Testimony

Of

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"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

My name is Mel Stern. I am here on behalf of the families I care for, the Maryland Chapter of the American Academy of Pediatrics and the National Physician Alliance. I wish to thank you for the opportunity to testify on this very important, and in fact critical national issue. I am a board certified pediatrician and have been in solo practice for thirty years. I am a member of the volunteer faculty of the University Of Maryland School Of Medicine, and for the last 20 years I have been chairman of the Legislative Committee of the Maryland Chapter of the American Academy of Pediatrics.

As a result of my public policy work it has become apparent to me that any public policy that is good for children is good for the entire community, whether it involves economics, environment, education or national security, or health. If it is not good for the kids, it should be re-examined. It probably is not beneficial for the community. Simply stated, if we do not get healthcare reform done right our children and grandchildren will bear the burden.

With that in mind the purpose of my testimony today is to highlight two areas of concern in our healthcare delivery system:

- ○ the first is the current burden of bureaucracy on the delivery of health services.
- ○ the second equally important issue is the recent shift in control of standards of appropriate medical care from the medical academic and research community to the corporate boardroom and the halls of legislation.

On the macro level, Steffie Woolhandler in an article in the New England Journal of Medicine in 2003 noted that in 1999 health administration costs in the United States accounted for 31 percent of total health expenditures or $1,059 per capita. The impact of this is clearly demonstrated by the business operation required by my practice as well as several vignettes of patient management issues.

As a solo practitioner, I have approximately 75 to 100 patient encounters in my office and an additional 3-5 hospital encounters each week. At the current time I have a staff of four individuals which approximates 3.5 full time equivalents. All personnel are directly involved in non-medical administrative functions ranging from communicating directly with insurance carriers regarding coverage of medical services, to preparing carrier mandated documentation for patient referrals to other medical specialist, as well as required documentation for prior approval for testing, medication and necessary durable medical equipment. Two of the employees are exclusively tasked to non-medical administrative functions. **I am the only individual delivering direct medical care services.**

It is important to note that when I began practicing in rural Washington State in 1975 I only required a single office receptionist dealing with scheduling, and billing. My nurse was exclusively involved in direct patient care. Despite the tripling in the ratio of non-clinical support staff I have not noted a significant improvement in the delivery of medical care.

Moving from the business impact of this expanding non-governmental bureaucracy to the patient, and with permission of the family, I have provided you with my notes on my interaction with Aetna Insurance regarding Ciana Rutledge, an infant with a life threatening tumor. I need to emphasize that while my example highlights an exchange with Aetna it is illustrative of the many interactions that are required with all insurers, **virtually on a daily basis!**

In brief, Ciana was born following a normal pregnancy and delivery. At the time of birth she was noted to have a very large pelvic mass which was rapidly diagnosed as a malignant tumor. Her birth occurred at an internationally known hospital in Baltimore. As a result world renowned pediatric experts in surgery, pediatric urology and oncology were immediately available to participate in her care, and they did!

However, from the very outset the insurance bureaucracy interceded with irrelevant and unnecessary paperwork and reviews. At my first encounter I informed the insurer that this was a rare occurrence and the expertise for diagnosis and management was appropriately in the hands of international experts at this hospital. However, Aetna threatened to withhold payment if the referral papers from my office were not in the hands of the hospital physicians. Please understand that at this point the infant had been strictly under the care of the hospital physicians. I had not had an opportunity to examine the child and in fact was **not medically responsible for the care**.

In coordination, with the institutional provider we produced and delivered the initial paperwork to comply with Aetna's demands. In the initial phase, Aetna never disapproved of any service. They only added additional administrative burden to the provision of these services. Not only was it a significant burden on my office and in fact my other patients, but it required significant resources from the institutional staff. Did it improve care? Did it reduce cost? Did it responsibly support the patient? No, it did not!

Despite the fact that Aetna staff was aware that the treatment was long term and on a very specific timeline, they continued to require "referral forms" at unpredictable times. On several occasions this required rescheduling needed clinical intervention.

At the time that Ciana required chemotherapy Aetna was supplied with the requested prior authorization information. At this point they became intrusive in the medical management and indicated that they would only authorize outpatient chemotherapy. While they did not disclose the standard they were referencing, I assumed it was Milliman and Robertson.

Milliman and Robertson with its "Optimal Recovery Guidelines" has been widely used to reduce hospital costs[1]. While the guidelines were developed by a panel of physicians, they are not based on patient specific physiological data. Most importantly, in this case **there were no Milliman and Robertson guideline for infants**. Yet, in the face of repeated requests from the institutional providers and myself, Aetna personnel were adamant about applying these adult standards to an infant.

They only relented when I threatened to go public with this abuse, when I threatened to alert the media to Aetna's inappropriate and potentially life threatening intervention in the care of this infant.

This is a clear illustration of private free enterprise bureaucracy (not government) functioning in a manner that attempts to ration care and impedes the optimal, and efficient implementation of best medical practices.

Aetna as you are well aware is a for-profit corporation which has an absolute fiduciary responsibility to generate a profit for its stockholders. What about the non-profit or not for profit insurer? Unfortunately, despite the fact that their charter requires that they do not generate profit, and if they do so they are to return all such profits to the community, their performance in clinical interactions are generally indistinguishable from the for-profit sector.

Johnny (not his real name) is a four year old who has been afflicted with reactive airway disease or asthma since age one. Since diagnosis he has been treated according to national guidelines with inhaled corticosteroids and beta-adrenergic medication for rescue. He has been on the same medication for the entire time. As may be surmised this family is insured by the major non-profit insurer in the region.

For reasons that remain unclear to me, four months ago, they refused to renew the beta-adrenergic medication he had been using for almost three years. They requested additional documents from my office which we provided several times. This failed to result in the approval of the medication. It was only when I moved this matter up to the level of the Vice President of Governmental Affairs (not a medical director) that medication was approved and the family was assured this inappropriate interference in care would not occur again.

[1] http://www.ama-assn.org/ama/no-index/about-ama/13663_print.html

Here again the medical care was straight forward and efficient. However, my office as well as the family had to invest an inordinate amount of resource to effect appropriate, and cost effective medical care.

It is unfortunate that in both the case of for-profit as well as non-profit insurers their bureaucracy has served to increase the cost medical care, decrease provider productivity and adversely impact medical care.

It is appropriate to note that this national non-profit insurer has also been at the forefront of the media campaign against obesity. However, they have persistently refused to pay for any services where the diagnosis is obesity. This illustrates the unfortunate dichotomy of an industry which recognizes what should be done and simply doesn't do it.

My second issue of concern is the movement of medical care policy from the research and academic community to the corporate board room. As I noted earlier, the other hat I wear is that of Chairman of the Legislative Committee of the Maryland Chapter of the American Academy of Pediatrics. It was in this capacity that I had occasion to institute medical policy in the halls of the legislature rather than the medical school.

Beginning in 1986 the Academy introduced legislation in the Maryland General Assembly which was to mandate well child care including immunizations as a standard insurance benefit. Despite the fact that the effectiveness of immunizations and the benefit of routine well child visits had been previously well established, the insurance industry fought this bill for five years.

In 1991 the benefit was finally passed after five years of battle with the insurance industry. It is very telling that at that last hearing the lobbyist of the major non-profit insurer turned to me and stated that "I hate arguing against your position, because it is right." Today, child well care visits and immunization rates are used to evaluate the performance of insurers.

A second major initiative began in 1992 when a part-time admitting clerk at a local hospital commented to me, "don't these insurance companies know that these babies cannot go home in 24 hours or less." The problems resulting from early discharge were easily observed and remarkable to a part-time clerk. However, it required a three year battle with insurers in the Maryland General assembly to pass a mandated benefit requiring a minimum of 48 hour stay for a routine delivery and 4

day stay for mothers and infants undergoing a caesarian section delivery. As many of you know this particular issue moved onto this body and culminated in The Newborns and Mothers Health Protection Act of 1996 (PL 104-204 Title VI). In both these instances the money saved by not providing important and at times life saving medical care was profit which went directly to the bottom line of the insurers. However, the real cost of this business decision was placed on our children. While industry profited the community suffered.

As a matter of public policy it must be recognized that **healthcare is not a commodity where pricing and availability can or should be left to the free market. The free market requires the free flow of necessary information, as well as consumers and providers equally capable of analyzing the available information. This is virtually never the case in healthcare.**

Additionally, it must be noted that there has been a lot of attention paid to the uninsured. While this is very necessary, it is far from sufficient. As the unfortunate death of Diamonte Driver has pointed out, coverage is not the issue. People must have access to care. In the case of Diamonte Driver he had medicaid coverage for dental care. However, the reimbursements were so poor that very few providers were available. Diamonte Driver died of a dental abscess with coverage but no available services.

Similarly, a leader in the Maryland General Assembly revealed during a recent hearing on healthcare that his primary care provider had retired and he had to contact four other practices and "name drop," before he was accepted into the practice. Even then, in eight months in the practice and several visits he had yet to see a physician. Again I emphasize that we must keep our eye on the real issue of access to medical care.

In summary, it is clear that our health care budget cannot continue to grow at the current rate. A major area of cost in the system is in non-medical overhead. Finally, the provision of services must be evaluated on a community wide basis, and not simply on the profitability that might accrue to a corporate entity. We must recognize that to deliver care to the public in a manner that is effective, affordable and medically appropriate demands a "public option." I hope that the examples I have

given above illustrate that a system which is based upon equity in search of return is not working. "The system" of healthcare requires real change.

Please remember we need to do this for our children and grandchildren!

Thank you.