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To: Members of the Committee on Administrative Policies

From: The Acting Committee Secretary

Subject: Phase II of the Review of the Medical Benefits Plan: Utilization Review Measures - Additional Information

The attached newspaper article from The Wall Street Journal of July 28, 1992 is circulated for the information of the Committee at the suggestion of an Executive Director.

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The Wall Street Journal, July 28, 1992

Second Opinion

Firms That Promise Lower Medical Bills May Increase Them

Cost Police Pile Paper Work On Physicians, Hospitals, Which Pass On Expense

Is Patient Care Suffering?

By Thomas M. Burton
Staff Reporter of The Wall Street Journal

CHICAGO – The University of Chicago Medical Center has hired 15 employees to specialize in a new area of health care. They aren't treating patients or operating high-tech equipment. Rather, the sole task of the workers, who are costing the hospital $500,000 a year, is to answer questions from medical cost cutters known as utilization review companies.

In recent years, such firms have become immensely popular with employers seeking to control their health-care costs. According to a survey conducted by trade publisher Faulkner & Gray Inc., U.S. employers and insurance companies this year alone will pay an estimated $7 billion to have their medical expenses reviewed. Utilization review firms perform that service by questioning the necessity both of recommended treatment and treatment already administered.

But a backlash against these new companies is gathering momentum. Increasingly, doctors and other health-care officials complain that these firms are denying required care to people with serious problems.

Defeated Purpose

And now doubt is growing about the new industry's most basic promise—lower medical costs. While utilization review often does cut such costs for employers, the administrative burden it imposes on doctors and hospitals may actually be increasing rather than lowering the nation's total medical bill. For every form a utilization firm sends out and every phone call one of its employees makes, someone in the medical community must respond, usually with equal or greater effort.

"It's a cost that ends up getting passed on," says Sandra Harden Austin, executive vice president of the University of Chicago hospital. J. Ian Morrison, president of the Institute for the Future, a private research group in Menlo Park, Calif., that has researched medical economics, contends: "There's no evidence [utilization review] saves money."

To some industry specialists, the issue embodies a Catch-22 of medical economics: Efforts to police costs add to the industry's administrative burden. In a New England Journal of Medicine article last year, Harvard University physicians Steffie Woolhandler and David Himmelstein wrote that utilization review and similar programs "have required an army of bureaucrats to eliminate modest amounts of unnecessary care." They calculated that at current growth rates, administrative spending, including such things as utilization review, would account for half of total health-care costs by the year 2020, up from one-fifth now.

Widespread Scrutiny

Today, there are more than 350 review firms nationwide, and many insurance companies have created departments with a similar function. About 80% of Americans have their medical treatment scrutinized by some type of utilization review, says the American Psychiatric Association.

Employers who hire utilization review firms don't always see past the initial savings. Their expenses appear to go down by more than the fee charged by the utilization review company as it cuts services. But the costs eventually come back in the form of higher fees charged by hospitals and doctors required to offset their own increased expenses in dealing with the increased paper work, health economists say.

Even some in the medical review industry worry about this. The increase in administrative costs "is a valid concern; we do add to the administrative cost burden," says Vicki Merrill, president of Pacific Review Services in Cypress, Calif. Even so, she contends, the best medical review companies can target real cases of unnecessary care and save money.

Losing Proposition

In 1990, the inspector general of the U.S. Health and Human Services Department looked at review companies' scrutiny of 500,000 cataract operations paid for by Medicare. The conclusion: The U.S. paid $13.3 million to utilization reviewers to save $1.4 million in possibly unnecessary surgery.

Utilization review companies remain unregulated in many states. In 20 states, anyone with a telephone can become a medical reviewer and interrogate doctors with years of medical training. Seven other states have passed laws, but their regulations aren't in effect yet. Because of complaints arising from the widespread annoying of doctors, other state legislatures are expected to pass laws concerning review companies in coming months.

Meanwhile, the complaints about the industry's impact on patient care are receiving more attention. "Utilization review can be an attempt to intimidate people out of using their benefits," charges Laura Wimbish, a Northwestern University psychologist. Jack Pickleman, chief of general surgery at Loyola University Medical Center in suburban Chicago, contends that utilization review "largely boils down to harassment of physicians that is an insidious incursion into medicine."

Defenders of the industry point out that doctors and mental-health professionals have an obvious ax to grind: They are the ones financially hurt by reviewers' cutbacks. Industry officials also claim that utilization review firms offer medical information and expertise that doctors often find of value.

Even so, critics' points are borne out by individual cases such as Iris Serrano's. The 38-year-old woman had a 101-degree fever and sharp chest pain when she arrived at the emergency room of Chicago's Northwestern Memorial Hospital on May 15, 1991. The internist who saw her suspected pulmonary blood clots or pneumonia and admitted her instantly.

After Mrs. Serrano was released from Northwestern three days later, recovering from pneumonia, Sunderbruch Corp., a review firm of West Des Moines, Iowa, concluded her insurer shouldn't pay for her hospitalization because she was on a normal diet while in the hospital, and thus couldn't have been as sick as the doctors had said she was. The hospital replied that a liquid diet isn't recommended for pneumonia, but Sunderbruch still refused to approve half of the $6,000 hospital bill.

Reversed Position

James Schroeder, a Northwestern doctor involved in the matter, says, "The analysis by which this utilization review firm issued a denial is discouragingly superficial and without substance." (Later, Northwestern doctors informed the company that had hired Sunderbruch that this newspaper was looking into Mrs. Serrano's case. Subsequently – about 10 months after she was treated – she says she received payment. Sunderbruch declines to comment on the case.)

To deal with criticism, the Utilization Review Accreditation Commission in Washington, a group composed of utilization review companies and hospitals, drew up standards last year so review companies would "cause minimal disruption to the health-care delivery system."

The new standards include a requirement that a licensed medical specialist make decisions in his or her speciality. That is designed to curb the problem of nurses second-guessing doctors and dermatologists second-guessing complex surgical decisions. Ms. Merrill, president of Pacific Review Services, says she knows of one review firm "where the nurse was just told to subtract one day" of recommended hospitalization in each case.

Another problem has been protracted delays in approving or disapproving recommended medical treatment. Under the new standards, review firms are expected to give a verdict in two days. Intracorp Inc., based in Berwin, Pa., perhaps the largest utilization review company with some $300 million in annual revenue, says it can dispatch a reviewer to any hospital within the U.S. in four hours to evaluate the most urgent cases. "Abuses do exist in our industry, but I think they're decreasing," says Doug Leland, a vice president of the Cigna Corp. subsidiary.

Payment Denied

To stop the indiscriminate harassing of doctors and hospitals, some review firms are using computers to analyze health-care data and focus on those doctors, hospitals and procedures most plagued by inefficiency.

Still, the industry's record is spotty. In Connecticut in 1990, a panel of psychiatrists selected by the state insurance department evaluated another Cigna Corp. unit, MCC Managed Behavioral Care Inc., and found "many cases" of "serious compromises of care." In one case, MCC wouldn't approve hospitalization of a 10-year-old boy who had pulled a knife on his teacher and, on a separate occasion, threatened to jump off the roof of his school. (The report didn't provide the outcome of the case.) The panel also concluded that in many cases MCC required patients in need of individual psychiatric treatment to engage in less costly group therapy.

Theodore Zanker, a Yale psychiatry professor who chaired the Connecticut panel, says its study of MCC proves that "some [review firms] just set lower medical standards."

MCC says problems highlighted in the report were fixed by "significant procedural changes" in late 1990.

In a 1991 survey of San Diego psychologists, 60% reported that medical reviewers had denied clearly necessary medical benefits; 39% reported that one or more patients had deteriorated because of improperly denied coverage. Also, clinics dealing with alcohol and drug dependency report medical reviewers often find ways of recommending denial of coverage when insurance policies appear to pay for such treatment.

Legal Danger

The legal implications of denied medical care are beginning to make some corporations skittish. Although experts don't know of any big judgments yet against employers, "utilization review is a growing area of potential liability for the employer," says Nancy Severson, a Denver attorney who represents employers in managed-care issues. Indeed, a California appellate court recently ruled that employers and insurers "can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms."

Some courts already have allowed massive punitive damages against the review firms or insurers' review offices. Take the case of 21-year-old Patrick Hughes. Despite two suicide attempts – one in which he stabbed himself repeatedly with a screwdriver – the utilization review section of Blue Cross of Northern California deemed him, after 11 weeks of in-patient therapy, no longer in need of it.

After his parents sued, evidence emerged that the Blue Cross consultant who recommended denying coverage spent an average of 12 minutes reviewing such claims – and hadn't looked at the entire Patrick Hughes file. After a state court jury in San Francisco assessed $700,000 in punitive damages and $150,000 in compensatory damages against Blue Cross, an appellate court upheld the award, finding that Blue Cross used "a standard of medical necessity substantially at variance with community standards."

In court documents, Blue Cross defended its decision, saying 11 weeks in the hospital was sufficient for Mr. Hughes.

Diminishing Returns

The argument for utilization review might be compelling—even given the occasional mistreatment of patients – if the service truly saved America lots of money on health-care costs. At first, it did. A study in the journal Medical Care analyzed 223 insured groups from 1984 to 1986 and concluded utilization review reduced hospital admissions 13% and cut overall medical costs 6%. But the industry was relatively new then. As the percentage of health-insurance plans covered by utilization review rose from 3% in 1984 to 65% in 1988 to an estimated 80% now, the law of diminishing returns set in.

"Insurance companies, whose money is on the line, have calculated that utilization review is worth about 2% to 5% today," says Stephen C. MacGill, a principal at Godwins Inc., the international benefits consulting firm. Yet he notes that all or virtually all of that "saving" is just a shifted cost to another insurer or the patients themselves – a kind of health-insurance shell game.

At McDonnell Douglas Corp., Daniel C. Smith, until recently director of the company's employee assistance program, says utilization review "holds out great promise to reduce costs, but that doesn't appear to be sustained over time."

As a result, some see a major shakeout looming in the utilization-review industry. Peter Boland, a health-benefits consultant who has audited review firms, predicts, "Fewer than 10% of the utilization review companies will be in business in three years performing the same service."