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MStudy: Elderly and Poor Fare Worse in Managed Care

CHICAGO (AP) Poor and elderly people with diabetes, high blood pressure and heart problems fare much worse under managed care than similar patients in traditional fee-for-service insurance plans, a study found.

Twice as many poor and elderly patients in managed care said their health declined over a four-year period, according to the study in Wednesday's Journal of the American Medical Association.

And only one of five poor patients in managed care felt better after four years, compared with more than half of those in traditional plans.

John Ware Jr., a research psychologist at the New England Medical Center and author of the study, called the work ``an indictment of the whole notion that we are going to implement cost containment and it's going to be just as good for everybody.''

The study involved 1,574 patients in Chicago, Los Angeles and Boston who filled out health questionnaires in 1986 and again in 1990.

The self-reporting method was criticized by Susan Pisano of the American Association of Health Plans, which represents 1,000 managed care plans. She said medical evaluations should have been used instead.

Also, Pisano said managed care plans have greatly improved their care of the poor and elderly since the study concluded in 1990.

Managed care plans try to cut costs by discouraging unnecessary procedures. Patients pay a set fee for a doctor who serves as the gatekeeper and must authorize further treatment or referrals to a specialist.

Millions of Americans belong to health maintenance organizations, one of the most popular forms of managed care. Millions of people covered by Medicare are joining HMOs, which then receive their fees from the government.

The study found that the average patient relatively young and not poor fared equally well in managed care and traditional plans. But the story was different for the poor and elderly.

Patients were studied with any of four chronic conditions high blood pressure, non-insulin-dependent diabetes, a recent heart attack and congestive heart failure. Four years apart, they filled out questionnaires.

Fifty-four percent of patients 65 and older who were treated in HMOs reported a decline in health, compared with 28 percent of those in fee-for-service plans. Only 22 percent of poor patients treated in HMOs reported improvement after four years, compared with 57 percent with traditional insurance.

Among HMO patients who were both elderly and poor, 68 percent reported a decline in health, compared with 27 percent in fee-for-service.

The pattern was the same for all the conditions studied, in all three cities.

Ware theorized that elderly and poor patients treated in HMOs received less care. The study illustrates that ``not all HMOs are created equal'' and that managed-care plans must address the fact that the elderly and poor tend to need more care, not less, he said.

This week's JAMA also includes a study that found rheumatoid arthritis patients in Northern California did just as well in managed care as in fee-for-service; a report showing no significant

differences in hospital lengths-of-stay for critically ill patients in managed care and fee-for-service plans in Massachusetts; and California research suggesting that hospitals are used less in areas with lots of HMOs.

An editorial in the journal called managed care ``a work in progress,'' operating well but with plenty of room for improvement.

``It has contained costs, it provides easily accessible comprehensive health care to its insured, and, on the whole, it has not yet jeopardized quality,'' wrote Dr. George Lundberg, JAMA's editor, and Dr. Paul Ellwood Jr., a neurologist and one of the nation's earliest advocates of managed care.

Ellwood also founded the Jackson Hole Group, a collection of academics and health professionals who came up with some of the ideas in President Clinton's ill-fated health reform plan.
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Lauren Dame and Sidney M. Wolfe

Truly Radical Mastectomies

Some HMO payment plans create a conflict of interest between doctors' finances and their patients' needs.

A woman who loses a breast to cancer must deal with some obvious burdens. To these may now be added a managed-care cost-cutting measure—outpatient mastectomies. At least two Connecticut health maintenance organizations (HMOs) have said that they will not pay for an overnight hospital stay for a woman who has had a mastectomy—the surgical removal of a breast—unless her doctor declares that an overnight stay is "medically necessary."

CIGNA HealthCare and ConnectiCare, the HMOs involved, claim that it is safe and medically appropriate for some mastectomies to be performed on an outpatient basis. If the woman develops a medical problem after surgery, the doctor then can admit her for an overnight stay. Patients discharged on the same day as surgery may be visited at home by an HMO nurse.

Critics of this cost-cutting measure argue that problems may develop 12 to 24 hours after surgery, and it is not always possible to predict in which patients. After surgery, a mastectomy patient has a large wound, drainage tubes hanging out of her body, and pain. An overnight stay allows the doctor and nurses to care for problems that arise, and gives the woman enough time to recover from the anesthesia to learn how to care for the wound. If the painkillers prove ineffective, she can obtain more powerful medication in the hospital. The overnight stay also gives her some time to face the emotional pain that accompanies such surgery.

The HMOs defend their policy by claiming that decisions on when to discharge a patient are made on a case-by-case basis, using HMO guidelines. But guidelines have a way of becoming the norm, establishing a standard against which any patient who needs to be treated differently must fight. The issue is not whether outpatient mastectomies ever are appropriate (although this is likely to be extremely rare); the issue is whether HMOs should set standards based on the small number of the most "successful" (atypical) patients, and then place the burden on doctors to prove that additional treatment is needed for the rest.

The HMOs claim that the doctor makes the decision, but this ignores the fact that the HMO still has to approve the request. If it says no, the patient must rely on her doctor to appeal. Because of the way some HMOs pay their doctors, a conflict of interest exists between the doctors' financial well-being and their patients' needs. Some HMOs keep track of what tests, referrals and hospital stays their doctors order, and doctors who order "too much," according to HMO standards, may find themselves

BY PAUL LACHINE

financially penalized or even dismissed from the HMO. Doctors who fight for their patients in spite of this may find themselves spending hours arguing with HMO officials over each contested authorization.

In Connecticut, two physicians wrote to a newspaper explaining that doctors who fight HMO policies on behalf of their patients may face a protracted appeals process or removal from the HMO's roster. They were not members of the HMO in question, but had been asked to write by colleagues who were, and thus were "in jeopardy of de-selection' for criticizing it." If doctors who work for these HMOs are afraid to criticize such policies publicly, how vigorously can they be expected to fight treatment denials on behalf of their patients?

Connecticut state Sen. Edith Prague wants to require insurers to cover hospitalization when it is deemed necessary by a patient's doctor. On the federal level, U.S. Rep. Rosa DeLauro (D-Conn.) is drafting legislation to require insurers to pay for a minimum two-day stay for a mastectomy and one-day stay for lymph-node removal, unless doctor and patient decide less time is appropriate.

Managed-care organizations argue that it does not make sense to mandate minimum hospital stays, and they have a point—it does not make sense to protect patients with one type of illness when HMOs can simply turn their cost-cutting eyes on another. Without more general limits on what HMOs can do to save money, consumers will find themselves fighting HMOs disease by disease and procedure by procedure. Comprehensive laws dealing with the interconnected problems of HMOs are needed to avoid a piecemeal approach.

HMOs exist in a system where profits are increasingly the goal, and every dollar spent on medical care—drugs, hospitalization, doctors' visits, referrals to specialists—comes out of the HMO's pocket. While this system eliminates the incentives to overtreat that existed under fee-for-service, it goes too far in the opposite direction. HMOs cut back on both unnecessary *and* necessary care, and have not always done a great job distinguishing between the two.

Although HMOs argue that it is not in their interest to deny care to patients, it is in their financial interest, as long as complications do not develop that require additional medical care, and as long as the costs of the denial of treatment are borne by the patient and are difficult to quantify—costs such as additional pain and suffering. Managed "care" actually means managed "cost," and nowhere is this more evident than with this latest cost-cutting outrage.

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