Dynamic Chiropractic

BILLING / FEES / INSURANCE

Propositions 214 and 216 -- Managing Managed Care

Louis B. Rubin

Proposition 214 on the California ballot in Novemeber is the HMO Patient Rights Initiative. Proponents characterize the proposition as essentially requiring all HMOs to follow the practices of the "best HMOs," instead of the worst ones. Supporters of 214 say it will impose no new taxes or fees, nor create any new government agency.

The HMO industry claims that Prop. 214 will increase medical costs.

Proposition 216, the Patient Protection Act, seeks reform of business practices of HMOs that deny patient care in favor of increased profits: gag orders, conflicts of interest, mergers and acquisitions, hospital closings, and de-staffing. Proponents paint a picture of patients maimed or killed at the hands of corporate bureaucrats.

The HMO industry has spent $50 million in television ads to defeat the two initiatives.

Attorney Louis Rubin of San Diego, California has sent us two short articles, printed below, that relate why he favors passage of 214 and 216.

Whole Life Health Insurance

By Louis Rubin, Esq.

As a personal injury attorney, I have no formal education or training in health care, insurance or government. I negotiate claims daily with insurance companies. From experience I can safely state that the insurance industry collects as much money as possible and pays back as little as possible to settle claims. I therefore conclude using insurance companies as fiscal intermediaries for health care is a sure recipe for disaster.

San Diego, California is a prime example of the devastation wrought by using the insurance industry to market health care services. Hospitals here are selling out or shutting their doors because of deep discounting by HMOs. Doctors are closing shop, moving out of town or joining large group practices for the same reason. Anyone familiar with medical care provided by the Veterans Administration knows the danger associated with large bureaucratic clinical medicine: disorganization, delays, fragmented care, lack of physician responsibility.

Why are we forced to accept clinical medicine? Managed care reimbursement cuts are forcing the aggregation of providers. However, no mandatory standards exist to force these large groups to develop systems necessary to replace the mind of alert, concerned physicians. Credentialling organizations exist, but they act without the sanction of law or government to enforce their decrees on quality. Licensing boards revoke single doctor licenses. They can't close the doors of a whole capitated

group practice.

Large medical groupings will continue to walk a tightrope between quality and survival as long as they are totally dependent on insurance controlled dollars. Insurance is a Wall Street driven industry. The success of insurance companies depend on increasing share value. The value of stock rests on increased revenues and greater profits. Revenues can be increased by increased enrollment. Increasing profits depend on decreasing the costs of (reimbursement to) providers.

There is no real profit in insuring health care. There is only deferred loss. A healthy enrollee can pay minimal premiums for years and generate yearly profits to the HMO. Every healthy enrollee will age, get sick, and die. Yet that enrollee receives only term health insurance. No reserves are set aside for certain future medical care. The insurance industry is free to suck up phony profits generated by healthy insureds because it is not required to set aside legitimate reserves to deal with certain future losses.

Medicare is forced to pay for the aged and disabled. The source of Medicare's revenue is a health care tax visited upon all those healthy HMO enrollees who are also paying for term health insurance.

If a significant portion of health insurance premiums were set aside each year for the health care needs of an aging population, would Medicare ever be threatened with insolvency?

HMOs are not insuring health care costs, they are brokering medical services. Every dollar spent on bill boards, TV ads, and free breakfast at Denny's is a dollar removed from a nurse's salary or a teaching hospital's budget.

Can a nation's health care system continue to be downsized to increase the profits of an handful of insurance giants? As an aging baby boomer, I shudder to think of the consequences.

Managed Care's New Medical Standards -- Is the Forest Silently Falling?

As a plaintiff's personal injury attorney, I used to feel like Robin Hood -- taking from the rich, giving to the poor, and keeping a third for myself. After my last trial, I felt like Don Quixote, spouting meaningless prose to the glazed over faces of 12 uncaring jurors.

The trial was about medical malpractice. The injury was down played by the defense (a frozen pip joint of the middle finger) but the issue was profound -- or so I thought. "What standard of care applies in deciding whether or not to obtain the opinion of an orthopedic surgeon?" In my case the community (jury) chose managed care's new standards.

My expert in general practice testified clearly and without equivocation that the defendant's general practitioner had the obligation to consult an orthopedist when an x-ray report revealed an interarticular fracture "extending into the joint." Because of the delayed referral, my client wound up with a fused joint and useless middle finger.

The defendant's expert, a doctor who doubles as an executive with a large medical management system, testified that a prompt referral was not indicated. According to him, the radiology report was not alarming. It stated the joint was only minimally displaced, all that was needed was a simple splint and return visit two weeks later.

The trouble with the defendant's position was the undiagnosed joint instability caused by the fracture.

Within two weeks, the soft tissues gave way, leading to subluxation of the joint and the need for reconstructive surgery. The reconstruction failed, and the joint was then fused.

Because of the way the issues were framed by pretrial motions, I was not free to tell the jury the managed care spin to the story. My client couldn't go immediately to an emergency room because he first had to see his primary care physicians. His primary care physicians had no orthopedic surgeons on staff. The x-rays were read by a radiologist the day following his exam. The unmotivated gatekeeper physician simply initialed the radiology report without grasping its significance.

Two weeks passed while no one in the system warned my client that his condition was worsening.

All of these gaps existed because of the cost savings forced by managed care.

The system was inherently inferior to a single chiropractor acting in a patient's best interest. Because managed care won, the jury allowed a lowering of the community standard. A clear indication to refer was ignored because a general practitioner was free to claim ignorance of orthopaedic medicine as an excuse to continue treating an orthopedic injury. The defendant did not know enough to refer, but had sufficient knowledge to treat. The real reason for the error was simply cost. Having an orthopaedist on staff was too expensive.

What should have been a textbook violation of medical standards, was a defense verdict. A conservative jury sided with the sympathetic family doctor, not realizing that a hidden medical monopoly is reaping profits from this and similar deceptions.

Should an isolated plaintiff and his attorney be the guardians of medical standards? My client's loss was like a tree falling in the forest with no one around to hear. Medicine was appreciably diminished for no reason other than money. Look at the way medicine is changing. Is the forest silently falling.

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NOVEMBER 1996