

DR. DON LISS, one of  
Aetna's senior medical  
decision makers

# Paging Dr. NO

Patients, employers and politicians are clamoring for somebody to cut the costs of health care—but when costs do get cut, **it can mean somebody gets hurt.** SMARTMONEY goes behind the scenes to see how doctors for insurance companies decide who gets a thumbs-down.

## By Angie C. Marek

■ T'S A TYPICAL MEETING FOR THE DOZEN OR so men and women convening at a conference table in the Philadelphia suburb of Blue Bell, Pa. Doctors by profession, they're dressed casually in fleece jackets and sweaters, peering at their laptops and making the occasional wisecrack. They run through the cases in their files one by one—a cancer survivor who's trying to get new CAT scans, a New Jersey man with a long history of seizures and Bell's palsy. The language is technical, and the mood is sedate; the latest episode of *House*, it isn't. "My kids like to joke with me that I used to be a real doctor," says Don Liss, who chairs the group.

But behind this mundane veil lies a stark reality: Over the next hour, and without meeting any of the patients they're discussing, the team will hammer out whether their employer, the giant insurer Aetna, should pay for the patients' medical claims. At the moment, Liss, a 46-year-old former internist with a crew cut, and his colleagues are focused on the case of a 19-year-old with dermatomyositis. To deal with her condition, a painful disease that causes severe rashes and muscle weakness, her doctor switched her from a steroid therapy that costs pennies per pill to an antibody regimen that can run up to \$10,000 a month. It's a move that's raising some qualms in this room. Did her physician give the steroids enough time to work? Why do some of her other doctors disagree about her care? And last but not least, is it worth the price?

It's a moment that anyone fighting an illness has learned to dread: the decision from the insurance company. Of the more than 1 billion medical claims filed with private insurers each year, a significant amount—as many as 75 million—get

rejected outright, leaving patients unable to get treatment or stuck with medical bills that add up to at least \$50 billion annually. The denial hammer often comes down because the insurer decides the treatment is experimental, less effective than others or "medically unnecessary." And with increasing frequency, the employers paying the insurance premiums are scaling back or even ruling out paying for treatments because they're concerned about their soaring costs. The rejections often reach patients as no more than a form letter, and many can't help but wonder what kind of black-box computer program has decided their fate.

But it's not a computer making the call. A small but powerful group of doctors at big insurance companies are reading files, talking to practicing physicians and ultimately, making decisive judgments on millions of cases a year. Nationwide there are roughly 1,000 of these doctors, usually known as medical directors. Many are drawn to making policy rather than treating patients directly; Liss, for his part, says that if he could start again, he'd become an engineer instead of a physician. These doctors describe themselves as the key to a working health care system, people who keep costs down so that the maximum number of patients can get care. Critics see them as insurance-company henchmen, branding them with a derisive nickname: Doctor No.

Though they work in relative anonymity, medical directors are playing an increasingly crucial role as the nation looks for ways to control the cost of health care. In the push for health care reform, President Obama has called skyrocketing prices "the biggest threat to our nation's balance sheet," and insurers have come under growing pressure to keep a lid on spending. Medical directors operate with relatively little public scrutiny, however, and their decisions can leave patients and their advocates in the dark. They're far from infallible, too: In 2006, the most recent year for which figures are available, 41 percent of the claim rejections that were appealed to state regulators were reversed, according to the trade group America's Health Insurance Plans. It's a situation that exasperates their fellow physicians, who often argue fruitlessly with medical directors over their judgment calls. "They might be fabu-

lous doctors," says Lennox McNeary, a rehabilitation specialist in Roanoke, Va., "but they haven't seen my patients."

**M**OST MEDICAL DIRECTORS, of course, don't expect to win popularity contests. But without them, their defenders say, health insurance could never work financially. The country's huge and tangled medical system does little to discourage patients and doctors from trying all kinds of expensive treatments and technology, even in cases where those approaches haven't been proven to work well. The U.S. spent almost \$8,000 per person on health care last year, according to the Centers for Medicare and Medicaid Services. That's 2.5 times as much as the average developed nation, but the U.S. doesn't have much to show for it in terms of better quality of care or longer life expectancy. Medical directors say they're the ones who can apply the brakes to runaway spending, by monitoring the relevant science and data to decide what kind of care is the most effective. Indeed, even their critics say medical directors are becoming more important players. "We're all headed for a health care train wreck if things don't change," says Shannon Brownlee, senior fellow at the New America Foundation and author of *Overtreated*.

But playing bad cop has earned medical directors their share of enemies over the years. At the height of the HMO era in the early 1990s, they denied coverage so frequently—and hounded doctors so often with scorecards comparing their costs with their peers—that doctors came to see them as antagonists and tormentors. Some directors testified that they got bonuses if they denied more doctor bills. While insurers say those specific practices have long since stopped, physicians in the field remain frustrated with the system; some refuse even to refer to their counterparts on the insurance side as "doctors." It doesn't help that as medicine grows more specialized, many of the doctors evaluating claims have backgrounds in primary care (as is the case with eight out of 12 of the members of Liss's team). "How do you even argue necessity with insurers," says prominent Los Angeles orthopedist Ralph Gambardella, "if the only time a joint surgery is truly 'necessary' is when you've got a bone sticking out of your skin?"

## Who's Likely to Hear a "No" ...

Each year, insurers refuse to pay at least \$50 billion worth of medical bills. But the denial hammer doesn't fall on everyone equally. Some areas where disputes often arise:

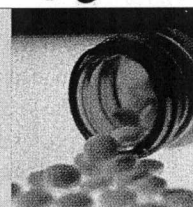
**X Home nursing.** Nursing care for disabled patients is a frequent bone of contention, since a full-time home nurse costs at least \$73,000 a year, according to a survey by MetLife. But doing without can be costly, too. "Parents can push food through a feeding tube," argues Beth Dworetzky, of the Federation for Children with Special Needs, but "they might not realize when there's an infection."



**X Medical equipment.** Many insurance policies cap the amount of money that can be spent each year per person on medical equipment like wheelchairs, canes and ventilation machines. Other companies might pay for, say, a \$20,000 wheelchair but refuse to pay for spare parts, batteries or maintenance. "Pretty insane," says Karen Mariner, of the National Multiple Sclerosis Society.



**X Prescription drugs.** Insurers balk at "off-label" prescriptions that use drugs in ways not approved by the Food and Drug Administration. Some breast-cancer patients taking tumor-slowing drug Avastin, for instance, had to pay as much as \$85,000 annually for the medication before it gained approval for their disease last year; those with rare, less-studied conditions face the issue often.



**X Rehabilitative therapy.** Insurers and patients frequently tussle over appropriate care after injury or stroke. But the fiercest debates center on services for someone who never had certain skills or won't fully recover them—like developmentally delayed children or patients with degenerative conditions like Huntington's disease. Stays in some inpatient facilities can top \$15,000 per stint.



After 12 years with Aetna, Liss has gotten used to being on the front lines of this battle. (Even, occasionally, at home: Liss's wife is a primary-care doctor.) Over the years, he's had to say no in various tough calls, involving mental health care, injury rehab and more, though he says all those rulings were medically justified. Recently, Liss says, he traveled to New Jersey to defend Aetna's decision to stop covering home nursing care for a child. He describes the girl as a "neurologically devastated 6-year-old" who was "cute as a button" and "clearly needs care day and night." But as Liss told her family and its lawyer, because her seizures had lessened recently, Aetna believed that a parent or nanny—instead of a \$150,000-a-year nurse—could handle tasks like feeding the child through the tube in her stomach. The family's reaction, says Liss, was "businesslike."

Like other medical directors, Liss often serves as a defense witness when Aetna gets sued, a role he's wryly proud of. (A plaque on his desk reads THEY WANTED BILLIONS. THEY GOT NOTHING.) He makes no apologies for embracing the business



side of medicine, with all its controversies; he says it enticed him early in his career, when he left regular practice in internal medicine after only three years. Today, Liss says, he's in charge of about 2.5 million "lives" for Aetna, which means his team cranks through roughly 1,000 disputed cases a month, a routine that has shaped the way he looks at the costs of health care. "I don't mean to sound cold here," he says. "But sometimes when \$3 million is being spent to extend someone's life with a really high-tech treatment, I say, 'Gee, that's incredible, but can you imagine how many people that could've provided dental care to?'"

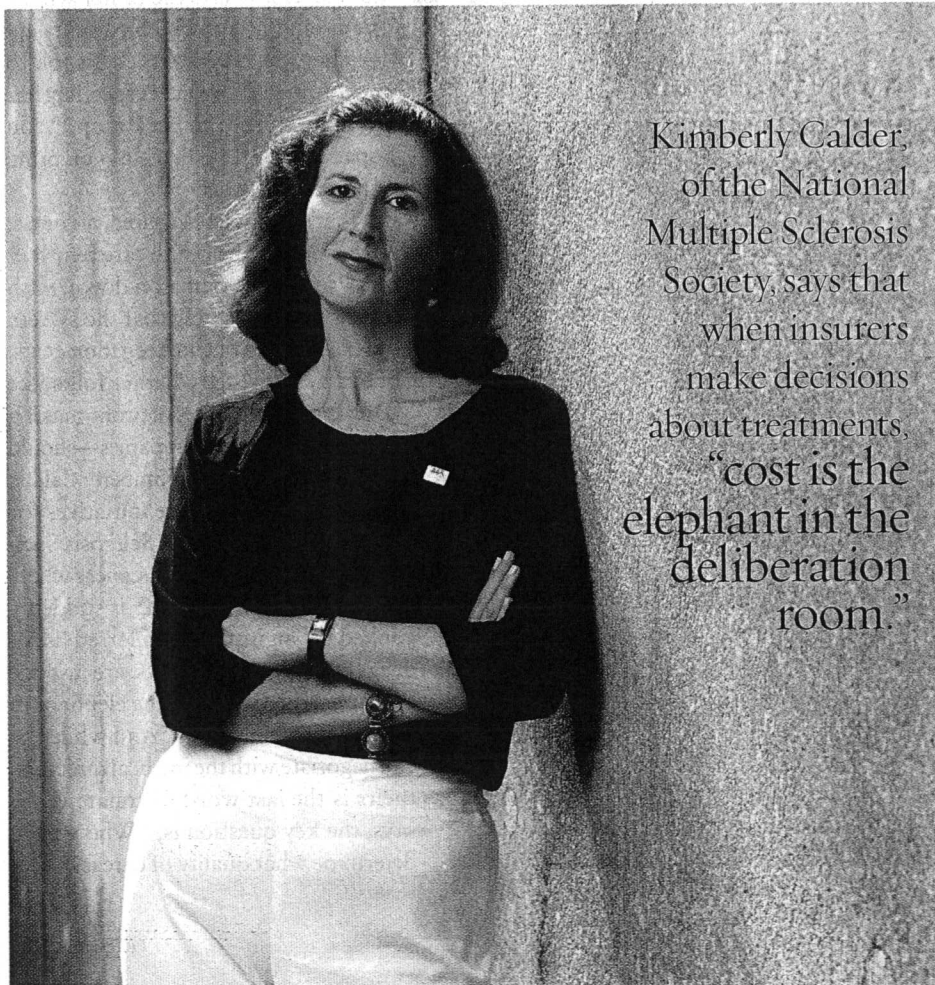
**S**OW HOW DO THOSE TRADE-OFFS GET DECIDED? Liss says that cost issues would never trump the medical needs of a patient, but he's acutely aware of how much money is spent on claims each month for each of the Aetna clients in his region. In fact, he and his team keep track of high-spending individual patients, a degree of Big Brother surveillance that would probably surprise most consumers. Ruth Caine, one of Liss's subordinates, says she knows the names and health histories of the 10 most expensive Aetna patients in the suburban Philadelphia region that she's

responsible for. And when an employer sees a spike in health expenses, a measure Liss calls "the speedometer," it's often Liss who has to explain the aberration to the insurer's executives. (For its part, Aetna says medical directors are not evaluated based on how many claims they deny or how much money they spend, adding that they're directed "to approve the care that people truly need.")

In the conference room where Liss's team frequently meets ("Welcome to our clubhouse," he jokes), the bean counters are present only in spirit. One case at a time, Liss and his team briskly discuss the issues they've reviewed. That 19-year-old with dermatomyositis may be going back on steroids, despite her difficulty with the side effects; she'll have to wean herself off the more expensive antibody therapy, which Aetna won't cover. Next up: A patient with seizures faces a quandary—should he try an antibiotic treatment before resorting to brain surgery? The antibiotic is "a shot in the dark," says one doctor; it's designed for Lyme disease, and the team isn't even sure that's what this guy has, but it's less invasive. (It also happens to be much cheaper.) Green light. One 42-year-old woman's doctor has recommended Viagra to treat a connective-tissue condition. But because her plan explicitly bars Viagra, Caine explains,

Aetna is denying the request, and Caine is advising the doctor to write a prescription for a different medicine with the same chemical makeup.

Although few patients realize it, most of the decisions on tough claims are closely dictated by a document known as the "summary plan description." That's the contract each patient's employer has signed with its insurers, dictating what will and won't be covered. For the physicians here, the contracts are a road map that gets them in the habit of parsing language like lawyers. But for Liss, the by-laws offer emotional cover when he's grappling with a decision he knows will cause hardship for a patient. "I tell myself, 'The plan is the plan,'" Liss says. "I can't rewrite your policy." And ultimately, it's in these contracts, more than in the conference room, that efforts to control costs exert their full force.



Kimberly Calder,  
of the National  
Multiple Sclerosis  
Society, says that  
when insurers  
make decisions  
about treatments,  
"cost is the  
elephant in the  
deliberation  
room."

Still, these rules aren't irrevocable. Every year, patients appeal hundreds of thousands of rejections—first to their insurers and then to state officials—and the reviewers often find flaws in the decision making. In 2006, almost 19,000 appeals nationwide made it to the state level, and insurance-industry data suggests that the ratio of complaints to customers has risen 34 percent since 2000. Liss says the appeals reflect how complicated or unprecedented some disputes can be and adds that, often, more information about a case emerges during the appeals process. “There are lots of shades of gray,” he explains. But consumer advocates see a far bigger problem: “There’s something wrong with a system when just *questioning* a denial can cause insurers to reverse their decision so quickly,” says Cheryl Fish-Parcham, deputy director of health policy at advocacy group Families USA.

**O**F ALL THE MEDICAL-COST BATTLEFIELDS, none are hotter than the ones centered on technological breakthroughs, which generate headlines and hopes long before they become standard practice. For insurers, keeping up with the advances is no easy task. That’s why Liss makes frequent visits to places like the University of Pennsylvania’s proton-beam radiation center,

a new facility with a \$140 million price tag. During a two-hour tour with other Aetna brass, Liss got a close look at the center’s cyclotron, a particle accelerator bigger than a football field, and listened to a presentation by a guide who spoke of the machine as a game-changing innovation in cancer care. Indeed, many doctors think proton beams could be ideal for treating tumors near the eye or spine, since they do less damage to surrounding tissue than traditional radiation. Prostate-cancer patients want the treatment too, since it may help them avoid complications like incontinence.

But Liss sees two nagging issues here: For most cancers, the medical community is still debating the effectiveness of proton-beam treatment, and it typically costs four times as much as traditional radiation. Aetna staff are continually churning out “bulletins” outlining the evidence behind new and controversial treatments like this. So Liss was shocked when, at the end of his grip-and-grin outing, a Penn official said the university hoped to put about half their radiation patients

through the center by 2012. “I walked out of there a whiter shade of pale,” Liss recalls. (Stephen Hahn, chairman of radiation oncology at the university, says the center will be “prudent” about which patients get the therapy.) Liss says it’s his job to make sure such big-ticket spending has enough evidence to back it up. “You hope at least on the margins you bring some sanity,” he says.

That’s a hope that’s shared, of course, by every would-be health care reformer from President Obama on down, with most of them believing that the system needs some kind of gatekeeper on costs. But critics wonder whether folks like Don Liss—employees of profit-making private insurance companies—should be making that call. Kimberly Calder, director of insurance initiatives for the National Multiple Sclerosis Society, says she’s seen many instances where a medicine for treating MS is suddenly yanked off an insurer’s preferred list of drugs. These cases, she says, are just one example where “cost is the elephant in the deliberation room.” And while she can negotiate with the medical directors, theirs is the last word. Ultimately, she says, the key question is, “Who gets to determine what quality of care is?” **S**

## ...And How to Fight Back

The rate at which consumers appealed insurers’ rejections to state regulators rose by 34 percent between 2000 and 2006, the most recent year tracked. Here are some of the strategies they’re pursuing:

- ✓ **Pen a dense letter.** Patients who write insurers to appeal are more likely to succeed if they pack the letter with references to medical research. Some advocacy groups like the Pulmonary Hypertension Association offer helpful letter templates for common denials.
- ✓ **Get a second opinion.** An extra, concurring opinion adds heft to the patient’s argument, experts say. Prestige matters: Philadelphia attorney Mark Gallant says he had success overturning a friend’s optical-scan denial when he recruited a top doctor in the field to speak on his behalf.
- ✓ **Stay collected.** When appeals reach a second round, the aggrieved often get to talk on the phone or meet in person with a medical director. But the conferences are often as little as 10 to 15 minutes long. And “yelling and screaming,” says Mariner, of the National Multiple Sclerosis Society, “just eats up time.”
- ✓ **Look for holes.** Larry Gelb, CEO of the advocacy firm CareCounsel, says many employers still have outdated or poorly written summary plan documents—or contracts—with insurers, which can “open doors” in appeals. Copies of the contracts should be available in an employer’s benefits office.

