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Symposium Introduction: Past as Prolog: Can Managed Care Overcome the Conflicts Inherited from Fee-For-Service Medicine?

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SYMPOSIUM INTRODUCTION
PAST AS PROLOG: CAN MANAGED CARE OVERCOME THE CONFLICTS INHERITED FROM FEE-FOR-SERVICE MEDICINE?

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This symposium issue of the University of Missouri-Kansas City Law Review is devoted to the legal issues posed by managed care. The articles deal with: suing plans over denial of care;[1] whether managed care plan decisions should be subject to claims for corporate negligence and bad faith;[2] ethical problems in delivering care in a managed care system;[3] regulation of managed care plans by the Missouri Insurance Commission;[4] and the problems posed by the electronic transfer of medical information.[5] The common thread in the articles is that there are substantial problems with managed care, and that the legal and regulatory systems are having a difficult time shifting from a fee-for-service[6] system to a managed care system of health care delivery.

I. INTRODUCTION

Medical practice in the United States is undergoing a transition from individualized, physician-driven health care services to generic, corporatized health care services. This shift is fueled by concerns that we are spending too much on health care as a percentage of the GNP and that it costs too much per worker to provide health care benefits. The first concern is based on the assumption that there are other, more important uses for health care dollars. The second is that we need to drive down the cost of labor to compete in a global, low cost labor market. In both cases the solution is seen to be managed care: the provision of medical services in a manner that subjects the medical care decisions of the patient's physician to

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1. Mark O. Hiepler, *Representing the Patient Wrongfully Denied Treatment: How Can the Lawyer Make a Difference?*, 66 UMKC L. REV. (in this issue).

2. James Bartimus & Christopher A. Wright, *HMO Liability: From Corporate Negligence Claims For Negligent Credentialing and Utilization to Bad Faith*, 66 UMKC L. REV. (in this issue).

3. Mary Carroll Sullivan, *Ethical Considerations in Managed Care: A Commentary*, 66 UMKC L. REV. (in this issue).

4. Gretchen Garrison, *House Bill 335 -- Managed Care in Missouri*, 66 UMKC L. REV. (in this issue).

5. Amy M. Jurevic, *When Technology & Health Care Collide: Issues with Electronic Medical Records and Electronic Mail*, 66 UMKC L. REV. (in this issue).

6. Fee-for-service is the general term used by health care economists to refer to payment systems that pay health care providers based on the specific services they provide. It is a broad umbrella, covering everything from patients paying for medical care with their own funds, to the Medicare system, where the federal government pays for the patient's care, albeit with strict limits on charges and the medical necessity of that care.

review and approval of a third party decision-maker whose role is to assure that the care provided is cost-effective and within the constraints established by the patient's insurance contract. The first part of this article explores the basis for the assumption that we spend too much on health care and whether comparisons with other Westernized countries is an appropriate way to answer this question.

Managed care is being imposed on the existing fee-for-service[7] health care delivery system. This means that most of the players in the managed care world – physicians, hospitals, and insurers – are the same that made up the fee-for-service world only a few years (or few weeks) earlier. The second part of this article analyzes the post World War II evolution of health care delivery in the United States and how this shaped the culture of the existing health services infrastructure. The implications of this analysis are that managed care is captive of this culture. Rather than tying to restructure the problem areas of health care services – the role of financial incentives in distorting health care choices – managed care plans are using the same incentive systems to distort care choices in different directions. The problems arise because this eliminates the checks and balances of the fee-for-service system. This leaves patients with too little care, a much more dangerous situation than too much care.

II. FALSE COMPARISONS WITH OTHER COUNTRIES

The shift from traditional health insurance to managed care is premised on the assumption that health care is too expensive in the United States because health care providers charge too much for the services they provide and that they they provide unnecessary services.[8] The second assumption is that the country would be better off if health care dollars were diverted into other areas of the economy. Most of these assumptions are driven by: 1) comparisons with health care systems in other countries that provide health care a lower percentage of their GNP and have better general indices of societal health, such as lower infant mortality and a higher life expectancy;[9] and 2) the observation that health care costs in the United States, as a percentage of GNP, have risen sharply from the 1950s.

If the health care problems of the United States are the same as those of the countries it is compared with, and the role of health care in society has not changed since the 1950s, then these comparisons correctly indicate massive financial mismanagement in health care. Such mismanagement should be amenable to managed care solutions and the result will be more effective medical care at a substantially lower cost. The extent to which the United States is different from

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7. Perhaps the most pervasive example is specialty referrals. As discussed later, fee-for-service has many incentives toward multiple referrals. This increases the cost of medical care and can lead to the fragmentation of care. It has a strong positive value as well because it increases the chance that an incorrect diagnosis or therapeutic recommendation will be corrected by a subsequent physician. Many managed care plans limit these referrals and encourage primary care physicians to treat all the patient's conditions. If the primary care physician is mistaken in diagnosis or treatment, or is not competent to provide the care, there is less chance that these problems will be detected because there is little review of the physician's care of the patient.

8. Both in the sense of ineffective treatments and treatments that, while effective, cost more than the value of the benefit.

9. Specifically, the more affluent European countries and Canada.

other countries, and different from itself in the 1950s, is the extent to which managed care solutions may fail to provide either real savings or more effective care.

III. LIFE EXPECTANCY IS NOT A USEFUL MEASURE

The United States heath care system is criticized because we spend so much money and still have a lower life expectancy than many other industrialized countries. Yet it is not clear that statistical life expectancy, at least at the upper limits, is a useful measure of health. In 1850, the life expectancy in many cities of the United States was 25 years and the predominant cause of death was infectious disease. In warfare, more soldiers died of dysentery, typhus, and other diseases related to bad living conditions than from wounds.[10] Tuberculosis killed several times as many persons per 1000 population than AIDS does now. Between 1850 and 1950, the life expectancy more than doubled in many parts of the U.S.[11] The health care system had little to do with the change in life expectancy. It was due almost entirely to public health measures: drinking water sanitation; food sanitation; immunizations; quarantine and isolation of carriers of diseases such as tuberculosis; improved nutrition and living conditions, especially in urban slums; and public health education of the general populace in how to prepare and store food safely, the importance of only drinking sanitary water, and the importance of immunizations. The development of many classes of antibiotics during the 1950s and 1960s, including ones that could treat tuberculosis, further reduced the threat of infectious diseases and probably made some contribution to life expectancy.

This information about the importance of public health is often used to downplay the importance of modern medical care. Without denigrating the critical importance of public health, public health indictors are not necessarily good indicators of individual health. Life expectancy is primarily a measure of the health of the younger members of society, especially babies and children. Saving a five year old from dysentery has a much greater effect on the life expectancy of the population than saving a 75 year old with pneumonia. Life expectancy also says nothing about the health of the old. An 80 year old woman confined to a nursing home bed counts the same as an octogenarian water skiing in Florida.

IV. THE COSTS OF A FAILED PUBLIC HEALTH SYSTEM

The U.S. has substantially more severe problems with disparities in income, education,[12] and access to health care than other developed westernized countries.

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10. Even for the wounded, secondary infection of the wound was much more deadly than the damage inflicted by the weapons themselves.

11. Neither public health nor medical care has yet to change the potential life expectancy of individuals; only their chance to live to that potential old age. Thus an old person in Roman times would live to the same 80+ years that is considered old today. The difference is that many more people survive childhood illnesses and mid-life diseases to reach 80.

12. Lack of basic education about nutrition and personal health habits leads to many life style related medical problems. The most costly example is lack of knowledge about contraception, pregnancy, childbearing and child rearing. Many women do not appreciate the need for prenatal care and the importance of stopping smoking and limiting drinking during pregnancy.

Some of the problems with access to care arise from the lack of a national health insurance system. Many people have limited access to all but emergency care. This means their medical problems are treated later in the course of the disease, when treatment requires more skilled personnel, technology, and hospital resources. Geography complicates health care delivery in rural areas. A substantial number of people live in remote areas with too little population density to support full-service health care. This increases their morbidity and mortality, and makes caring for them, especially when transport is involved, much more expensive.

The U.S. has substantial life style related problems. We lead the developed world in teen pregnancy, with a corresponding high level of premature infants requiring neonatal intensive care. This care is very expensive and many of the children who now survive suffer from severe life-long disabilities that continue to very expensive to treat.[13] Reducing the number of teen pregnancies and assuring better nutrition and prenatal care could reduce these costs. A related problem is the high level of sexually transmitted diseases (STDs), especially HIV/AIDS. The United States has many more HIV cases than the countries to which its health care system is compared. Treating these infected persons is very costly, and their premature deaths have a big impact on life expectancy.

While premature births to teenagers and the spread of communicable diseases appear to be health care issues, they are really public health issues and are managed outside the health care system. The United States has a very poorly organized public health system.[14] Among other problems, its failures increase the cost of health care. This is a government policy failure, not a failure of the health care system. It is not a money issue, because most public health initiatives are relatively cheap, but one of the government's inability to deal with sex, drugs, and individual liberties. This failing is exacerbated by the fragmentation of the public health system into state and local departments of health, with no effective central guidance, control, and funding by the federal government.

V. HOW THE DEFINITION OF HEALTH CARE HAS CHANGED SINCE 1950

One of the major assumptions about the cost health care is that since it consumes a much higher percentage of GNP than it did in the 1950s, it must be too expensive. Yet this assumes that health care in 1950 is the same as it is in 1999. Health care has changed in many ways, not the least of which is what is included under the health care umbrella. Part of the rise in the percentage of GNP devoted to health care since 1950 is due to redefining expenses from other parts of the budget as health care expenses. For example, as alcoholism and drug abuse were medicalized, the cost of treatment and rehabilitation programs becomes a medical cost, rather than a charity done by religious organizations.[15] A substantial part of the

13. Neonatal Intensive Care for Low Birth-weight Infants: Costs and Effectiveness, 38 Office of Technology Assessment – Health Technology Case Study 4-5 (1987).

14. STEPHEN C. JOSEPH, DRAGON WITHIN THE GATES (1992); L. J. Legters, et al., *Are We Prepared for a Viral Epidemic Emergency?, in* EMERGING VIRUSES 269-282 (S. S. Morse ed., 1993); INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH (1988).

15. The cost is higher when a service is done with full medical trappings, rather than in the austere circumstances associated with the repentance of sin.

health care budget is nursing home care, much of which is really housing. Fifty years ago, the majority of such care was done in the home by extended families. Modern life styles do not include the care of the elderly, so we expect others to provide care that families once provided. This is now part of the health care budget. Even home care assistance for the elderly or infirm is often done my home health aids and called a health care expenditure.

Just the increased morbidity in the U.S. makes it more expensive to provide medical services, other differences arise from the value Americans put on convenience. They do not like to wait for anything, including medical care. Delays in the scheduling of elective surgery, which allow more efficient use of the facilities and staff, are intolerable to most Americans. Most fundamentally, the U.S. has an individual rights oriented culture. This makes individuals less willing to sacrifice individual care for the greater good of society. This is a legitimate societal value, but one that comes at a cost. Interestingly, the existence of the U.S. health care system makes it easier for other countries to run lower cost systems. Wealthy Canadians and Europeans come to the U.S. for care that is not available locally or requires a lengthy wait.[16] Because they are able to buy out of their own system, they put less political pressure on the system to provide certain types of expensive care. In contrast, the wealthy in the U.S. have no where else to go, so they create tremendous pressure on the system to provide expensive, quick care. Even if they pay for it themselves, this still raises the overall share of the GNP devoted to health care.[17]

VI. HEALTH CARE AS VICTIM OF ITS OWN SUCCESS

Medicine has a long history, dating back to shamanistic drawings on cave walls. From its inception, medicine has had two threads: the technology of healing and the psychology of comforting the sick. For much of its history the technology of healing was ineffective and acted almost solely as a prop for the comforting the sick. Unlike the spiritual comfort of religion, the comfort of medicine was that of fighting the good fight, of doing everything to try to defeat disease.[18] Most of the treatments were ineffective, and some, such as bleeding, hastened the patient's demise.[19] Surgery was barbaric because there were no effective anesthetics. Before the discovery of germs and antisepsis, most surgical patients died from infection.

16. The Canadian health care system sometimes buys services from U.S. hospitals, taking advantage of the excess capacity in the U.S. system to provide care at reduced costs.

17. The extreme example is cosmetic surgery. While no one would countenance preventing access to cosmetic surgery, expenditures on cosmetic surgery increase the size of the health care budget and thus help fuel more general rationing. This could be ameliorated if the government were to classify cosmetic surgery as part of the recreation budget, rather than as part of health care.

18. Medicine and the church were in conflict during the middle ages because the church believed that medicine sought to thwart God's will. Medicine was banned for Christians. The early hospitals, which were run by the church, provided shelter and food and nursing, but no medical services.

19. There were exceptions: foxglove (digitalis) was used to treat dropsy (congestive heart failure) and laudanum (tincture of opium, containing morphine) was used for pain.

Modern medicine began with the experimental search for effective treatments[20] and began to advance with the introduction of scientific methods.[21] By 1910, the combination of anesthesia and antisepsis meant that surgery could be done with reasonable chances of successful recovery. Advances in understanding of non-surgical diseases began to produce useful pharmaceuticals. World War II fueled research in technology in general, especially electronics. The need to care for huge numbers of wounded soldiers stimulated the research into antibiotics. While penicillin was used in a limited number of civilian cases only during the war, large scale supplies became available in the civilian market after the war.

The post-war era saw the development of the technology-based specialty medicine that is practiced today. The demobilization of military physicians caused a glut in the supply of physician, encouraging many physicians to go back to school for professional training. This postgraduate work became the norm for physician training. Building on the success of penicillin, the pharmaceutical industry developed many new antibiotics, including effective treatments for tuberculosis. Combined with new vaccines for diseases such as polio, these became the first "wonder drugs." Advances in medical devices brought better cardiac monitors, heart-lung machines, ventilators, and dialysis units. Medicine could now offer effective treatments for most illnesses. Many of these treatments involved expensive technology, changing hospitals from low tech nursing hotels to capital intensive technology centers.

VII. TOO MANY PEOPLE SURVIVE

One result of this enormous improvements in the technology of healing is that persons over 75 are the fastest growing segment of U.S. society. While health care, as opposed to public health, has little affect on life expectancy, it has a great effect on an individual's chance of living to his or her own potential life span. Effective antibiotics, heart disease drugs, specialty surgery, cancer treatment, and other modern medical treatments have allowed many people to live longer and healthier lives. This creates a third order demographic shift in health care costs as a percentage of GNP. First, the absolute number of persons increases, which requires a linear increase in health care costs proportional to the increased population of elderly. Second, older people, on average, require more care than younger people.[22] Third, as these are almost all retired persons, an increase in this demographic group does not increase the GNP as would an increase in a working age cohort. Thus the third order effect: more people, who each require more care, while contributing little to the GNP. This alone has a substantial effect in driving up the cost of health care as a percentage of GNP.

A second factor that increases the cost of health care is that as treatments become more effective and less dangerous, they are used more frequently. Millions

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20. This is best dated from the work of Paracelsus, a Swiss physician and alchemist who died in 1541.

21. Ignaz Semmelweis, a French obstetrician, introduced controlled observations and statistical analysis with his studies of childbed fever in the mid 1800s. This was followed by the work of Louis Pasteur, Koch, Lister, and others at the end of the 1800s.

22. Life-Sustaining Technologies and the Elderly, 306 Office of Technology Assessment 5 (1987).

of people are on daily doses of anti-hypertensive medications that did not exist 50 years ago. Over their lifetimes, these medications will reduce strokes and heart disease, but at a yearly cost of billions of dollars. With modern technology and drugs we can treat heart attacks much more effectively than 50 years ago, but at a greatly increased cost, including the cost of the extra health care the individual consumes by living another 30 years. Kidney transplants are very successful and their recipients can live nearly normal lives, but at a high medical cost.[23]

At a fundamental level, improved health does not lower health care costs for society, although it can lower yearly costs for an individual. For persons saved from quick, medically cheap deaths, effective health care is much more expensive for individuals and for society. In the extreme case, this leads to the often cited concern with the "cost of dying" – that we waste too much money on dying people who will not get better no matter what we do:

> "Concern about the "high cost of dying" persists despite recent analyses that put this cost in a different perspective. First, understandably, the cost of care is highest for people who get the most care, that is, those who are the sickest. Thus, what some decry as the high cost of dying others recognize as simply the cost of health care for very sick people, some of whom live, some of whom die, and many of whom are elderly. Equally important, analyses of Medicare expenditures show that the majority of elderly people who die do not incur high Medicare costs in their final year. And, of those elderly patients whose health care costs are very high, while approximately half die, the other half survive. Analysis of Medicare expenditures over the past 20 years also shows that the rate of increase has been about the same for patients who survive as for those who die, suggesting that the increase in expenditures is not due to disproportionate use of expensive life-sustaining technologies for those who die."[24]

VIII. IMPACT OF HEALTH CARE ON THE U.S. ECONOMY

Putting aside problems in unequal access to health insurance, our booming economy clearly has enough money to pay for health care. This raises the question: If we take money from health care, where do we put it that will be better for society? Scholars have debated this at length, arguing for more money for education, for business investment, and various other uses that they believe would better than health care.[25] These analyses ignore the labor market aspects of health care and most share a hidden bias against service industries, presuming that real jobs are in manufacturing. Health care is very labor intensive, and much of the labor requires a college degree or less. There are many technician jobs that require only 2 years technical training, yet provide a good income and benefits. These are jobs with no transferable skills, so reducing them will only increase the pool of unskilled labor. Even nursing and medical training does not prepare its professionals for a career outside of health care. Health care also supports ancillary industries such as

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23. Not as high as the intermediate technology of dialysis.

24. 306 Office of Technology Assessment at 9.

25. Twenty-five years ago this debate was over the military budget as a percentage of the GNP. Grand projections were made about all the good things this money could be spent on if it were not used for the military. The military budget is now a much smaller percentage of the GNP, but that military money never materialized to solve society's problems.

medical devices and pharmaceuticals, that do some of the best research of any U.S. businesses.

Perhaps most importantly from a labor stability perspective, health care, outside of the 15% or so that is drugs and devices, is not a global market. Health care jobs are not exportable and do not have to compete with low wage alternatives in the third world. Compare this with old style automotive manufacturing jobs, which is still many economists' model for a good job. In the golden years of American manufacturing, the 1950s, the biggest industry was automobiles. Yet, since few of these cars were exported, this industry generated little import revenue: it was just a business that circulated money in the U.S. economy. Health care is like the 1950s automotive industry: good jobs based on selling something to other Americans.

IV. RETHINKING THE COSTS OF HEALTH CARE

As discussed below, there are many areas of the United States health care system that are badly managed. These should be reformed, irrespective of the potential costs to be saved. However, it is inappropriate to compare health care in the United States with other Westernized countries because it is impossible to control for the substantial differences in factors that affect health in these countries. As a start, it would be more illuminating to compare total social welfare budgets, with health care as just one component. This would capture the expenses that the United States calls health care, but other countries pay for in other categories of social welfare. Such a comparison would find that the U.S. spends less of its GNP on social welfare than countries such as Germany with which the narrow category of health care expenditures are compared unfavorably.

X. PAYING FOR MEDICAL CARE

The real problem with health care in the United States is how it is paid for.[26] Historically, medicine was for the well-off. The poor might see a physician when *in extremis*, and there were some free clinic available at some teaching hospitals, but there was little routine care available for the poor.[27] This became an important concern as medicine became more effective and offered treatment for many previously untreatable illnesses. Employers were the first to see the benefit of medical care to keep their employees fit for work. This care was mostly limited to the workers themselves, rather their families, but in some communities the company clinics provided general medical care. There were also efforts by unions and benevolent organizations to provide care for their members and families.[28] In the

26. This is not to denigrate the importance of the social justice problem of universal access to health care, but to recognize that universal access depends on a rational model of paying for health care.

27. This was even more true for blacks. Even wealthy blacks could have trouble finding medical care in many parts of the U.S. As with hotels and restaurants, this became a critical problem for blacks who had to travel.

28. These usually took the form of what we would now call an HMO. There were a series of cases litigating whether these violated state laws barring the corporate practice of medicine. For a more general discussion of this ban, see Mars, *The Corporate Practice Of Medicine: A Call For*

1930s the Kaiser company started the Kaiser health plan to care for the workers at the Grande Coulee dam. Because of the remote location of the work, this was a comprehensive plan that included the worker's families.[29]

The move to health insurance started during World War II. Because of the wartime price and wage controls limited the ability of employers to compete for the a limited workforce, employers started offering health insurance as a benefit. This continued after the war and health insurance, paid for by the employer, became the norm during the 1950s.[30] As a percentage of both GNP and wages, health care was still cheap during this period and well into the 1960s so there was no concern with controlling health care costs. Physicians were paid on generous scales that they had a significant role in shaping,[31] there was no review for medical necessity, and few restrictions on coverage for new treatments. From the perspective of physicians and the public, this was the golden age of medicine. Physicians as a class became wealthy and shaped the current stereotype of the rich physician.[32] New treatments were being discovered and scourges such as polio and tuberculosis were brought under control.

While private health insurance made medical care freely available to most employees, the poor and the retired or disabled were left out. This became a major social justice issue as the public began to see medicine as working miracle cures with magic bullets. President Johnson, as part of this Great Society programs, proposed the formation of Medicare to provide medical care for the old and Medicaid to provide care for the poor. These programs were bitterly opposed by the American Medical Association and several other medical professional groups.[33] These groups believed that this was the first step to socialized medicine and would eventually result in the destruction of private medical practice. Despite their opposition, these programs were passed into law and became mainstays of medical care funding. Physicians who had opposed governmental funding of health care quickly overcame their reluctance and took full advantage of the programs. While

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Action, 7 HEALTH MATRIX 241 (1997); Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445 (1987).

29. This evolved into the Kaiser Permanente Health Plan. *See* Hall, *Hard Times Forged Kaiser*, SAN FRANCISCO CHRONICLE, Feb. 12, 1996, at A7.

30. This was not universal coverage. Many people did not have employer paid insurance; most agricultural workers, the self-employed, the unemployed, and those that worked at temporary jobs such as day labor. The most glaring omission was the retired and the old.

31. For example, the Blue Cross/Blue Shield plans were essentially physician run.

32. While there were always rich physicians, many physicians' wealth reflected their patient's situation. If they lived in and served a poor or lower middle class community, they could not make a great deal of money. Employer paid insurance greatly increased the pool of money to pay for health care in these communities.

33. A significant minority of physicians supported these programs. The AMA in reality represented fewer physicians than its membership indicated; many hospitals required local medical society membership for hospital privileges and the local medical societies required AMA membership. This effectively segregated the hospital medical staffs because many of the medical societies would not accept blacks, women, or Jews as members. Thus many physicians who did not support the aims of the AMA were forced to join it. When the courts ruled that hospital privileges could not be predicated on belonging to the local medical society, AMA membership began to fall off dramatically.

Medicaid was never a generous program,[34] Medicare was run very much as were the private insurance plans and became the backbone of many medical practices.[35]

By the 1970s, there was an ocean of money flowing through American medicine. This had many beneficial effects, especially in medical research, but it also engendered waste. One of the worst aspects of Medicare, and one that was followed by most private insurers, was basing physician reimbursement on usual and customary charges. This meant that physicians got paid what other physicians were paid for the same procedure. There was no incentive to compete on price because the patients did not choose their physicians based on prices that the government paid, so prices never went down. There was a powerful incentive to introduce new treatments, irrespective of whether they were actually better, because you could charge more for them than the limits posed by the usual and customary charges for the existing treatment. Physicians were also paid more for the same activities if they were specialists, thus by becoming a cardiologist a general practitioner could increase his/her income dramatically for the same procedures. In the most significant distortion of the market, insurers paid more for performing procedures than for other patient care activities, such as diagnosing and medically treating illness,[36] and paid even more if these were performed in hospitals.[37]

XI. ECONOMICS OF HOSPITALS UNDER FEE-FOR-SERVICE MEDICINE

Hospitals are the engine that drives the health care financing crisis. The success of any scheme to reduce health care costs depends to great extent on how effective it is in keeping patients out of the hospital and controlling the cost of care when the patient must be admitted. Before managed care, physicians controlled most of the health care budget, in that they determined who would be admitted to the hospital, what was done to them there or in outpatient clinics, and what drugs they were prescribed. However, physicians, their offices, and staff, only got about 25% of the health care budget. Most of the rest went to hospitals, with perhaps 12-15% going to the suppliers of medical supplies and pharmaceuticals.

Traditionally hospitals were charities, run by religious orders or by local government.[38] They provided low tech nursing services and generated little income. To expand they had to raise money from private donors or through tax revenue. They had little ability to borrow because of their limited income stream, so they did not do debt financing. This greatly limited their ability to expand or construct new facilities. Pre-World War II, hospitals usually were debt free and most of their nursing staff was in religious orders. The remainder were paid relatively poorly for a professional position. This made their operating costs very low so that occupancy

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34. Since Medicaid is also the program that pays for nursing home care, even its limited budget really overstates the amount of money that is put into indigent health care.

35. At this time, Medicare, Medicaid, and Champus (the federal system for military dependents and retired personnel) account for about 40% of the health care budget.

36. In cardiology, for example, cardiologists who performed procedures as opposed to medically managing their patients could expect to make several times as high an income.

37. Many insurance policies would not pay for medical tests unless they were done in a hospital.

38. The federal government ran the Veterans Administration hospitals and the Public Health Service hospitals.

rates were not critical to the hospital's financial survival. Since the hospital's primary costs were labor, they could close a floor when admissions were low and substantially reduce their operating costs.

After World War II, Congress decided to fund a massive campaign to build hospitals. The Hill-Burton Act was passed by Congress to fund hospital construction.[39] Coupled with the increase in technology and specialist physicians, hospitals shifted from their traditional role and began to be technology centers. Both the federal government and private insurers increased their payments to hospitals to pay for this new technology. As hospitals began to be seen as cash cows, they could raise money through bond issues and build new facilities to reach ever more patients. Hospitals assumed huge bond liabilities that transformed their economics.

By the 1970s, hospitals began to shift to debt financing for new construction, rather than paying for construction with charitable donations. With their now substantial cash flow, hospitals were able to raise almost unlimited money in the bond market. The result was that many hospitals had substantial debt for the first time, with debt service making up a substantial part of the hospital's budget. There were few nuns left and nurses were now being paid a rates more consistent with their education and experience. Operating expenses were much higher, and were less amenable to reductions through closing floors because of the fixed cost of the debt service. With the advent of private hospital corporations, hospitals could also raise money from the stock market. While this did not carry the debt load of bonds, it did create tremendous pressures to make money each quarter.

This debt and Hill-Burton financed expansion of hospital capacity left many communities with as many as double the number of hospital beds per 1000 population that could be filled by the expected rates of hospitalization. The increased operating costs made even 85% occupancy barely profitable for many hospitals, while the excess beds in the community made it hard to maintain this occupancy. It was not unusual to see hospitals operating at 50% or less occupancy. Even if the hospital closed floors and laid-off nurses and staff, the debt service made it impossible to reduce expenses enough to remain profitable at these occupancy levels. Hospitals that had been doing budgets on the shoe box system – pay bills until you run out of money, then ask for more money – suddenly adopted business accounting systems and started worrying about profit centers and avoidable losses. Hospital administrators called this a patient shortage[40] and adopted three strategies to deal with it: 1) get more patients into the hospital; 2) change the case mix to more profitable patients; and 3) do more to the patients you have.

XII. THE IMPACT OF MAXIMIZING PATIENT SERVICES

When a business wants to get more customers, it advertises to the potential customers, and provides them with incentives to buy from the business. Hospitals and most other medical businesses are no different, except that the persons who get the services – patients – are not the customers. Patients must have a physician's order to be admitted to a hospital,[41] making the physician the hospital's customer.

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39. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. § 291 (1982)).

40. It is also called the "bodies in beds" problem.

41. More specifically, a patient must be admitted by a member of the medical staff or a

Hospitals began to compete for physicians by offering various inducements to admit patients to the medical staff. Legal inducements included renovations of the buildings and new medical equipment to make the facility more attractive to physicians. This fueled the increase in debt and increased the financial pressure on the hospitals. More questionable inducements included subsidized office space in professional buildings, shares in the income from hospital services such as the surgery suite and laboratory, and other payments based on the volume of admissions and the quality of those admissions, i.e., how much money the hospital made per patient.[42] These strategies worked very well because it is easy to admit a patient for testing, increase the tests that are ordered on a patient,[43] keep the patient in the hospital for a few extra days, and even to do unnecessary surgery on the patient. Physicians who generated income for the hospital were favored in many ways, including having control of key of medical staff committees that controlled who could practice medicine at the hospital. This made is easy to ignore the problems in medical care: the docs in charge were often the most problematic. In some egregious cases physicians with terrible surgical outcomes were tolerated for what could only have been economic reasons.[44]

Congress was aware of these practices and passed amendments to the social security act to ban all kickbacks and incentive schemes that might increase the cost of caring for Medicare and Medicaid patients.[45] These were a low enforcement

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contractor, such as an emergency room physician, with special admitting privileges. As podiatrists and certain other non-physician specialists are given medical staff privileges, they also get the right to admit patients to the hospital.

42. Such inducements or kickback are illegal under federal law for federal pay patients. *See* Carpenter v. United States, 484 U.S. 19 (1987); United States v. Hancock, 604 F.2d 999 (7th Cir. 1979); United States v. Greber, 760 F.2d 68 (3rd Cir. 1985); Polk Cty. v. Peters, 800 F. Supp. 1451 (E.D.Tex.1992); The Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995). In addition, some states prohibit them for all patients, regardless of payment source. As discussed later, these laws were not enforced until recently.

43. It was very convenient to worry about defense medicine and order extra tests when those tests were reimbursed by the insurers and the hospital was generous in showing its appreciation for physicians who were big billers.

44. Most perversely, a surgeon with a high complication rate would make more money for the hospital because all the extra expense caused by the patient's injuries were also paid by the insurer. *See, e.g.*, Gonzales v. Nork, No. 228566, slip op. (Superior Ct., County of Sacramento, Cal. Nov. 19, 1973).

45. The Medicare fraud statute was amended by P.L. 95-142, 91 Stat. 1183 (1977). Congress, concerned with the growing problem of fraud and abuse in the system, wished to strengthen the penalties to enhance the deterrent effect of the statute. To achieve this purpose, the crime was upgraded from a misdemeanor to a felony.

Another aim of the amendments was to address the complaints of the United States Attorneys who were responsible for prosecuting fraud cases. They informed Congress that the language of the predecessor statute was "unclear and needed clarification." H.R. 393, 95th Cong., § 53, (1977).

A particular concern was the practice of giving "kickbacks" to encourage the referral of work. Testimony before the Congressional committee was that "physicians often determine which laboratories would do the test work for their medicaid patients by the amount of the kickbacks and rebates offered by the laboratory . . . . Kickbacks take a number of forms including cash, long-term credit arrangements, gifts, supplies and equipment, and the furnishing of business machines." *Id.*

To remedy the deficiencies in the statute and achieve more certainty, the present version of 42 U.S.C. s 1395nn(b)(2) was enacted. It provides: "whoever knowingly and willfully offers or pays

priority for the Department of Justice (DOJ) and the Health and Human Services Office of Inspector General (OIG), resulting in only a hand full of prosecutions during the 1980s and early 1990s.[46] The lack of prosecutions lead to an assumption that the law did not really mean what it seemed to say. Health care providers, with the tacit approval of their lawyers, clients continued to enter into aggressive deals intended to capture physician referrals, often driving up the cost of health care services.[47]

Looking for a more efficient way to control costs, HCFA adopted the DRG (diagnosis related groups) system and began to phase it in starting in 1983.[48] The DRG system pays hospitals the average cost of caring for a patient with a given diagnosis. For example, if a Medicare patient is admitted with bacterial pneumonia, the hospital gets a fixed payment based on the diagnosis, say $10,000. If the patient is admitted with a diagnosis of appendicitis, the payment might be $7,000. For this fixed payment, the hospital has to provide all the care the patient needs – tests, drugs, nursing care – except for physician services, which are paid separately to the physician.[49] If the hospital spends more than the DRG payment on the patient, then the amount the hospital goes over the DRG is a loss. If the hospital can treat and discharge the patient for less than the DRG, the hospital gets to keep the difference as profit.

The DRG system is the first major example of a managed care model based on paying health care providers a fixed fee for services. This shifts the hospital's incentive away from ordering tests and doing procedures because these run up costs that are not reimbursed. (Physicians still have an incentive do procedures in the hospital because their fees are paid separately and are not under the DRG cap.) While many hospitals were frightened by the prospect of fixed fees, it was quickly realized that they could cut costs dramatically below their previous estimates. Most hospitals made more money under the DRG system than under the previous cost-based reimbursement system. They continued to cut costs and make more money as the system was tightened up.[50] The implications were clear: providers who had previously manipulated patient care to increase billable services were more than willing to manipulate the system to provide fewer services if that was the way to make money.

The history of the last 30 years of health care services in the United States is an ambivalent mix of better treatments, especially drugs and medical devices, and a system progressively distorted by greedy providers seeking to maximize their

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any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly in cash or in kind to induce such person— [. . .] (B) to purchase, lease, order, or arrange for or recommend purchasing... or ordering any service or item for which payment may be made . . . under this title, shall be guilty of a felony." United States v. Greber, 760 F.2d 68, 70-71 (3rd Cir. 1985).

46. For a review of the law as of 1989, see United States v. Bay State Ambulance & Hosp. Rental Service, Inc., 874 F.2d 20 (1st Cir. 1989).

47. In the mid 1990s, the DOJ and OIG changed their posture on enforcement, making health care fraud their number one enforcement priority. This has lead to many criminal convictions and over $1 billion in fines, with many more cases under adjudication.

48. This was the proposed thesis of a public health student.

49. There are certain corrections for outliers, i.e., illnesses of unusual severity and length of stay, but by their nature as outliers, these are very rare.

50. Judith Feder, et al., *How did Medicare's prospective payment system affect hospitals?*, 317 N. ENG. J. MED. 867-73 (1987).

reimbursement. In the last ten years the insurers, especially the federal government, have cut reimbursement in ways that make it more difficult for the honest providers to survive, while encouraging dishonest providers to cut their services to the payment provided. Most of this has had nothing to do with managed care, and many of its manifestations, especially unnecessary surgery, were harmful to patients. Managed care is the logical extension of this Procrustean reimbursement system: the insurers themselves either take over medical care decision-making or are so closely controlling physician payments as to amount to the same thing.

XIII. CONCLUSION

Managed care is being imposed on a system that was already adroit at manipulating patient care to maximize reimbursement. Physicians were willing to make referral decisions based on kick backs rather than the quality of services, and hospitals were willing to overlook deficient medical services if they earned a profit. Yet there are fundamental differences. First, our legal and regulatory systems are much better at judging acts than they are failures to act. It is much easier to regulate what you can see than to try to regulate what is withheld. Second, the fee-for-service system encourages testing and referrals to other physicians, especially specialists. While no assurance of quality care, it increases the probability that an incorrect diagnosis will be corrected. When physicians who ordered extra tests because they did not really know which ones are important now order fewer tests, there is no assurance that they will order the correct tests.

Finally, and often ignored, most physicians are personally honest and do try to do the best for their patients. Like most well-paid professionals, however, they are unwilling to risk their livelihood for principle. The main strategy of most of the managed care plans has been to capitalize on this weakness by putting physicians in positions where disagreeing with the plan threatens the physicians very ability to practice medicine. Some plans do this by employing the physicians and restricting their ability to quit with Draconian non-compete agreements. A variant on this strategy is to buy up the primary care physicians so the plan can control the stream of referrals without having to actually buy up the specialists. Other plans seek to get enough market share so that no physician can afford to lose their patients.

At base, the legal regulation of health care depends on the integrity of the individual physicians. As the most recent managed care cases recognize, the practice of medicine is a fiduciary obligation.[51] If insurers manage care through the same types of financial incentives directed to physician that lead to the crisis in the fee-for-service system, it can be expected that both the quality and availability of health care will decline further. Bribes and kickbacks that were wrong under fee-for-service are no better in managed care, and can potentially be even more dangerous because of the narrower margin of error when denying care. Insurers who use them can expect ever more regulation and litigation. Conversely, if insurers take the time to learn from the errors of the fee-for-service system, they may be able to craft a way to manage care that is based on defensible clinical

51. For an extensive and heated discussion of the problems posed by improper managed care incentives, see Herdrich v. Pegram, — F.3d ——, 1998 WL 483926 (7th Cir., Aug 18, 1998).

standards. Such a quality of care based system might realize the early promise that managed care would both improve the quality of care and reduce the costs of care.