been allowed to proceed suggests that it is certainly crossed too often.

Although there are many areas I can address, there are three main concerns about denials of care, which I believe must be considered: 1. The use of company nurses and doctors to deprive patients of clinical care, a direct contradiction in professional oaths and responsibilities; 2. The use of treating physicians as agents of rationing and denial; and 3. Denial in the form of economic rationing done at the level of the for-profit corporation.

First, with regard to the use of company nurses and doctors: As a medical reviewer in one job, I was told at the beginning I was expected to keep a minimum 10% denial rate, a quantity that had no relationship to the appropriateness of the denials. In fact, when my supervising physician reviewed my clinical judgments, he only reviewed my approvals, often chastising me for failing to make them denials and instructing me in the myriad covert ways we could use our medical training to justify denials. In other jobs, no percentage was every high enough, and I was, in at least one instance, set competitively against my other physician reviewers, and we received bonuses based upon the highest percentage of denials. Again, there was no evaluation or measurement of the quality of our decisions; we were driven by numbers and dollars alone. Later, in some legal cases, I have seen documents that rewarded company nurses and doctors. In fact, I have written an article[3] about how difficult it was to even do what was clearly appropriate for a patient in a culture in which everyone and everything is organized to achieve as much limitation and denial of care as possible. The entire utilization machine is designed to eliminate as much as possible the "art" of medicine, the very kind of experience and knowledge nurses and physicians bring to specific patient conditions and needs. Over the past five years, documents from legal cases have confirmed that my early experience as a medical reviewer or medical director was typical for the industry, and, if anything, the past decade has been marked by increasing capitulation by physicians working for lucrative compensation packages for companies—using their medical expertise not for the benefit of patients, but often to their detriment.

[3] Linda Peeno, *What is the Value of a Voice?*, US News and World Report, March 9, 1998.

Second, with regard to the co-opt of treating physicians: When treating physicians are made, through risk arrangements, the instruments of limitation and denial, the most egregious system results. The trusted physician becomes the company doctor, and patients cannot know what they do not know. Health plans then achieve something I refer to as "denying without denying"—i.e. they cause limitation and denials to occur that are not explicit and are not provided to the patients in any kind of tangible form. This results in cost-savings on two levels for health plans: services and treatments are limited prospectively and patients have no specific written denial for which to access the appeal process, so health plans eliminate some of the costly burden of staffing and operations for appeals. It should be noted, as the U.S. believes that "patient protection" provisions will have the means to provide checks on the for-profit machines, that nearly all the patient protection provisions, from expedited appeals to external reviews, require an actual denial in hand to activate. If plans limit and deny care stealthily, then patients cannot benefit from these so-called protections. I have administered capitated arrangements as a medical director, and I have been the expert in several cases involving these tactics, and the unsuspecting, trusting public is not prepared to deal with the degree of exploitation and subterfuge represented by this trend.

Third, the economic rationing by for-profit companies to further their own financial interests: In a recent case, a health plan was found to have developed a plan whereby it denied care to one group of patients in order to shift their internal resources to another group of patients from whom greater savings/profits could be generated. Although I had participated in such practices as a medical director of a plan, and knew that such practices occurred, this landmark case documented for the first time the kinds of cost-cutting strategies developed and implemented at the corporate level. Only after a judge compelled production of documents and the company received a default judgment on liability for their failure to fulfill the court's orders, did the incriminating documentation of a pervasive business practice emerge. This case represents not only the degree to which secretive actions occur, which are never disclosed to the public and would never come under the scrutiny of the law, policy makers or potential patients, if health plans are left to their own claims and self-disclosure.

It should be noted that the health industry eludes accountability for the denial of care through a variety of tactics. On one hand, they claim that they do not deny care, they only deny payment, ignoring, of course, that in our country denial of payment equals denial of care, and the effects on the patient are the same.

To the degree that denials of care are acknowledged, the industry claims that it is only a small percent. In fact, the only support for this that occurs on the managed care trade organization (American Association of Health Plans) web page is from an article in which 2000 physicians were interviewed and asked about their experience of denials—a seriously flawed way to determine a denial rate, and representative of the

lack of real information. Based on this survey, AAHP states that no more than 3% is denied. One must ask: 3% of what?

This argument represents the most serious indictment of the health industry. Adverse patient events are reduced to “mere anecdotes,” and the human costs are lost in the numbers. One health plan representative, in an attempt to defend a charge that they had denied a heart transplant causing a man to die, stated glibly that the company pays “26 million claims a year” but only one or two end up in court. This figure can tell us quite a bit. First, these are 26 million paid claims, and if they denied 3%, the figure estimated by AAHP, that would mean that over 800,000 claims were potentially denied. Of course, that would represent only the actual “denials,” not the tactic, stealth forms of limitation and denial. I can guarantee to you that there was no process that examined a single one of those denials, overt or covert, to determine if it was appropriate, if it represented the failure to discern between unnecessary and necessary care, or if it resulted from unchecked cost-cutting practices that impaired quality. Furthermore, the claim that only one or two end up in court as the means by which a health plan should be assessed for its failure to perform its functions is seriously flawed in the U.S. With federal protection, the few cases for which health plans have actual legal accountability are like a snowflake atop an iceberg. Finally, the problem with limitation and denial of care is that statistics do not reveal the degree of individual, family and community costs, suffering and even loss that results when even one person suffers needlessly at the hands of machinery that places money before people.

When the emphasis shifts to cost cutting for profit making, the consequences are not surprising. There is, to name a few of the major effects:

1. restricted access for vulnerable and expensive patients for testing, referrals to specialists, treatments, hospitalizations, emergency care, rehabilitation, home health, medical equipment – anything that costs money;
2. reduced spending for clinical services as money is shifted from clinical care to administration, marketing, public relations, executive salaries and bonuses;
3. shifting costs to patients themselves introduces barriers and obstacles that cause the patients to limit their care; and
4. shifting costs to public sectors as private companies use a variety of methods to limit or deny care, e.g. shifting to Medicaid and other social services; shifting back to regular Medicare.

It should be clear that the savings and profits from for-profit delivery and managed care companies will be obtained and maintained at the expense—money and human—of the government, communities, families and individuals.

We are at a point where the one time savings from managed care have been nearly exhausted in the U.S., and health plans face public backlash for their long-standing egregious practices. Over time, the model has moved from the limitation and denial of

care by the boardrooms to the bedside. Now the next phase is to move to the bed itself. Health plans and doctors will no longer limit or deny care – the patients will do it themselves as more and more costs are shifted to the public. Even this may not be enough to return U.S. companies to the kinds of profits obtained in the glory days of early managed care. As the health care business in the U.S. faces decreases in profits and saturation of its markets, it will proceed as other businesses, and search for new markets outside of the U.S. Like the U.S. tobacco industry, the health care business will offset the costs of its national restraints and regulation with increased perpetuation of its deadly deeds in more vulnerable populations—the less sophisticated, less empowered, less protected overseas patients.

I urge you to make your decisions regarding changes to your health system with caution. If there are further details and evidence I can provide to you, please do not hesitate to contract me.