

Covered Services of Managed Care: the Enigma the Insurance Industry Creates

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The ever growing dominance of managed care in the American health care market is largely the result of a desire on the part of Congress to expand private health insurance while bringing the unsustainable rise in the cost of care under control. In fact, Congress has viewed managed care as the primary tool for reining in the cost of health care. Unfortunately, the laudatory but conflicting goals of Congress, along with managed care's appetite for ever greater profits, has led managed care to defraud the American people in order to circumvent the law and usurp the authority of attending physicians and surgeons. Nowhere is this defrauding of the American people more evident than in managed care's misrepresentation of "coverage" and "covered services" in managed-care plans.

What Is a Covered Service?

As much as the managed care insurance industry would like us all to believe that covered services in managed-care "health insurance" are the services an insurer approves and pays for, they are not. Covered services, by law, precedent, and contract, are the services available in a managed-care plan, irrespective of whether one's plan agrees to approve and pay for them in a particular instance. In other words, "covered services" and "coverage" (payment) are not the same. While this might seem a trivial point, I assure you it is not. It is a widely held misunderstanding that robs enrollees in managed-care plans of their rights and distorts the entire process of accessing "necessary and appropriate" care—a misunderstanding that is actively encouraged by the insurance industry. Furthermore, it is important to understand why the insurance industry and state insurance agencies are so willing to allow enrollees to mistakenly pursue arguments about covered services rather than an insurer's refusal to pay for care that has been promised and properly prescribed. We need to ask how a term that is so well defined and understood within the insurance industry can be so misunderstood by the millions of people who depend on managed-care plans.

Managed Care Is Not Insurance

A critical point is that managed care is insurance in name only. In fact, by any reasonable definition, it isn't insurance at all—a fact the federal bankruptcy courts drove home in the Maxicare HMO decision of June 1989.^{1,2} While insurance is well understood to be a contractual indemnification against unforeseen loss, managed care is a group purchase of future health care, usually for a coming month. Consequently, enrollees, subscribers, or participants—or whatever a plan chooses to call its members—are simply participants in a group purchase of medical services. They are not policyholders.

While insurance entails a written and enforceable contract (a policy) between an individual and the insurer, managed care provides no such contract or ownership. Enrollees in managed-care plans are simply handed a booklet describing the plan and promising them all the care they will need so long as they follow a

few simple rules and pay the monthly premium. While insurance provides individuals with actual ownership of their contract/policy along with its detailed definition of covered services, managed care provides no such ownership, enforceability, or list of covered services. Managed care simply provides an image of exemplary coverage while leaving the determination of the care to be provided solely in the hands of the plan's managers. It is like a Chinese buffet. You pay up front for all the advertised food you want so long as you stay in line and enter with a clean plate. However, all you are ever handed is a receipt showing you paid for a meal, and management gets to determine the menu and its availability.

It is this stark difference between the promoted assurance of broad and exemplary covered services and the reality of managed care's ability to deny payment on the basis of a plan's determination of need and the availability of a less expensive standard of care that has doctors directly in the liability target zone in our broken health care system. On one hand, managed care actively promotes the breadth of their coverage along with their dedication to delivering the highest standard of care. However, when they deny payment or insist on a less expensive course of treatment, as is their right under the fine print in their plans and the law, they transfer responsibility unequivocally to the treating physician or surgeon. Plans then rely on their carefully worded provider contracts to ensure that the problem stays there.

In order to avoid a charge of practicing medicine when denying payment and care, managed-care plans have providers sign contracts (provider contracts) that require the rendering of all properly prescribed care even if the insurer refuses to approve and pay for it—the Enrollee Hold Harmless Clause.³ The only exception allowed is for elective cosmetic procedures and experimental treatments, which are typically defined as non-covered services. However, instead of sharing this information, plans hide it.

In short, while managed-care plans force network hospitals to contractually guarantee the rendering of all properly prescribed care, they knowingly allow these same hospitals to deny care whenever the plan denies payment. It's a scheme that provides a triple win for the plan at the direct expense of the trusting enrollee. Managed-care plans are thereby enabled to: 1) erect a wall against the charge of practicing medicine; 2) make providers completely responsible for any failure to deliver proper care under law; and 3) ration care to reduce the total cost of care while delivering a stronger bottom line. Enrollees, along with their attending physicians and surgeons, are left to flounder in the enigma of the plan's "covered services" and appeal process rather than pressing the hospital to honor its contractual obligation to deliver properly prescribed care.

Managed-care plans don't explicitly deny care; they simply make decisions on how to distribute resources across the needs of their membership while depending on the naiveté of physicians, surgeons, and patients to keep denial of care buried in

the morass of the appeal process rather than in the applicable law and contractual obligations.

For those who would argue this point, please consider that the typical provider contract has providers agreeing to allow plans to retroactively review earlier decisions on coverage (utilization review) and return monies determined to have been misspent. However, there is no claim, or even a hint, that earlier approved and delivered care was anything but medically necessary and appropriate in law. In other words, the insurer's utilization review demonstrates conclusively that managed-care plans view their decisions on the distribution of benefits (their definition of "coverage") as separate and distinct from an attending physician's or surgeon's decision on necessary and appropriate care as authorized and licensed under law.

This ability to promote an assurance of broad and exemplary covered services while retaining the freedom to deny that same standard of care in pursuit of lower costs and higher profits forms the bedrock of the managed-care business model. Were we, as a nation, to require managed-care plans to disclose their use of covert rationing and the pursuit of an average standard of care, who would buy the product? Likewise, if plans and the states were to allow enrollees to recognize that a denial of "coverage" is actually a refusal to pay for what has been promised, legally authorized, and pre-purchased, they would moot the entire managed-care appeal process, gut its business model, and have managed care headed for the dustbin of history—an outcome neither managed care nor the states can afford. They simply have too much invested in the system. However, if enrollees and the legal profession are allowed to recognize that network providers, most importantly hospitals, have signed provider contracts guaranteeing the rendering of promoted covered services and the highest standard of care, irrespective of whether an insurer denies payment, the liability for hospitals can only grow substantially.

Providers' Decisions versus Physicians' Judgment

The legerdemain of making the managed-care company's decisions regarding the allocation of prepaid "covered services" congruent with "coverage" of "all necessary and appropriate services" requires that physicians agree with the managed-care company's determination. If the patient's physician prescribes a service as necessary and appropriate, but the plan refuses to pay, then the patient should not accept delay in treatment while awaiting the outcome of a drawn-out appeals process. The patient should demand prompt treatment, as required by the provider contracts applicable to his plan—contracts that have providers agreeing to render properly prescribed care regardless of whether payment is forthcoming. Thus, the payment dispute should be between the provider and the plan, not the patient and the plan. Unfortunately, providers (particularly hospitals) have every incentive to agree with the plan's determination of medical necessity and to do everything possible to overrule or circumvent the opinion of an attending physician or surgeon exercising independent judgment on behalf of the patient. This explains why hospitals and plans are so intent on discouraging patients from seeing out-of-network physicians.

Liability Considerations

If the content of provider contracts were made public, a managed-care plan's denial of coverage would translate immediately into a failure of a provider (typically a hospital) to render necessary and appropriate care as required under law and an obligation under the applicable provider contract and

managed-care plan. Consequently, these plans hide their provider contracts as confidential documents even though these contracts are defined as public documents in the law and are an inseparable part of any managed-care arrangement.

If enrollees were informed of the responsibilities of hospitals under these provider contracts and demanded they be fulfilled, denial of covered service could open the plan, and most likely the enrollee's employer who offered the plan, to a lawsuit under any number of consumer protection, bad faith, and fraud causes of action, circumventing the plan's appeal process and the Employee Retirement Income Security Act (ERISA) limitations on liability. The U.S. Supreme Court ruled in *Aetna v Davila* that "a fiduciary of an ERISA plan has an 'affirmative duty' to enrollees." Furthermore, if an enrollee directly purchased the plan, there would be no ERISA limitation on liability, and both the plan and the hospital would be open to such causes of action.

As hospitals increasingly become the contractual delivery arm of the insurance/managed-care industry and doctors become hospital employees, the separation of provider liability that has served managed care and hospitals so well disappears. Hospitals become the sole responsible party for delivering covered services regardless of whether they are reimbursed by a managed-care plan. It is the hospitals that should be appealing insurers' decisions on coverage, not enrollees. Instead, they stand idly by, claiming there is nothing they can do. What enrollees need to know, in order to untangle this supposedly impossible knot, is that their plan guarantees delivery of pre-purchased covered services independently of whatever the insurer decides in the way of payment to its contracted providers. Patients simply need independent physicians and surgeons willing to advocate for them and prescribe necessary and appropriate care, regardless of the managed-care plan's determination on payment.

Details of this exquisitely constructed managed-care fraud are in the public domain in my book,² which I have asked many to review, including the Heritage Foundation, Cato Institute, Institute for Justice, and the chairman of the U. S. House of Representatives Subcommittee on Health. No one has yet cited a single error of fact or law.

Conclusion

The question of exactly what is and what is not a covered service under managed care is a deliberately false issue that the industry actively promotes. Rather than allowing the public to understand that covered services in a managed-care plan are best described as all necessary and appropriate care as determined by an enrollee's attending physician or surgeon, and that all such care has been pre-purchased, managed care promotes a ruse that the issue is one of coverage and whether the plan should approve and pay for the care in an individual case. This subterfuge, depending on a confusion of terms, protects the industry's bottom line while shielding it from the liability it will face when the scheme is exposed and managed-care companies are shown to be rationing agents rather than responsible fiduciaries of their plans.

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