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# Staying Well Within the Law

A newsletter on the current legal issues facing today's health care industry

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## The Myth of Managed Care

By Elizabeth G. Litten



Is it a generally accepted fact that health care costs less when we keep it in the confines of a managed care company's network of contracted providers? I asked myself this question after a few sentences in the summary of the proposed regulations recently published by the New Jersey Department of Banking and Insurance caught my attention: "The Department recognizes that, given the current circumstances surrounding ... contract negotiations with carriers, many providers have been unable to enter into network arrangements that they consider to be fair and equitable... [and] ... that it is in the public interest to maintain provider networks as an efficient means of promoting affordable health care to consumers."<sup>1</sup>

I remembered a conversation I had several years ago with a client, a radiology services provider, after she asked me to review a contract with a large managed care carrier that referenced separate fee schedules for different types of radiology services and separate sub-schedules for "managed" versus "non-managed" care coverage products purchased by employers and individuals. As a health care attorney with more than 20 years of practice representing both providers and carriers, I can navigate through barely comprehensible and completely incomprehensible contracts with the best of them. I did, though, dare to ask what was meant by "managed" and "non-managed" since the contract did not define them.

The contract included a list of several products offered by the carrier, which names would presumably be included on the patient's insurance card. Some of the names included the word "managed" or "HMO" but it was unclear which products were considered "managed" for reimbursement purposes. If my client submitted a bill for services provided to a patient with a card having a "managed"-sounding name as directed in the "managed" care fee schedule but it turned out to be a "non-managed" care product, would the claim be denied, requiring my client to resubmit the claim? Would the insurance carrier simply pay the claim at the "non-managed" care amount listed in the fee schedule? How many people would my client have to hire to decide where and how to bill and under what fee schedules and to track and resubmit incorrect claims or claim information?

We called the attorney representing the insurance carrier and asked where the products were defined as "managed" and "non-managed" care products. The attorney did not know and said she would get back to us. My client was strangely excited about signing the contract and getting "in" the carrier's network and was not willing to wait for the answer before signing the contract. She explained that there were many ambiguous terms in most managed care contracts and the added administrative costs with navigating the billing and reimbursement issues went with being a health care provider. I asked, "If you didn't have to hire people to help you navigate these murky waters, what would you accept in terms of payment? In other

words, how much do you need to get paid to break even, and how much do you think this contract promises to pay at the end of the day (or billing cycle)?"

"Fifty percent" was her answer. Fifty percent of what you think you will eventually receive? Yes, she confirmed. The client ended up signing the contract, likely recognizing the mysterious reality that being part of a managed care network has some value either to the provider, the patient, the purchaser of the insurance or managed care coverage or to someone else.

While this conversation is an isolated example of the inefficiency of our "managed" health care system, it has stayed with me as I've thought about recent reform proposals and the need to re-evaluate how we get and pay for health care in this country and as I read the regulatory proposals that endlessly attempt to clarify the system. While we may be well past the point where simplification is possible, the complexity of the system adds to its cost. When "managed care" means complex contracts, actuarial analyses that must include the common and mundane with the rare and catastrophic risks of injury or illness, and more terms of art with varied meanings than the most brilliant linguist can decipher, what are we getting in exchange for the "management" of our health care? Are we healthier? Does it cost less? Most experts and probably most ordinary people would vehemently say, "No."

If we were to go to the doctor when we were sick or to the emergency room when we had an emergency and pay for these

<sup>1</sup> 41 N.J.R. 2426 (June 15, 2009).

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services directly and immediately without the involvement of outsiders, there would be little or no role for “management.” Then again, while I know when I feel sick or need emergency care, I have little idea not only of what services I might need when I get to the doctor or ER but also what I should pay for these services. Buying food is much easier than buying health care; not only do I know when I’m hungry and what I like to eat but I trust that the food I buy is safe and I generally know what it should cost. I realize that the cereal at the gourmet grocery store costs more than the same cereal at the large chain, but if I go to the gourmet store because it has an ingredient not available at the chain store or has a product that I like better, then I’m willing to pay extra for the convenience of getting my cereal there. At a simplistic level, one reason to have someone else manage my health care purchases is that I do not know how to get information on price or quality or how to coordinate disparate information in a way that will benefit or protect me.

Recent efforts to coordinate the sharing of health information through technology also show how complicated our health care system has become and how readily we accept its complexity. A work committee on the Health Information Technology (HIT) Policy Committee, established by the federal American Recovery and Reinvestment Act of 2009 (ARRA), was

charged with defining the parameters of “meaningful use” of HIT under ARRA. The Center for Medicare and Medicaid (CMS) is expected to publish a proposed rule in late 2009 setting forth a definition of “meaningful use” of electronic health records (EHR) technology and establishing criteria for an incentive program. The proposed recommendations range from the relatively simple, like demonstrating use of electronic prescribing tools and recording patient health data in an electronic medical record that can be shared with other providers, to the more complex, such as reporting a number of specified medical “quality” measures in electronic format and conducting security risk assessments.

A degree of “management” of our access to and payment for health care is probably good and necessary, but multiple layers of management and assumptions that more is good suffocate the original benefit. Similarly, the best way to get everyone to shift to an interoperable system of HIT may be to pay providers for their “meaningful use” of HIT, but heaping a wish list of ultimate health care quality and systems goals onto that little carrot is more likely to suffocate it into a shriveled, unrecognizable piece of compost.

Back to the “myth” of managed care. The idea that having a third party, the health insurance carrier (and any and all other contractors and consultants required to assist in purchasing coverage or

administrative services from the carrier or to assist the provider in getting paid), step into the patient-provider relationship was once hailed as being able to control costs and improve health. Outside management of our health care is something most people accept without wondering whether the cost-saving, health-improving goals are being met. If these goals are not being met, “managed care” is really just encumbered care.

Third-party involvement of some type is inevitable because insuring against unanticipated health care needs is a good idea and there are aspects of accessing and paying for health care that can benefit from the involvement of third parties. For example, if I have no health insurance coverage of any type, I may need an outside source to provide information so that I can go to the provider I can afford. When the involvement of the third party is beneficial, it is more likely to result in cost efficiencies and quality improvements and not be an encumbrance adding complexity and unnecessary oversight disguised as management.

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