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## THE HEALTH INSURANCE INDUSTRY AND THE MEDIA: WHY THE INSURERS AREN'T ALWAYS WRONG

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### INTRODUCTION

It is both tempting and easy to blame the health insurance industry for the sad state of the personal health care delivery system in the United States. As a visible and inviting target, the health insurance industry has provided many opportunities for harsh public condemnation. At least in its incarnation as the managed care industry (which combines the health insurance and health care delivery functions), the insurers have suffered (rightly in the view of many commentators) from adverse media attention and an inability to convince the public of its good intentions.

In previous work, one of us (PDJ) has joined the condemnation chorus.<sup>1</sup> Although supporting the concept of managed care, Jacobson has been highly critical of how it has been implemented. Among other arguments, Jacobson maintained that the industry has not engaged the public in a full and open discussion of the need for limits in medical care, has paid insufficient attention to legitimate patient and physician grievances, and has garnered a well-deserved reputation for acting in its own self-interest.<sup>2</sup> The implementation failures have been exacerbated by an industry-wide

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<sup>1</sup> See generally PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA (2002) [hereinafter JACOBSON, STRANGERS]; Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365 (2003) [hereinafter Jacobson, *Whodunit*].

<sup>2</sup> See generally JACOBSON, STRANGERS, *supra* note 1; Jacobson, *Whodunit*, *supra* note 1.

strategy, reflected in the major trade association's policies, that has largely focused on image management rather than responding to legitimate concerns.<sup>3</sup> Repeatedly, the industry has allowed the perception to fester that it is more interested in managing costs than in providing care—a perception of profits over care that has fueled patients' suspicions of rampant conflicts of interest.<sup>4</sup> The industry has failed to educate patients about the concept of managed care and the need to control costs, and has failed to include patients in determining how cost containment operates.<sup>5</sup> Widespread reports of high salaries for industry executives have merely reinforced the industry's reputation for avarice and willingness to subordinate patients to profits.<sup>6</sup>

As such, the health insurance industry presents a wonderful target for media opprobrium and deserves almost all of the scorn and derision it has received—almost all because health insurers are not always wrong. In making difficult coverage decisions with imperfect scientific information, health insurers are caught between individual patient demands for services and the need to preserve assets for the patient population. Whenever an insurer denies coverage, the affected patient (or set of patients with similar conditions) is unlikely to be satisfied. Two values often conflict: the need to make new therapies, such as cancer treatments, readily available to patients for whom conventional therapy offers few prospects; and the need to evaluate the medical effectiveness of such therapies before their widespread use. When no other viable treatment option exists, patients and their physicians may understandably push for new procedures, regardless of proven effectiveness.<sup>7</sup> These circumstances place skeptical insurers in the position of denying coverage and payment for a treatment that may represent a patient's best hope for recovery even when its scientific effectiveness remains either unproven or highly controversial.

<sup>3</sup> See generally Jacobson, *Whodunit*, *supra* note 1.

<sup>4</sup> See Joshua Michael Kaye, Comment, *Closing the Lid on Pandora's Box: ERISA Preemption of Tort Actions Against Managed Care Organizations in State Courts*, 54 U. MIAMI L. REV. 373, 373 (2000); Thomas R. McLean, *The Implications of Patient Safety Research and Risk Managed Care*, 26 S. ILL. U. L.J. 227, 256 (2002).

<sup>5</sup> See Neelam K. Sekhri, *Managed Care: The U.S. Experience*, 78 BULL. OF WORLD HEALTH ORG. 830, 830, 837 (2000).

<sup>6</sup> See Dionne Koller Fine, *Exploitation of the Elite: A Case for Physician Unionization*, 45 ST. LOUIS U. L.J. 207, 222 (noting that MCO senior executives earn "two thirds more compensation than their counterparts in other industries," an average of \$2 million a year).

<sup>7</sup> Patricia C. Kuszler, *Financing Clinical Research and Experimental Therapies: Payment Due, But from Whom?*, 3 DEPAUL J. HEALTH CARE L. 441, 493 (2000).

But the complex choices insurers face receive very little media attention. The media almost always report about the excitement of a new technology or medical procedure, the unbearable suffering of individual patients, and the insurance industry's wanton callousness in denying the patient's last hope.<sup>8</sup> The reality that many of the procedures being demanded have not been proven scientifically effective is rarely considered.

In this Article, we will discuss the role of media influence in the health insurance industry's struggle to determine whether it should cover the use of high-dose chemotherapy with autologous bone marrow transplant (HDC/ABMT) for breast cancer patients.<sup>9</sup> After emerging in the late 1980s, HDC/ABMT diffused along two pathways: slow evaluation through randomized clinical trials (RCTs), and rapid adoption by many clinical oncologists and bone marrow transplanters.<sup>10</sup> With little optimism for effectively treating either metastatic or early stage, high-risk breast cancer through conventional dose chemotherapy, many clinical oncologists recommended HDC/ABMT as a new approach that, they argued, represented a patient's only chance for survival.<sup>11</sup> The problem was that the procedure had not been proven through RCTs to be an effective alternative to standard chemotherapy.<sup>12</sup> Absent persuasive evidence from RCTs, insurers balked at reimbursing a procedure that, though promising, was very expensive and controversial.<sup>13</sup> Naturally, breast cancer patients brought litigation to compel insurers to pay.<sup>14</sup>

<sup>8</sup> Michelle M. Mello & Troyen A. Brennan, *The Controversy Over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer*, 20 HEALTH AFF. 101, 107 (2001).

<sup>9</sup> The research for this article relied on a number of methodologies and data sources to examine the HCD/ABMT experience. In preparing FALSE HOPE, RETTIG ET AL. relied upon semi-structured interviews with key actors in every stage of the research, conducted an extensive review of published and unpublished scientific literature, analyzed all published court decisions, used data on utilization of HDC/ABMT from the Health Care Utilization Project and the American Bone Marrow Transplantation Registry, and augmented this with analysis of the print and electronic media to ensure that they understood the full sweep of the HCD/ABMT story. See RETTIG ET AL., *supra* note \*.

<sup>10</sup> Dorothy Puzio, *Health Insurance Coverage for Emerging Medical Technologies: A New Approach*, 38 TORT TRIAL & INS. PRAC. L.J. 1019, 1024-25 (2003).

<sup>11</sup> David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427, 1456 (2001).

<sup>12</sup> See E. Haavi Morreim, *A Dose of Our Own Medicine: Alternative Medicine, Conventional Medicine, and the Standards of Science*, 31 J.L. MED. & ETHICS 222, 224 (2003).

<sup>13</sup> See Mello & Brennan, *supra* note 8, at 102.

<sup>14</sup> See Christine Nardi, Comment, *When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WIS. L. REV. 777, 787 (1997).

In retrospect, the health insurance industry's skepticism about this procedure was entirely justified. Subsequent studies have confirmed that HDC/ABMT is no more effective than conventional therapy.<sup>15</sup> Even though the industry was correct, its inability to manage the often harsh (and equally often incorrect or sensationalistic) media scrutiny compromises its future ability to sustain coverage denials of similarly unproven procedures and technologies.<sup>16</sup> Much like the Tet Offensive during the Vietnam War, being right may mean very little if the accompanying negative media portrayal of the industry's decision-making processes lingers in shaping public opinion. In turn, this media portrayal has a direct influence in shaping health policy.

## I. MEDIA INFLUENCE ON PUBLIC POLICY

Media and the law have been called intimately linked institutions; indeed, an understanding of the media's role in forming policy is necessary to understand the law.<sup>17</sup> Press bias, television revelations of industry failures (i.e., horror stories), and even feature films easily sway public opinion and are often the driving force behind policy.<sup>18</sup> Among other things, the media has been cited for influencing policies on taxes, drugs, and human rights.<sup>19</sup> The media constantly influence policy and legislation by forming the public's opinion or perception of an issue. Reporters and editors make decisions every day as to what is newsworthy, what is not newsworthy,

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<sup>15</sup> See, e.g., Martin S. Tallman et al., *Conventional Adjuvant Chemotherapy with or without High-Dose Chemotherapy and Autologous Stem-Cell Transplantation in High-Risk Breast Cancer*, 349 *NEW ENG. J. MED.* 17, 22 (2003); Edward A. Stadtmauer et al., *Conventional-Dose Chemotherapy Compared with High-Dose Chemotherapy Plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 *NEW ENG. J. MED.* 1069, 1069 (2000).

<sup>16</sup> See Kuszler, *supra* note 7, at 473–74.

<sup>17</sup> See M. ETHAN KATSH, *LAW IN A DIGITAL WORLD* 9 (1995).

<sup>18</sup> See, e.g., Frank R. Baumgartner et al., *Media Attention and Congressional Agendas*, in *DO THE MEDIA GOVERN? POLITICIANS, VOTERS, AND REPORTERS IN AMERICA* 349, 350 (Shanto Iyengar & Richard Reeves eds., 1997) (describing the media's influence in political campaigns, on public opinion, and in public policy).

<sup>19</sup> See Sheldon D. Pollack, *A New Dynamics of Tax Policy?*, 12 *AM. J. TAX POL'Y* 61, 84 (1995); STEVEN R. BELENKO, *CRACK AND THE EVOLUTION OF ANTI-DRUG POLICY* 30 (1993); James Finn, *The Cultivation and Protection of Religious Human Rights: The Role of the Media*, in *RELIGIOUS HUMAN RIGHTS IN GLOBAL PERSPECTIVE* 161, 166 (Johan D. van der Vyver & John Witte, Jr. eds., 1996).

and what aspects of an event to emphasize.<sup>20</sup> This selection bias directly influences public opinion.

Consider, for example, the news coverage of school shootings. The major television networks (ABC, NBC, and CBS) bombarded viewers with twelve hours of coverage on the Columbine High School shooting in Littleton, Colorado within a week of the incident. The 319 stories about the Columbine shootings comprised almost 54% of all news stories about murder in 1999.<sup>21</sup> The overwhelming coverage of the event changed how adults felt about school safety.<sup>22</sup> While statistical data on school safety showed that youth violence was actually diminishing, seventy-one percent of one thousand adults polled after the Columbine shooting stated that they believed a school shooting was likely to happen in their community.<sup>23</sup> Thus, thanks largely to the media's skewed portrayal of school violence and massacres, informed Americans had almost no choice but to believe that school shootings were likely.<sup>24</sup> Reviewers noted that "[t]he media's failure to adequately or accurately report statistics indicating the recent decline in school violence only perpetuates this erroneous belief."<sup>25</sup> One New York Times journalist commented that "anyone watching the news would find it almost impossible to believe that school violence has decreased."<sup>26</sup>

The influence of public opinion on policy is "at once obvious to all observers yet is ultimately not provable."<sup>27</sup> Congress rarely cites public opinion as the cause for its legislation.<sup>28</sup> To make this connection, one must thoroughly search specific pieces of legislation, read statements politicians make to the media, or make some other causal connection between public opinion on specific issues and

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<sup>20</sup> See Andrew Kohut, *The Truth About Self-Censorship*, COLUM. JOURNALISM REV., May/June 2000, at 42–43.

<sup>21</sup> Alicia Insley, Comment, *Suspending and Expelling Children from Educational Opportunity: Time to Reevaluate Zero Tolerance Policy*, 50 AM. U. L. REV. 1039, 1058 (2001).

<sup>22</sup> See *id.* at 1060.

<sup>23</sup> See Kim Brooks et al., *School House Hype: Two Years Later*, Policy Rep., 2000 JUST. POL'Y INST. 6.

<sup>24</sup> Barry Glassner, *School Violence: The Fears, the Facts*, N.Y. TIMES, Aug. 13, 1999, at A21.

<sup>25</sup> Insley, *supra* note 21, at 1060.

<sup>26</sup> See *id.* (citing Ira M. Schwartz et al., *School Bells, Death Knells, and Body Counts: No Apocalypse Now*, 37 HOUS. L. REV. 1, 4 (2000) (quoting Barry Glassner, *School Violence: The Fears, the Facts*, N.Y. TIMES, Aug. 13, 1999, at A21)).

<sup>27</sup> See Julian V. Roberts, *Public Opinion and Youth Justice*, in 31 CRIME & JUST. 495, 522 (Michael Tonry ed., 2004).

<sup>28</sup> See *id.*

policies made regarding those issues.<sup>29</sup> Media can even be the direct inspiration for certain legislation. One example is the recent focus on corporate greed and the resulting Sarbanes-Oxley Act of 2002, which requires corporate executives to verify their companies' accounting statements.<sup>30</sup>

Most importantly, the media help set the policy agenda. As a vast enterprise with the ability to keep a story alive for as long as they want, the media can create a groundswell of interest that can be disproportionate to the seriousness of the event. Witness the frenzy over the O.J. Simpson trial.<sup>31</sup> On the other hand, media attention to a particular problem can be beneficial in forcing politicians to respond to social problems or in holding public officials and corporate executives accountable. In short, the media have an extraordinary opportunity through vast reach, repetition via multiple media, and attention-getting headlines to diminish managed care or to adulate it.

#### A. Media Coverage of Managed Care

Since the early 1990s, newspapers and other media have spent much time and space discussing problems with the health care system and its organization, delivery, and cost. A search on LexisNexis shows that from 1980 to 1990, only 137 news articles were written about health maintenance organizations (HMOs).<sup>32</sup> From 1990 to 2000, this number grew exponentially to 2,659 articles.<sup>33</sup> In the last five years, it has become even more common—from January 2000 to November 2004, more than 2,700 articles have been written about

<sup>29</sup> See *id.* Nevertheless, the connection between media and policymakers has been frequently commented on, inspiring one disgusted commentator to say, “[p]ublic debate over the future of media and communication has been effectively eliminated by powerful and arrogant corporate media, which metaphorically floss their teeth with politicians’ underpants.” See ROBERT W. MCCHESENEY, *RICH MEDIA, POOR DEMOCRACY: COMMUNICATION POLITICS IN DUBIOUS TIMES* 77 (1999).

<sup>30</sup> See 17 C.F.R. § 210.2-01 (2002). Another example is the case of Erin Brockovich and hexavalent chromium (chromium 6) regulations in California. See Sedina Banks, *The “Erin Brockovich Effect”: How Media Shapes Toxics Policy*, 26 *ENVIRONS* 219, 249 (2003).

<sup>31</sup> See Sherry F. Colb, *Allen Iverson and the Presumption of Innocence*, June 17, 2002, <http://writ.corporate.findlaw.com/colb/20020617.html> (last visited Oct. 7, 2005); Michael C. Dorf., *Can Kobe Bryant be Convicted on ‘He Said, She Said’ Evidence Alone?*, July 23, 2003, <http://writ.corporate.findlaw.com/dorf/20030723.html> (last visited Oct. 7, 2005) (the media is still interested in the O.J. Simpson trial).

<sup>32</sup> Information available by searching LexisNexis News database. <http://www.lexis.com/> (determined by searching abstracts for keywords HMO or health maintenance organizations).

<sup>33</sup> *Id.*

HMOs.<sup>34</sup> A similar pattern is found when searching articles about health care costs. For the same time periods, the number of articles written about health care costs grew from 75 to 685 to over 1000.<sup>35</sup>

Newspapers, magazines, network and cable news reports, television programs, and even movies have led the charge to discredit managed care. It may be an overstatement to suggest that entertainment and broadcast media, particularly television and movies, thrive on salaciousness, controversy, and creating a villain—but not by much. Not too long ago, one local television news broadcast attempted to downplay local crime by breaking the cardinal rule of local news—if it bleeds, it leads—focusing instead on in-depth reports of local interest.<sup>36</sup> Ratings tanked, and the experiment ended quickly.<sup>37</sup> One reason for this is that crime and similar stories grab our attention, while softer features or serious investigative pieces tend to drift by largely unnoticed. Instead, media circuses such as the O.J. Simpson trial capture the public's interest much more readily than other events.<sup>38</sup> The media do not publish or broadcast information for their own use or gratification; without the ability to hold readers and viewers, the media would cease to exist. Ratings drive advertising revenue, which drives survival.

In this race-to-the-bottom environment, managed care provided everything the media needed to galvanize the public's outrage. Corporate profiteers, a plethora of tear-jerking human interest pieces, double-minded and double-crossing politicians, a labyrinth of indecipherable regulations and legislation, and physicians reduced to assembly-line medical bureaucrats all contribute mightily to wave upon wave of assaults on an embattled industry.<sup>39</sup> Horror story after horror story has decried managed care's heartlessness, callousness, indifference, and venality. What the media forgot, or chose not to report, was managed care's successes. There has been little balance in media coverage of the industry.<sup>40</sup> Even assuming that the horror stories are true, the question is one of balance and perspective. Out of the millions of patient encounters, it is not sur-

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<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> Authors' observations of local events.

<sup>37</sup> Authors' observations of local events.

<sup>38</sup> Colb, *supra* note 31.

<sup>39</sup> See B. Martinez, *Tired of Being Cast as the Villain*, WALL ST. J., July 9, 2002, at B1.

<sup>40</sup> Michael Levin-Epstein, *Coverage of Managed Care Shown to be Less Positive*, MANAGED CARE MAG. (Feb. 1998), <http://www.managedcaremag.com/archives/9802/9802.media.shtml> (last visited Oct. 7, 2005).

prising that a few result in bad outcomes or involve industry acts of bad faith. Yet, how representative are the horror stories and how much media play do they deserve? To what extent are the horror stories evidence of systematic failures or merely aberrations that deserve, at best, only brief media attention? How should those instances be weighed against the many encounters that result in appropriate outcomes with overall reduced costs?

## B. Media Influence on Public Opinion of Health Policy

It is often difficult to gauge how the media's spotlight on health care problems influences public opinion. Single articles in single newspapers usually have very little discernible effect on public opinion. For that reason, it is helpful to focus on feature films. Films are one instance where a single piece of media is seen by millions, directly influencing the nation's public opinion rather than that of one city or county.

Several recent blockbuster films have centered on deficiencies in the current health care system, including *As Good as It Gets*, *Critical Care*, *The Rainmaker* and *John Q*.<sup>41</sup> In *As Good as it Gets*, Academy Award winner Helen Hunt delivered an eloquent soliloquy on the villainous HMOs refusing her son's care.<sup>42</sup> *Critical Care* is a dark portrayal of doctors and residents who treat only patients with insurance in an impersonal intensive care unit.<sup>43</sup> *The Rainmaker* tells the story of a young attorney facing off against a giant insurance company, whose coverage denials resulted in a leukemia patient's death.<sup>44</sup> Insurance denials are also the focus of *John Q*, which depicts a frustrated working father whose inadequate employer-based HMO will not pay for his son's heart transplant.<sup>45</sup> The movie tapped into a deep well of resentment that left audiences cheering when the father took the hospital's emergency room hostage at gunpoint until doctors agreed to perform the operation.<sup>46</sup> While these films reflect, through somewhat exaggerated situations, society's

<sup>41</sup> See Elizabeth A. Pendo, *Images of Health Insurance in Popular Film: The Dissolving Critique*, 37 J. HEALTH L. 267 (2004) [hereinafter Pendo, *Images*]; Elizabeth A. Pendo, *Telling Stories About Health Insurance: Using New Films in the Classroom*, 5 HOUS. J. HEALTH L. & POL'Y 269 (2005) (providing detailed discussions of *Critical Care*, *The Rainmaker*, and *John Q*).

<sup>42</sup> *Id.* at 267-68; see also *AS GOOD AS IT GETS* (Columbia Tri-Star 1997).

<sup>43</sup> See *CRITICAL CARE* (Artisan Ent. 1997); see also Pendo, *Images*, *supra* note 41, at 269.

<sup>44</sup> See *THE RAINMAKER* (Paramount Pictures 1997); see also Pendo, *Images*, *supra* note 41, at 272-73.

<sup>45</sup> See *JOHN Q.* (New Line Productions 2002); see also Pendo, *Images*, *supra* note 41, at 274.

<sup>46</sup> See *JOHN Q.*, *supra* note 45.



discontent with the health care system, each film is resolved not with system-wide change but with conservative, individualistic solutions.<sup>47</sup> At least one commentator feels that these films missed an opportunity to propose real policy solutions to the problems of restrictive HMOs, inappropriate coverage denials, and lack of available treatment for uninsured individuals.<sup>48</sup> The films opted for simpler solutions—a gun wielding father in a hospital securing a transplant for his son, a rich and friendly physician offering treatment (and home visits) to an asthmatic child.<sup>49</sup> Pendo calls this phenomenon of movies addressing major problems in the health care system, but retreating to simple, individual solutions to the problems, the “dissolving critique.”<sup>50</sup> She suggests that films should “reflect and reinforce public opinion regarding the healthcare crisis and. . . imagine inclusive solutions” to someday create a better system.<sup>51</sup>

Thus far, it appears that none of these films has directly influenced federal policy. Indeed, patients’ rights legislation to overturn ERISA preemption has consistently failed in Congress.<sup>52</sup> Nonetheless, the films’ messages have not escaped political attention. In President Clinton’s speech presenting the Patients’ Bill of Rights in 1998, for instance, he joked that the film *As Good As it Gets* was “going to be disqualified for an Academy Award because it’s too close to real life.”<sup>53</sup> House Democrats later discussed the same scene in opposing the Medicare Prescription Drug Act.<sup>54</sup> After commenting on how restrictive the act was, the minority report added:

Remember the laughter and cheers in theaters all across America when the heroine in *As Good as it Gets* expresses her true feelings about HMOs? Wait ’til seniors experience the hassle of the Republican Rx private insurers! They won’t be laughing. They will be begging every Member of Congress for help.<sup>55</sup>

<sup>47</sup> See Pendo, *Images*, *supra* note 41, at 288.

<sup>48</sup> *Id.* at 291.

<sup>49</sup> See *id.* at 274–75; *AS GOOD AS IT GETS*, *supra* note 42.

<sup>50</sup> See Pendo, *Images*, *supra* note 41, at 291.

<sup>51</sup> *Id.* at 294.

<sup>52</sup> See 29 U.S.C. § 1144 (2005).

<sup>53</sup> President’s Remarks at the Holiday Senior Park Center in Wheaton Maryland, 34 WEEKLY COMP. PRES. DOC. 295, 296 (Feb. 20, 1998), <http://www.clintonfoundation.org/legacy/022098-speech-by-president-on-health-care-protections.htm> (last visited Oct. 7, 2005).

<sup>54</sup> Medicare Rx 2000 Act, H.R. Rep. No. 106-703, pt. 1, at 158 (2000).

<sup>55</sup> *Id.*

These off the cuff comments are just a glimpse into the influence that feature films have on public opinion and the extent to which they may affect policy. At a minimum, as the first mainstream films to focus on health insurance and healthcare arrangements, they have sparked public and media attention to the growing problems of healthcare access in the United States. In addition, the films have likely influenced state-level managed care regulation.

### C. A Related Example

In this context it is useful to examine a related instance where a film led to very specific policy changes in environmental health—the Erin Brockovich saga. Based on a true story, the movie *Erin Brockovich* tells the story of an unemployed single mother who discovers that Pacific Gas & Electric Company (“PG&E”) is polluting the small town of Hinkley, California’s drinking water with chromium 6, a potentially highly toxic carcinogen.<sup>56</sup> The residents of Brockovich’s hometown Hinkley, (California, pop. 3500) suspected that PG&E’s dumping of chromium 6 was responsible for the health problems in Hinkley including birth defects, cancer and tumors.<sup>57</sup> PG&E spent millions of dollars to purchase contaminated properties and eventually settled with 650 residents of Hinkley for \$333 million which, at the time, was the largest settlement amount ever paid in a direct-action lawsuit in United States history.<sup>58</sup> Beyond the film’s commercial success, it had a major impact on policy.

A reporter commented that “what press coverage chromium 6 and the Hinkley story first received paled in comparison to the media frenzy after the release of *Erin Brockovich*.”<sup>59</sup> Although the events depicted in the film occurred around 1990, state and federal legislatures did not act until the film was released in 2000.<sup>60</sup> Both legislatures quickly enacted policy regarding chromium 6.<sup>61</sup> California passed two bills requiring assessment of chromium 6 levels in drinking water in the San Fernando Basin aquifer and requiring

<sup>56</sup> See Kathleen Sharp, “*Erin Brockovich*: The Real Story,” SALON.COM (Apr. 14, 1998), <http://archive.salon.com/ent/feature/2000/04/14/sharp/index.html> (last visited Oct. 7, 2005).

<sup>57</sup> See Banks, *supra* note 30, at 229.

<sup>58</sup> *Id.* at 230.

<sup>59</sup> *Id.* at 232 (citing Andrew Gumbel, *This Woman is at a Film Premiere but She is Not a Film Star*, INDEP. (London), Apr. 1, 2000, Features at 1, available at <http://www.lexis.com> (last visited Oct. 7, 2005)).

<sup>60</sup> See *id.* at 249–51.

<sup>61</sup> See Banks, *supra* note 30, at 249–51.

drinking water standards for chromium 6.<sup>62</sup> Bill 351, one of the statutes enacted, even cited *Erin Brockovich* as one of the reasons for the law's enactment, stating "public concern . . . has been heightened because of the unusual circumstances surrounding a federal Superfund project in the San Fernando Valley and because of last year's popular film, '*Erin Brockovich*.'"<sup>63</sup> The federal government allocated \$3 million for a treatment plant and technology to remove chromium 6 from drinking water.<sup>64</sup> The film's influence on Senator Barbara Boxer was apparent when she introduced an amendment to the Safe Drinking Water Act to add chromium 6 as a contaminant.<sup>65</sup> In her remarks she gave credit to *Erin Brockovich* for putting the carcinogen into the spotlight.<sup>66</sup>

The case of *Erin Brockovich* and its direct influence on both state and federal policies shows how strongly a single feature film can influence environmental health policies. As more films emerge around the health care crisis, specific problems and specific solutions will be identified and likely made into policy. As a result, technically correct insurance industry coverage decisions may not insulate it from public opprobrium and scrutiny.

## II. THE MEDIA AND INSURERS' COVERAGE DECISIONS ON HDC/ABMT

As much as insurers and scholars might otherwise like, insurers do not make coverage decisions in a vacuum in which the only consideration is the evidence of scientific efficacy for a procedure or technology. Likewise, the legal system does not act in a vacuum where media perceptions of an event play no role. In both situations the media may play an important role in shaping outcomes. While it is easier to see the influence of the media on legislative and regulatory decisions, is there any reason to believe that perceptions the media create do not influence jury verdicts?

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<sup>62</sup> See S.B. 351, 2001 Leg., Reg. Sess. (Ca. 2001); S.B. 2127, 2000 Leg., Reg. Sess. (Ca. 2000).

<sup>63</sup> See Banks, *supra* note 30, at 250.

<sup>64</sup> See H.R. Rep. No. 107-272 (2001), H.R. 2620, 107th Cong. (2001) (allocating the money under the United States Environmental Protection Agency: Science and Technology in the final enacted appropriation version).

<sup>65</sup> See Banks, *supra* note 30, at 251.

<sup>66</sup> See *id.* (citing *Hexavalent Chromium: Drinking Water Standards: hearing on S.B. 351 Before the Senate Floor*, 2001 Leg., Reg. Sess. (Ca. 2001)).

### A. Media Coverage of Breast Cancer and HDC/ABMT<sup>67</sup>

From the moment the first story about high-dose chemotherapy appeared in 1988, the press played a central role in both shaping the debate about the treatment and encouraging women with breast cancer to demand it. The first story appeared on April 6, 1988,<sup>68</sup> seven years after Dr. William Peters first used high-dose chemotherapy to treat a patient with advanced breast cancer at the Dana Farber Cancer Institute in Boston.<sup>69</sup> By 1988, several advances had been made in breast cancer treatment, including the use of growth factors to shorten the period of time the patient spent without a functional immune system.<sup>70</sup> Daniel Haney, an established science journalist for the Associated Press, based his article on a paper in the *New England Journal of Medicine* reporting the use of a growth factor in the course of administering high-dose chemotherapy.<sup>71</sup>

Despite this initial coverage, it was Elizabeth Rosenthal of the *New York Times* who captured all the pieces of the story that would put high-dose chemotherapy on the map for both reporters and patients.<sup>72</sup> Rosenthal's piece, *Patient's Marrow Emerges as Key Cancer Tool*, conveyed the sense of hope that would characterize hundreds of newspaper, magazine, and television stories that would follow over the next decade.<sup>73</sup> Her piece appeared on page one of the Science Times section, on March 27, 1990, and at 1,904 words, it was long even by that section's standards.<sup>74</sup> By the third paragraph, Rosenthal made the case for the treatment, saying, "Although such autologous bone marrow transplants were first used experimentally over a decade ago as heroic treatments for hopeless cases, research-

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<sup>67</sup> This section relies heavily on Shannon Brownlee's contribution to *False Hope*. See generally Shannon Brownlee, *Health, Hope, and Hype: Why the Media Oversells 'Breakthroughs'*, WASH. POST, Aug. 3, 2003, at B1.

<sup>68</sup> Daniel Q. Haney, *Study Shows Blood Growth Factor Useful in Cancer Treatment*, ASSOC. PRESS, Apr. 7, 1988.

<sup>69</sup> See Shannon Brownlee, *Bad Science and Breast Cancer*, DISCOVER MAG., Aug. 2002, at 73-74.

<sup>70</sup> See Stephen J. Brandt et al., *Effect of Recombinant Human Granulocyte-Macrophage Colony-Stimulating Factor on Hematopoietic Reconstitution After High-Dose Chemotherapy and Autologous Bone Marrow Transplantation*, 318 NEW ENG. J. MED., Apr. 7, 1988, at 867-76.

<sup>71</sup> Haney, *supra* note 68.

<sup>72</sup> Elisabeth Rosenthal, *Patient's Marrow Emerges as Key Cancer Tool*, N. Y. TIMES, Mar. 27, 1990, at C1.

<sup>73</sup> See generally *id.*

<sup>74</sup> *Id.*

ers have only recently accumulated enough data to prove definitively that they work.”<sup>75</sup>

Rosenthal’s story went on to outline the rationale for the treatment—the idea that cancer could be killed, if only doctors could administer high enough doses of chemotherapy.<sup>76</sup> She also described some of the possible harrowing symptoms: the bleeding and daily fevers during the nadir period, a time after treatment when the body has little functional bone marrow left after the chemotherapy and virtually no capacity to fight infection.<sup>77</sup> But as she portrayed it, the risk of painful symptoms was offset by the potential reward of a cure, or at least an extra five years of life. Rosenthal wrote, “[s]ome of the initial patients have long outlived the time they were expected to survive with their fatal diseases . . . and, although the risk of dying in the procedure is still 5 to 15 percent, autologous transplants have taken off.”<sup>78</sup>

What Rosenthal could not have known was that her own story, and the hundreds that followed, would serve to spur autologous bone marrow transplants. By year’s end, at least fifteen stories about high-dose chemotherapy had appeared in major newspapers, including the *Wall Street Journal*, *Washington Post*, and *Los Angeles Times*.<sup>79</sup> By being out in front, Rosenthal and the *Times* gave high-dose chemotherapy a visibility that would get other reporters interested in writing stories of their own.

But it was not just the venue of her piece, it was also the content that made other reporters prick up their ears to the saga of combating a desperate disease with desperate measures. All of the stories that followed that year, with one significant exception, re-

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<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> Elisabeth Rosenthal, *Patient’s Marrow Emerges as Key Cancer Tool*, N. Y. TIMES, Mar. 27, 1990, at C1.

<sup>78</sup> *Id.*

<sup>79</sup> See, e.g., Jerry E. Bishop, *Father Gets Back Bone Marrow That He Donated to Son*, WALL ST. J., Aug. 13, 1990, at B1; Jerry E. Bishop, *French Doctors Avoid Surgery in Breast Cancer*, WALL ST. J., July 17, 1990, at B1; Patricia Gains-Carter & Carlos Sanchez, *College Athlete Takes on the Challenge of His Life: New Cancer Treatment a First for D.C. Area*, WASH. POST., Oct. 1, 1990, at C3; Robert Howe, *Patient Wins Coverage for Treatment*, WASH. POST., Apr. 19, 1990, at C1; Elaine Kirtenbach, *Mice, Men Join Forces in Cancer Fight*, L.A. TIMES, July 29, 1990, at B8; David Stipp, *Medicine: Breast Cancer Treatment Sparks Debate*, WALL ST. J., May 17, 1990, at B1; Larry Thompson, *Finding a Match Is Not Enough: The Gamble of Bone Marrow Transplants*, WASH. POST., Apr. 24, 1990, at Z12; Emanuel D. Thorne, *Tissue Donation Policies Endanger Altruism*, WALL ST. J., Mar. 22, 1990, at A14.

traced the format laid out by Rosenthal.<sup>80</sup> They relayed the hopelessness of a late-stage breast cancer diagnosis and contrasted it with the hope offered by the new treatment. At the same time the stories also highlighted the risks of the treatment, just as she had done, while explaining the rationale: more chemotherapy is better, if only it didn't tend to kill the patient.<sup>81</sup> The only thing missing from Rosenthal's piece that would become a staple of later stories was the use of an individual patient, usually a young person, whose tragic tale could be used to dramatize the need for the new treatment.<sup>82</sup> But the most critical part of Rosenthal's story, the one piece of information that would enrage reporters, breast cancer patients, and advocates over the coming years, focused on the fact that most insurers, including Medicare and Medicaid, refused to pay for the procedure.<sup>83</sup>

Combined, these elements made for great copy, the kind of tale that reporters want to tell. Medical reporters have learned that editors—and presumably readers—are more easily drawn in to the science of medicine when they are told a human-interest story first. High-dose chemotherapy is a ready-made allegory of good versus evil, of heroism in the face of overwhelming odds: A young woman with advanced breast cancer—and they were almost always young women in the stories, preferably with children still living at home—faces almost certain death, unless she braves a harrowing procedure, a fight for her life of Homeric proportions.<sup>84</sup> While the patient played the heroine and victim, the doctor in many stories was cast in the part of a God-like figure who took the patient to the brink of death only to snatch her back with a lifesaving dose of bone marrow.<sup>85</sup> The villain was not only breast cancer itself, but also the greedy insurance companies that refused to pay for the procedure.

<sup>80</sup> See, e.g., Diane Loupencancer, *Self-Transplants' Prolong Some Lives*, ATL. J. & CONST., Oct. 22, 1991, at A1; David Zinman, *Women Get Mad As Toll Mounts*, NEWSDAY, Oct. 24, 1991; *Marrow Transplant for Breast Cancer Shown to be Effective but Expensive*, HAMILTON SPECTATOR, Apr. 16, 1992, at D8.

<sup>81</sup> Stipp, *supra* note 79; see, e.g., Lisa Leff, *Md. Mother's Chance at Life Hinges on Trial: Patient Sues Insurer for Cancer Treatment Cost*, WASH. POST, Apr. 17, 1990, at B7.

<sup>82</sup> Stipp, *supra* note 79

<sup>83</sup> Rosenthal, *supra* note 73.

<sup>84</sup> See, e.g., Leff, *supra* note 81.

<sup>85</sup> See, e.g., Steve Berry, *Couple Fight Cancer with Surgery, Hope Kathi Lee Casey Learned a Week Before Her Wedding that She Was Gravely Ill*, ORLANDO SENTINEL, Feb. 16, 1992, at 1; Bob Hohler, *N.H. Woman to Fight Medicaid Policy*, BOSTON GLOBE, Mar. 16, 1992, at 13; Laura A. Kiernan, *N.H. Women Sue to Get Coverage of Cancer Treatment*, B. GLOBE, Oct. 6, 1991, at 31; James Quinn, *Supporters of Ill Woman Take Protest to Insurer; Warner Center: The Cancer Patient's Friends Demand that Health Net Cover a Bone Marrow Transplant. The Firm Calls it*

By 1994 nearly 200 stories a year on high-dose chemotherapy were appearing in magazines and newspapers around the country, the vast majority touching at least briefly on the treachery of insurers.<sup>86</sup>

As the issue of insurance companies refusing to pay for high-dose chemotherapy heated up, it too became politicized. Breast cancer advocacy groups took up the cause and pushed state legislatures to mandate coverage for the procedure.<sup>87</sup> This made the topic of high-dose chemotherapy even more appealing to reporters, especially medical reporters, who were always searching for ways to make their stories seem more like serious news worthy of front-page play. Now the story combined not only the pathos of young victims and the heroics of doctors, there was also a political controversy.<sup>88</sup>

The story became even more sensational when women took their insurers to court in an effort to force them to pay. Plaintiffs called on doctors to support their claims that high-dose chemotherapy was the only thing that could save them. Many physicians testified that high-dose chemotherapy is an effective cancer therapy, even though its effectiveness had not been proven scientifically.<sup>89</sup> But that fact was lost on most reporters, including medical reporters, who failed to grasp the difference between a randomized controlled trial (“RCT”), the gold standard of evidence in medicine, and the historical-control trials that were being used to justify the treatment. As a result, reporters rarely pointed out the lack of an RCT. Most of the reporters also failed to see the story behind the story, the fact that patients were now demanding high-dose chemotherapy in the absence of good evidence that it worked, and that hospitals and doctors were profiting handsomely from the procedure.

One reason these aspects of the story were missing was because those who wrote the human interest stories, which detailed the ordeal of high dose chemotherapy, often had no background in medicine. Most were writers from the newspapers’ lifestyle sec-

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*Experimental*, L.A. TIMES, June 20, 1992, at B7; Marc Shulgold, *A Chat with Judith Arron, Cancer Survivor*, ROCKY MTN. NEWS, Mar. 13, 1994, at 10M.

<sup>86</sup> See, e.g., Gina Kolata, *Study of Insurers Sees Decisions as “Arbitrary,”* N.Y. TIMES, Feb. 17, 1994, at A20; *Breast Cancer: a Taboo Transformed*, U.S. NEWS & WORLD REP., May 11, 1992, at 67.

<sup>87</sup> Kevin Fee, *No Place for Politics; Breast Cancer Treatment Debacle Shows What Happens When Politics Interferes with Science*, MOD. HEALTH, May 22, 2000, at 48.

<sup>88</sup> See, e.g., Peter Baker, *Virginia Breast Cancer Victim Beats System; Crusade Results in Law Requiring Insurers to Offer Special Coverage*, WASH. POST, Apr. 4, 1994, at A1.

<sup>89</sup> See Shannon Brownlee, *Bad Science and Breast Cancer*, DISCOVER MAG., Aug. 2002, at 75–77.

tions.<sup>90</sup> Other reporters who wrote about the insurance debate occurring in state legislatures saw only the political aspects, and simply repeated the unsubstantiated claims made by the treatment's proponents in medicine. For instance, in an article that appeared on May 6, 1990, *Boston Globe* reporter Brian McGrory wrote that insurers were refusing to pay for a treatment that "some doctors say represents [the] only hope against the fatal disease."<sup>91</sup>

One of the few reporters to recognize the real story was Robert Bazell, chief science correspondent for NBC.<sup>92</sup> Bazell became interested in the procedure in 1990 after a friend of his wife's died shortly after undergoing her transplant. With his curiosity piqued, Bazell began to search for answers by interviewing experts in the insurance industry.<sup>93</sup> Bazell wrote an article in the December 31, 1990, issue of *The New Republic* pointing out that the insurers might actually be right to question the use of high-dose chemotherapy.<sup>94</sup> He quoted Dr. I. Craig Henderson, one of the few oncologists willing to criticize the procedure, as saying the bone marrow transplant specialists who were treating breast cancer patients, "think they are performing miracles."<sup>95</sup> Bazell also wrote that high-dose chemotherapy was hugely profitable for doctors and hospitals, which charged insurers many times what the procedure cost.<sup>96</sup>

That story had little apparent effect on print reporters, and few newspaper stories picked up on Bazell's revelations. In any event, the few negative stories could not compete with the prevailing tide of optimism in the press, and as more stories appeared, more patients began to demand the treatment.<sup>97</sup> Stories about high-dose chemotherapy did not turn negative until 1999, when results from five prospective, randomized clinical trials were released at the an-

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<sup>90</sup> See Kiernan, *supra* note 85. Kiernan holds a Master of Studies in Law from Yale Law School and a Bachelor of Arts degree in politics from the Catholic University of America in Washington, D.C. She has covered the courts and the legal profession for many years. <http://www.courts.state.nh.us/press/kiernap.htm> (last visited Oct. 7, 2005).

<sup>91</sup> Brian McGrory, *Courts Overruling Insurers Reluctant to Cover Breast Cancer Therapy*, B. GLOBE, May 6, 1990, at 44.

<sup>92</sup> Robert Bazell, *Topic of Cancer*, NEW REPUBLIC, Dec. 31, 1990, at 9, 12.

<sup>93</sup> Interview with Robert Bazell, Chief Health and Science Correspondent for NBC News (Sept. 2004) (on file with author).

<sup>94</sup> See Bazell, *supra* note 92, at 9–12.

<sup>95</sup> *Id.* at 10.

<sup>96</sup> *Id.* at 12.

<sup>97</sup> Interview with Jeffrey Abrams, M.D., National Cancer Institute (Mar. 2001) (on file with author).



nual meeting of the American Society for Clinical Oncology.<sup>98</sup> Four of the five trials were negative; only a trial conducted in South Africa was positive.<sup>99</sup> That year, more than 300 stories about high-dose chemotherapy appeared in newspapers and on the wires—more than in any previous year.<sup>100</sup> Most were cautiously negative, reporting that the trials had shown no greater benefit than standard chemotherapy, but that the South African trial suggested there was still some uncertainty about the results.<sup>101</sup>

A year later, the South African study was shown to be fraudulent, and the media appeared more confident in its dismissal of the treatment.<sup>102</sup> Yet, despite their previous accolades for the treatment, there was virtually no acknowledgement by any reporters themselves that they had helped spread the gospel of high-dose chemotherapy. In a June 1999 story entitled *Shying Away from the Cutting Edge; Shortage of Patients in Clinical Trials Inhibits Cancer Research, Study Says*, *Washington Post* reporter Susan Okie bemoaned the fact that “no more than 5 percent of the nation’s adult cancer patients are enrolled in scientific studies that might lead to better treatments . . . .”<sup>103</sup> However, nowhere in the story did Okie suggest that glowing reports about new, unproven cancer therapies might contribute to patients’ reluctance to enter a trial where they could be randomized and subjected to the standard treatment.<sup>104</sup>

## B. Media Coverage and Legislative Mandates

One might dismiss the combined negative media coverage of managed care and positive coverage of HDC/ABMT were it not for the subsequent influence on public policy. At a minimum, this com-

<sup>98</sup> AMERICAN SOCIETY OF CLINICAL ONCOLOGY, *Patient Information—Mixed Results in High-Dose Chemotherapy/Bone Marrow Transplant Studies for Women With Breast Cancer*, <http://www.asco.org> (last visited Oct. 7, 2005).

<sup>99</sup> LexisNexis search for “1999.”

<sup>100</sup> *Id.*

<sup>101</sup> Scott Gottlieb, *Bone Marrow Transplants Do Not Help in Breast Cancer*, *W. J. MED.*, June 1, 1999, at 376; Lee Hopper, *High Doses of Chemo to Fight Breast Cancer Produce Mixed Results*, *HOUS. CHRON.*, May 18, 1999, at A2; Marilyn Marchione, *Cancer Check*, *MILWAUKEE J. SENTINEL*, Oct. 18, 1999, at 3.

<sup>102</sup> See, e.g., Henri E. Cauvin, *Cancer Researcher in South Africa Who Falsified Data Is Fired*, *N.Y. TIMES*, Mar. 11, 2000, at A16; Scott Gottlieb, *Breast Cancer Researcher Accused of Serious Scientific Misconduct*, *W.J. MED.*, Apr. 1, 2000, at 229; Delthia Ricks, *Report Plugs High-Dose Cancer Therapy*, *NEWSDAY*, Nov. 3, 2000, at A30.

<sup>103</sup> Susan Okie, *Shying Away from the Cutting Edge: Shortage of Patients in Clinical Trials Inhibits Cancer Research, Study Says*, *WASH. POST*, June 1, 1999, at Z7.

<sup>104</sup> See *id.*

bination had an effect on specific legislative debates over whether to mandate insurance coverage of HDC/ABMT, and may have contributed to individual litigation results.

During the 1990s, many states and the Federal Office of Personnel Management (OPM) debated whether to mandate insurance coverage of HDC/ABMT.<sup>105</sup> There is little doubt that the positive media attention to HDC/ABMT, along with the negative portrayal of health insurers, played a significant role in the outcomes.<sup>106</sup> As portrayed in the media, the basic story was deceptively simple: desperate patients with few, if any, realistic treatment options and little hope for a cure were posited against the evil, avaricious managed care industry.<sup>107</sup> This could be seen in Minnesota, where the debate over the legislative mandate cannot be untangled from the media attention to previous litigation to compel insurers to cover HDC/ABMT. Litigation preceding the Minnesota mandate debate garnered considerable media attention, which usually portrayed the “nasty” insurance industry denying women an opportunity for life-saving treatment.<sup>108</sup> In fact, critics accused the lead attorney in the Minnesota litigation of using the HDC/ABMT issue as a platform for seeking the governor’s office and of using the media to portray opponents as anti-woman.

One woman, denied participation in the clinical trial, became the “poster patient” in the legislative debate. She was the wife of the Speaker of the Minnesota House of Representatives. After she was diagnosed with high-risk (Stage II) breast cancer, her insurer determined that she was ineligible for the clinical trial and denied her coverage.<sup>109</sup> In a court trial that received considerable media atten-

<sup>105</sup> Stephen Barr, *House GOP Targets Federal Health Plan*, WASH. POST, Oct. 7, 1995, at A1; see also Matthew P. Schwartz, *FEHBP Expands Health Program of Federal Workers*, NAT’L UNDERWRITER LIFE & HEALTH—FIN. SERVS. EDITION, Sept. 26, 1990, at 26.

<sup>106</sup> RETTIG et al., *supra* note \*; see generally Doug Grow, *Breast Cancer Battle May Not Require Fight for Insurance*, MINNEAPOLIS STAR TRIB., Mar. 30, 1995, at 3B (showing an example of the media portraying insurance companies in a negative light). In this account, we will focus primarily on the Minnesota mandate rather than the OPM story. Both involve similar stories regarding the role of the media.

<sup>107</sup> See, e.g., Grow, *supra* note 106.

<sup>108</sup> Despite denying coverage, Minnesota health insurers agreed with the University of Minnesota and the Mayo Clinic, both major transplant centers, to participate in randomized clinical trials (a three-year timetable was anticipated) to determine the procedure’s effectiveness. Insurers covered the procedure for those enrolled in the trials, but refused to pay for off-trial use. Grow, *supra* note 106.

<sup>109</sup> Doug Grow, *Struggles Between Medicine and Money*, STAR TRIB., Feb. 3, 1993, at 1A. Although her survival was attributed to ABMT, the insurer denied coverage because she would have fared well under conventional therapy. Insurance industry respondents

tion, she sued the insurer and won.<sup>110</sup> As a teacher and wife of an elected representative, she was a very sympathetic media spokesperson. Her case stimulated substantial television coverage. In essence, she maintained that “I’d be dead” without the HDC/ABMT procedure, and it should be made available to those who could benefit. This coverage generated sufficient political momentum that made the mandate virtually unstoppable.<sup>111</sup>

Not surprisingly, there was little formal opposition once the proposal got to the floor of the entire legislature. Republicans viewed any act of opposition as a losing proposition. Several opponents in the legislature regarded opposition to the proposal as political suicide. A vote against the proposal would be seen as a vote in favor of the unpopular insurance industry. Subsequently, the Republican Governor, Arne Carlson, signed the legislation without voicing an opinion on it. Likewise, the Insurance Commissioner took no position on the legislation, even though the state insurance department did not require health plans to cover HDC/ABMT as there was no evidence of its effectiveness.<sup>112</sup>

Crucial to the outcome of most policy debates is how proponents and critics frame the issues. It might be reassuring to characterize the legislative debate as science versus a woman’s choice, which would at least suggest an important role for evidence in the proceedings. Instead, the Minnesota and OPM hearings framed the debate as a woman’s issue, primarily as a patient’s right to choose among various treatments recommended by her physician versus the evil, greedy insurance industry. This characterization put the insurance industry on the defensive from the outset. As one respondent noted, the debate “was positioned as these women will die. There is no other alternative.” Another characterized the story as one where “emotion overrode the science.”<sup>113</sup>

Proponents dominated the short debate in the Minnesota legislation, using two basic approaches. First, they argued that the patient should have a choice of treatments, conventional or HDC/

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thought she “was lucky to get through ABMT.” Indeed, these respondents considered it ethically wrong to place her in a clinical trial because her cancer was Stage II. Nonetheless, she had name recognition and was a highly effective spokesperson for the mandate effort. Author interviews (on file with the authors).

<sup>110</sup> Jim Parsons, *Phone Fiasco Surprising to Those Who Knew Welle as Ethical*, STAR TRIB., Mar. 23, 1993, at 9A.

<sup>111</sup> Grow, *supra* note 109, at 1A.

<sup>112</sup> Author interviews (on file with the authors).

<sup>113</sup> Author interviews (on file with the authors).

ABMT. Given their view that there was no hope without it, and as patients were likely to die anyway, it would be “mean” to disallow coverage of the treatment. Indeed, it would be unethical to do so. As one legislator put it, “Images of women were the debate.” Legislators were more interested in “looking out for the little guy” (as one mandate opponent stated) rather than waiting for the results of the clinical trials.<sup>114</sup>

Second, and equally important, mandate proponents consistently attacked the industry as “greedy and self-interested,” caring only about money. As some respondents graphically noted, “insurers sounded evil.” Patients were viewed as double victims—first by the disease and then by unsympathetic insurance companies. Proponents handily won the debate using this two-pronged approach. According to one legislator, “No one loses an election bashing insurance companies.”<sup>115</sup>

Faced with this, the insurance industry was unable to present its side of the story. Insurance industry respondents complained about inflammatory newspaper headlines and the media’s pro-patient bias. In part because it had already lost in court, the industry lacked credibility to oppose the mandate. To the public, the media portrayal featured a woman who had challenged the HDC/ABMT denial in court, had survived cancer, and therefore, was effective on camera. The complex nature of the insurance industry’s case made an alternative media strategy difficult to develop and present. As noted earlier, the litigation preceding the legislative debate was a significant factor shaping the legislative environment. That case garnered considerable media attention and portrayed the “nasty” insurance industry denying a woman an opportunity for life-saving treatment.<sup>116</sup>

Moreover, the insurance industry faced the reality of a two-pronged media attack. Both the print media and the local television stations reports were very favorable, if not predisposed, toward the women.<sup>117</sup> While not particularly surprising, the combination of pointed headlines followed up on the evening news with at least one very telegenic and sympathetic patient made any industry response seem defensive and grudging. The convergence of the print and television coverage therefore reinforced one another. Even if

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<sup>114</sup> Author interviews (on file with the authors).

<sup>115</sup> Author interviews (on file with the authors).

<sup>116</sup> Author interviews (on file with the authors).

<sup>117</sup> Author interviews (on file with the authors).

the insurance industry had been more successful in one venue, it still confronted hostile coverage from another source.

### C. Media Influence on Litigation

It is still unclear how media attention affects the outcomes of individual health care litigation. Intuitively, it seems that media attention should influence juror attitudes and behavior. That intuition would explain general business-sponsored advertising that informs citizens of the potential externalities (e.g., higher product costs) of large jury verdicts. It also explains specific advertising that influences the juror pool preceding product liability litigation.<sup>118</sup> Likewise, the American Bar Association took a preemptory strike against the media's influence on court cases with its Model Rules of Professional Conduct, developed in 1983.<sup>119</sup> Rule 3.6 deals solely with the media's influence on trials, including the rule that a lawyer may not make any public statements that are likely to influence the outcome of an adjudicative proceeding.<sup>120</sup> By regulating permissible attorney interaction with the media, the American Bar Association recognizes the enormous effect it can have on outcomes of individual cases.

In the HDC/ABMT fiasco, the press blasted insurers, filling newspapers with stories of gravely ill patients with no other options for treatment but the one being denied because it was "experimental."<sup>121</sup> These patients proceeded to take their insurance companies to court to sue for coverage of HDC/ABMT. Yet despite receiving negative coverage in the media for these denials, HMOs prevailed in many of the lawsuits brought regarding denials of HDC/ABMT for breast cancer.<sup>122</sup> The Sixth Circuit noted that "powerful evidence

<sup>118</sup> Authors' observations of local events. This would be consistent with what appears to be an increasingly blurred line between media-created perceptions and real life. Take, for instance, the recent reversal of a criminal conviction because an expert witness inaccurately relied on the defendant's viewing of two episodes of *Law and Order* to suggest that the defendant's actions were based on a belief that she could plead "not guilty by reason of insanity." See Edward Wyatt, *Even for an Expert, Blurred TV Images Became a False Reality*, N.Y. TIMES, Jan. 8, 2005, at B7.

<sup>119</sup> See MOD. R. PROF. CONDUCT (2002).

<sup>120</sup> See *id.* at R. 3.6.

<sup>121</sup> See, e.g., Seattle Times Staff; the AP, *Insurers Who Deny Coverage Can't be Sued – Woman Died While Waiting for Treatment*, SEATTLE TIMES, June 3, 1998, at B3; Evelyn Gilbert, *Striking Back at Empire*, THE VILLAGE VOICE, Mar. 18, 1997, at 44; Susan Brink, *The Cancer Wars at HMOs*, U.S. NEWS & WORLD REP., Feb. 5, 1996, at 69.

<sup>122</sup> See, e.g., *Peruzzi v. Summa Med. Plan*, 137 F.3d 431 (6th Cir. 1998); *Smith v. Office of Civilian Health & Med. Program of the Unif'd. Servs.*, 97 F.3d 950 (7th Cir., 1996); see generally RETTIG et al., *supra* note \*, for more details.

[exists] that HDC/ABMT remains experimental.”<sup>123</sup> At the same time, it seems naïve to assume that juror antipathy to managed care played no role in the few jury verdicts in HDC/ABMT cases.

The highly publicized case of *Fox v. HealthNet*<sup>124</sup> returned a jury verdict of \$89 million, including \$72 million in punitive damages for the plaintiff.<sup>125</sup> In *Fox*, the plaintiff’s deceased wife had been denied coverage for her breast cancer procedure.<sup>126</sup> Though only four cases proceeded to a verdict (most of the litigation was decided on motions to enjoin the insurer from denying coverage), there was considerable evidence of juror animus toward the health insurance industry and equally considerable juror sympathy for the plaintiff.<sup>127</sup>

The media’s focus on sympathetic plaintiffs had a secondary effect on insurance companies that reached much further than individual outlier cases. In 1996, the General Accounting Office/Health, Education, and Human Services Division spoke with twelve major insurance companies in the country, all of whom paid for HDC/ABMT, despite the fact that all twelve believed it was unproven and experimental.<sup>128</sup> Nine of the insurance companies considered the threat of litigation as a factor in their coverage decisions; indeed, six of the twelve had been sued for denying coverage.<sup>129</sup> According to one reviewer, the effect was that “[r]ather than bear the negative publicity, insurers often reluctantly pay for . . . experimental treatment.”<sup>130</sup> By reporting on individual cases or specific denials, the press undeniably influenced insurance company HDC/ABMT coverage decisions regardless of scientific effectiveness.

<sup>123</sup> *Smith*, 97 F.3d at 26.

<sup>124</sup> No. 219692, 1993 WL 794305 (Riverside County Sup. Ct./Central Cal. Dec. 23, 1993).

<sup>125</sup> See Mello & Brennan, *supra* note 8, at 101.

<sup>126</sup> David Leon Moore, *The \$89 Million Question: Ethics Pinched by the System, Lawyer Says*, USA TODAY, Jan. 22, 1996, at 1D.

<sup>127</sup> *Cf. id.* A defense attorney familiar with all four jury trials commented that juror attitudes changed between 1992 and 1994. As jurors became increasingly distrustful of arguments put forth by the managed care industry, they were increasingly more favorable towards the treating physicians. This attorney suggested that judicial sympathy might play a role in injunction hearings against denying the procedure. The least damaging mistake to make would be to err on the side of coverage and issue the injunction. Otherwise, the patient’s last chance is removed. Author interviews (on file with the authors).

<sup>128</sup> See, e.g., HEALTH, EDUC. & HUMAN SERVS. DIV., U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-96-83, HEALTH INSURANCE: COVERAGE OF AUTOLOGOUS BONE MARROW TRANSPLANTATION FOR BREAST CANCER 7 (1996).

<sup>129</sup> *Id.* at 9.

<sup>130</sup> See Natalie L. Regoli, *Insurance Roulette: The Experimental Treatment Exclusion & Desperate Patients*, 22 QUINNIPIAC L. REV. 697, 707 (2004).

In contrast to plaintiffs, the public had an unsympathetic view of managed care. In choosing between a dying patient and a bureaucratic enterprise, it is not surprising that sympathies lay entirely with patients. Plaintiffs' attorneys repeatedly complained that health insurers were arrogant and dismissive of the patients. Some defense counsel agreed. One said that cases were brought because patients got a bureaucratic run-around instead of an organization trying to work with the patient to obtain the best care. Better customer relations might have mitigated the urge to sue and the jury's reaction to the cases. In this view, managed care plans might have averted litigation by sharing information and including patients and their physicians in the decision-making process.<sup>131</sup> While it is difficult to quantify the effects of media coverage on juror attitudes and behavior, it is equally difficult to ignore the intuition that the media portrayals were reflected in the arguments presented at trial and in the ultimate disposition.

Likewise, it is hard to disentangle the effects of *Fox* and the attendant rise in anti-managed care sentiment. It may be that the attendant publicity surrounding *Fox* contributed to the managed care backlash.<sup>132</sup> *Fox* captured everyone's attention and has dominated the breast cancer litigation environment ever since. There is no evidence that *Fox* altered juror attitudes, but the decision and attendant publicity certainly reinforced the rising anti-managed care sentiment.

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<sup>131</sup> The respondent said that "Once the litigation started, plans retrenched and overreacted. They circled the wagons when attacked." A related problem was the process that insurers used to decide coverage requests. Aside from the inconsistencies in the *Fox* case, numerous respondents discussed the health plans' lack of attention to individual patients. Not only patients, but judges and jurors wanted to see individually handled cases. Jurors expected a deeper analysis of the individual case than insurers were providing. In those instances where the insurer lacked consistent processes for making individual clinical decisions, jurors punished them. From the insurers' point of view, however, individual decisions that were not standardized to conform to their medical policy raised the risk of liability from inconsistent decision making. To insurers, this was a doubled edge sword where they might be "damned if they do, damned if they don't." Author interviews (on file with the authors).

<sup>132</sup> See generally *The Managed Care Backlash*, 24 J. HEALTH POL., POL'Y & L. 873-1218 (1999), for a comprehensive discussion of the managed care backlash.

### III. ANALYSIS

#### A. The Role of the Media

The media played a critical role in promoting HDC/ABMT to breast cancer patients and persuading legislators to force insurers to pay for the procedure. Beginning with the first newspaper story about the experimental treatment, journalists told the HDC/ABMT story in heroic terms. Patients played the tragic victims, insurers and breast cancer the villains, and bold doctors the saviors. Reporters chose to write about the most tragic victims of all, young mothers with breast cancer. They were not intentionally promoting the treatment, but that was certainly the end result. The vast majority of articles that appeared in print about HDC and the dozens of television segments left readers and viewers with three principal conclusions. First, HDC made sense; if a little bit of chemotherapy could cure early cancers, then obviously higher doses were needed for more advanced cases. Second, HDC was an advanced breast cancer patient's only hope. And third, the only thing standing between a patient and the potential cure was money, which insurers did not want to spend.

There were, to be sure, exceptions. In 1993, *60 Minutes* ran a segment suggesting that HDC/ABMT was actually killing or disabling women, not curing them.<sup>133</sup> (This story was particularly unusual because the producer's wife died during her own HDC/ABMT treatment.) Even so, the critical stories that appeared before 1999, when the results of four randomized clinical trials showed that HDC was no better than standard dose chemotherapy, were too few and far between to erase the general impression that HDC/ABMT represented a major advance in the treatment of breast cancer.

Why did reporters get the story wrong? The question of why reporters failed to see the real story behind high-dose chemotherapy can be answered only by understanding the history of medical reporting and the relationship between the press and medicine, which have regularly colluded in the selling of unproven or dangerous treatments. Much of what passes as journalism in the field of medicine writing is more like hagiography, an exercise in hero-worship among reporters for the scientific and medical establishment. This adulation comes through clearly in a 1989 survey of science writers, conducted by the National Association of Science Writers,

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<sup>133</sup> *60 Minutes: The Most Promising Treatment? Is Bone Marrow Transplant Really the Answer to Curing Breast Cancer?* (CBS television broadcast) (Sept. 26, 1993).



in which one respondent commented that writing about science offered the privilege of sitting at the feet of the nation's greatest minds.<sup>134</sup>

Not surprisingly, most of the journalistic norms of skepticism and impartiality, of trusting neither side in a debate, have not been integral parts of medical writing. Many medical journalists would argue they could hardly be expected to have questioned HDC when the medical establishment, including prominent oncologists and bone marrow transplanters, were all telling them the treatment worked. But there were many dissenters, and many reporters dutifully represented their views in stories about the experimental nature of HDC treatment and its dangers. Even so, most stories left an overall impression that discounted the caveats of the very critics that reporters quoted.

There were other, more subtle reasons that reporters failed to get the story right, most of them having to do with the culture of journalism and changes in the wider society. Medical journalists (and their editors) are often in the thrall of both prominent doctors and new technologies. Dating well back into the twentieth century, reporters who covered medicine have seen themselves less as muckrakers than as “conduits” of hopeful news.<sup>135</sup> The media have traditionally embraced new treatments, especially when put forward by charismatic doctors holding prestigious positions in the medical establishment.<sup>136</sup> In the 1930s and 1940s, for instance, the *New York Times* and other newspapers fawned over Dr. Walter Freeman and his then seemingly miraculous new surgery, frontal lobotomy, with such glowing headlines as, “Surgeon’s knife restores sanity,” “Wizardry of surgery,” and “Brain surgery credited with cure.”<sup>137</sup>

This is understandable, to a degree; journalists must rely on “experts” in medicine, since they themselves generally lack medical training. The combination of an authoritative doctor or medical institution presenting a new—potentially lifesaving—treatment is almost irresistible to reporters. They proved unable to ignore the lure of experts touting high dose chemotherapy, accepting almost without question the opinion of institutions like the American Society

<sup>134</sup> National Association of Science Writers, 1989 survey of members, anonymous comment.

<sup>135</sup> See generally Mirriam Schuchman & Michael S. Wilkes, *Medical Scientists and Health News Reporting: A Case of Miscommunication*, 126 *ANNALS INTERNAL MED.* 976–82 (June 15, 1997); Jerome Aumente, *A Medical Breakthrough*, *AM. JOURNALISM REV.* (Dec. 1995).

<sup>136</sup> Author’s observations of colleagues and profession of 20 years.

<sup>137</sup> Quoted in ROBERT M. YOUNGSON & IAN SCHOTT, *MEDICAL BLUNDERS, AMAZING TRUE STORIES OF MAD, BAD AND DANGEROUS DOCTORS* (New York University Press 1996).

for Clinical Oncology and Duke University, as well as individual doctors.<sup>138</sup> When Elizabeth Rosenthal's story on high dose chemotherapy appeared, there was a lot of talk in the medical and science writing communities about being translators, or conduits of scientific information and medical information, and not much discussion of the equally important task of serving as critics of medicine.<sup>139</sup> This deference to medical authority was glaringly obvious in the stories that appeared after Dr. William Peters, in his 1994 article in the *New England Journal of Medicine*, which described insurers' HDC/ABMT coverage decisions as "arbitrary and capricious."<sup>140</sup> Stories in newspapers across the nation simply quoted Peters, some without even going to the insurers for comment. Only a handful of the few dozen stories pointed out the highly experimental nature of the treatment. Virtually none thought to wonder if the paper was at least a little self-serving. Peters was one of the principal proponents of the procedure, and Duke stood to make money whenever insurers agreed to pay for it.<sup>141</sup>

Reporters were also responding to wider changes in the perception of breast cancer and women's health. By the late 1980s, women were well established in the once all-male bastion of the newsroom, finding themselves for the first time in the position of being able to report and edit stories of their choosing. Women's health was a fresh and vitally interesting topic to both female reporters and readers. When insurers refused to pay for HDC, women reporters often saw their arguments that the treatment was too experimental as merely an excuse for not paying, and for ignoring

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<sup>138</sup> Authors' observations of local events.

<sup>139</sup> There still is. Many medical reporters continue to be more concerned with getting the facts of the science right than turning a skeptical eye toward medicine, and the pattern of trumpeting the newest treatment or technology continues. Today, the media are filled with uncritical stories about calcium screening to detect early heart disease, whole body CT scans, virtual colonoscopy, bone scans, and all manner of wonder drugs. See e.g., Tara Parker-Pope, *Five Tests Worth Paying For*, WALL ST. J., June 24, 2003, at D1; Leonard Jackson, *CT Scans to be Offered in Norman*, DAILY OKLAHOMAN, June 12, 2003, at 4; Karen Garloch, *What's Your 'Cardiac Score'?*, CHARLOTTE OBSERVER, Aug. 2, 2001, at 1E; Gina Kolata, *Hope in the Lab: a Special Report; A Cautious Awe Greets Drugs that Eradicate Tumors in Mice*, N.Y. TIMES, May 3, 1998, at A1.

<sup>140</sup> William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473, 476 (1994).

<sup>141</sup> See *id.* at 473; David Atkins et al., *Making Policy When the Evidence is in Dispute*, 24 HEALTH AFF. 102 (Jan. 2005).

women's health, which was already perceived as being sorely neglected by the National Institutes of Health and Congress.<sup>142</sup>

In the end, reporters found HDC stories compelling to write, and editors were willing to publish such stories, for the simple reason that hope sells. Indeed, the coverage of HDC serves as but one example of the flood of hope-filled stories about medicine that appeared in the second half of the 20th century, and no wonder: Truly miraculous medicine had been pouring out of laboratories and hospitals since shortly after World War II.<sup>143</sup> For the first time in human history, doctors could prevent childhood disease with vaccines, transplant organs, cure once-deadly infection, and even operate on a living heart. By the time HDC came along, medical reporters were accustomed to being the bearers of good news. Their employers knew from their sales figures that while readers were keenly interested in health information, they preferred stories that offered a sense of hope.<sup>144</sup>

Although there are many reasons for the media's failure to cast a critical eye over HDC, there are no easy remedies. The culture of medical reporting does not include the kind of skepticism that political reporters hold for politicians, or police reporters for law enforcement officials. There are few investigative reporters looking at medicine, and even fewer media outlets interested in publishing what they might find. As the media have grown increasingly dependent on advertising by drug companies, they appear to be increasingly reluctant to run stories that attack the pharmaceutical industry. The most effective remedy will be for journalism schools to start teaching a different kind of medical writing. Yet medical reporting classes still often emphasize the gathering of facts and the importance of getting the science right in medical stories, at the expense of critiquing the motives of their sources.<sup>145</sup> In the case of HDC, the accuracy of the facts should have been secondary to the

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<sup>142</sup> See Jane Gross, *Turning Disease Into Political Cause: First AIDS, and Now Breast Cancer*, N.Y. TIMES, Jan. 7, 1991, at A12.

<sup>143</sup> See PETER D. JACOBSON, *MEDICAL LIABILITY AND THE CULTURE OF TECHNOLOGY* (forthcoming 2005).

<sup>144</sup> See Shannon Brownlee, *Health, Hope and Hype: Why the Media Oversells Medical Breakthroughs*, WASH. POST, Aug. 3, 2003, at B01.

<sup>145</sup> See e.g., the syllabus for Medical Journalism JOMC 195, 2004, taught at the University of North Carolina, <http://www.unc.edu/%7Etrl/syllabi/195.html>; According to Melinda Voss, former executive director of the Association of Health Journalists, "Almost no program offers such journalistic fundamentals as how to interview health and medical researchers, or how to report medical research." *Nieman Reports: Reporting on Health*, THE NIEMAN FOUNDATION FOR JOURNALISM AT HARVARD (Spring 2003).

larger question of the lack of evidence in medicine, particularly when the treatment was so expensive and dangerous. While getting the science right is important, journalism schools should also be teaching students to question the motives of doctors and hospitals and to follow the money, as investigative reporters like to say. Young journalists should learn that medicine is not simply a long string of scientific breakthroughs and diseases vanquished, but a business, first and foremost, which is often only loosely based on scientific evidence. Like all businesses, medical practitioners have their own self-interests as well as the needs of patients in mind. Good reporters should always be aware of the motives of doctors and medical institutions. Most important, students of journalism should learn from the past. They should study the mistakes that have been made over the years in the coverage of new and seemingly promising treatments.

## B. Public Relations

No less than any other contestable public policy debate, science needs to be understandable to the public and to policymakers. Like anything else, science needs an effective public relations campaign to make its case. How to make it understandable, and, perhaps more importantly, who the messengers will be remain key questions. Although most of our respondents indicated that legislators' knowledge of science is generally low (i.e., limited understanding of statistical significance, ratios, etc.), some portrayed members of media in less than flattering terms as to how they mishandled the ABMT story. A common refrain was that the media looked for headlines—not for the value of the science.

In sum, the science was ignored, often by doctors and hospitals as much as by the media, legislatures, and the courts. But there should be no illusions about the difficulties of incorporating sound science into legislative decisions. A key lesson from the Minnesota experience is the importance of public relations. Opponents of similar mandates need to convince the public that the mandates can do more harm than good, both in terms of dollars spent on unproven medical care and on the adverse outcomes from unproven technologies. Images of women crying and publicly thanking their attorneys overwhelmed the insurance industry's story.<sup>146</sup> HDC/ABMT survivors were interviewed almost every day, shaping the media cover-

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<sup>146</sup> *Hard-won Cancer Care Paying Off for Family*, MILWAUKEE J. SENTINEL, July 21, 1997, at 1.

age in ways that mandate opponents could never match.<sup>147</sup> By contrast, making the scientific story understandable to non-scientists can be difficult, especially in the political arena. In addition, the media campaign needs to show why patients have a stake in cost containment. As it stands, it is doubtful that patients understand the tradeoffs required when certain benefits are mandated.

From the insurance industry's perspective, the Minnesota study suggests the need for two separate media strategies—one for the print journalists and another for television.<sup>148</sup> Given the synergies between the two media in covering the HDC/ABMT debate, developing a set of materials for print journalism may be necessary but not sufficient. For journalists, the industry can develop a set of materials that allow its story to be heard. But without a corresponding television strategy, it may be difficult to overcome the reinforcing effects of print and television coverage.<sup>149</sup>

Although the insurance industry is on the defensive because of the selective reporting of managed care, it is also fully capable of using the media to manipulate public opinion. One way to engage in this manipulation is to place advertisements that shape public policy. Another is to engage the public forthrightly in a discussion of the need for limits. The latter might offer a two-fold advantage. First, it could provide cover for legislators to rely on the market instead of the regulatory process to respond to public opinion. Second, it could reduce juror antipathy to managed care in individual cases. Yet neither strategy has been successful in changing the insurance industry's public image as an arrogant institution disinter-

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<sup>147</sup> Judith Yates Borger, *Issues of Life, Death and Dollars Circle Bill on Controversial Cancer Treatment*, ST. PAUL PIONEER PRESS, May 2, 1995, at 1A.

<sup>148</sup> See *infra* Section II, at 245.

<sup>149</sup> Ironically, some of the current pharmaceutical industry ads may well have the effect of stimulating the use of unproven therapies. Ads showing the latest pharmaceutical successes and breakthroughs (such as anti-anxiety medications, arthritis drugs, and chemotherapeutic agents) may make it difficult to convince the public that treatments such as HDC/ABMT, which can easily be characterized as the next breakthrough, should not be used without clinical trials. *E.g.*, Novartis ads that ran in various publications in 2003 boasting its cancer drug, Gleevec. One ad showed an actual cancer patient above the line, "Stunning Success. Deadly cancer at 23. Complete remission at 24." Merck's arthritis medication Vioxx, which it withdrew from the market in the fall of 2004 because the drug doubled the risk of heart attack and stroke, was often advertised with a photo of Olympic gold medalist Dorothy Hamill, ice skating.

ested in responding to legitimate patient and physician grievances.<sup>150</sup>

A major reason for failing to turn the tide of public opinion against the insurance industry is that there is a credibility gap in terms of the messenger. While not referring directly to the science, it is important to consider that the messengers of the HDC/ABMT scientific arguments were not very effective in disentangling the science from the insurers' economic interests. Perhaps more importantly, the messengers were mostly men. On a distinctly women's issue, guys in suits do not make the strongest witnesses. One male witness indicated that he was seen by the legislature as "cold." If insurers are unable to generate some visible support from women, it will be difficult to prevail in similar battles.

### C. Technology Assessment as an Antidote to Adverse Media Coverage

For those interested in technology assessment as a way to inform the legislative and policymaking process, the results from the Minnesota and the federal Office of Personnel Management (OPM) experiences are not terribly reassuring. Under previous legislation, Minnesota established the Health Technology Advisory Committee (HTAC) to provide advice to the legislature on the costs and benefits of controversial health care technology use.<sup>151</sup> But HTAC's work was to be advisory only—nothing bound the legislature to heed its findings (and it has now been disbanded).<sup>152</sup> Indeed, it does not appear that the legislature actively supported the effort generally. With regard to HDC/ABMT, HTAC's assessment that additional clinical trials were needed apparently played no role, and was not used as an information during the mandate debate.<sup>153</sup>

There are several possible reasons why the HTAC effort failed. By most accounts, the legislature was too overwhelmed with infor-

<sup>150</sup> JACOBSON, *STRANGERS*, *supra* note 1, at 264–65 (arguing that the insurance industry's refusal to stand behind its own quality of care claims indicates, at best, an indifference to public concerns).

<sup>151</sup> See Health Technology Advisory Committee, Minnesota Dep't of Health, <http://www.health.state.mn.us/htac/> (last visited Oct. 7, 2005).

<sup>152</sup> See *id.*

<sup>153</sup> The Technology Assessment Committee of the Institute for Clinical Systems Improvement, a Minnesota organization composed of various medical groups in the state, also concluded that HDC/ABMT was experimental and should not be mandated. But the legislature expressed no interest in working with ICSI, so the report was never conveyed to the legislature.

mation to listen to the HTAC.<sup>154</sup> Also, the full report was not available for the actual debate, but was issued after the mandate was enacted. In any event, the report made no explicit recommendations. It would be very difficult for a legislator to use the report effectively to oppose the mandate. Perhaps most importantly, there is no link between HTAC's findings and decisions. In litigation, an HTAC report could be introduced as one piece of evidence, but it alone would not be binding. Absent some mechanism forcing the legislature to take an HTAC report into account, the emotional nature of this particular legislative debate virtually ensured that the report would be ignored.<sup>155</sup> A final problem was that the referral process from HTAC to the legislature would have required an extra session before voting on the legislation, a delay the leadership was unwilling to consider.

HTAC reports were not usually accessible to laypersons, substantially limiting their effectiveness. Beyond that, there was apparently no mechanism to bind the legislature to HTAC findings. Even if there were such a mechanism, however, the HDC/ABMT HTAC report made no conclusive finding or recommendation. To expect legislators to plow through often dense scientific language without at least some guidance and recommendations is unrealistic.

A technology assessment process focused on a rigorous cost-benefit or cost-effectiveness analysis, as opposed to specific scientific recommendations, might help shape the debate. To the extent that the costs of health care may begin to play a more dominant role in state legislative debates, rigorous technology assessments will be integral to the legislative process.<sup>156</sup> One possibility for future consideration is to model the technology assessment process along the lines of how Congress now votes on military base closing recommendations.<sup>157</sup> After being unable to agree on any base closing recommendations, Congress established a commission to decide which bases should be closed. Once the commission makes its report,

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<sup>154</sup> Author interviews (on file with the authors).

<sup>155</sup> More than one observer noted that HTAC was set up as something of a consolation prize to Republicans and business interests when Democrats controlled both houses of the state government. Author interviews (on file with the authors).

<sup>156</sup> The Minnesota Insurance Commissioner has recommended that an independent panel should conduct a cost-benefit analysis before the legislature enacts any new mandates. Author interviews (on file with the authors). However, the legislature did not adopt this approach.

<sup>157</sup> One respondent suggested that a Medicare coverage analogy might be useful. But the respondent was doubtful, stating that the closer one gets to the political system, the likelihood is that the procedure will be covered.

Congress has two choices: an up or down vote.<sup>158</sup> No amendments are permitted.<sup>159</sup> The same might be tried for technology assessment. In this case, for example, HTAC might have recommended that the science did not support a mandate. The debate would then have been more focused on the science and less on anecdotal information. Nonetheless, it seems unlikely that HTAC's recommendation would have been adopted. But the nature of the debate might have been at least more illuminating and might have forced the legislature to deal with the scientific issues.

Two other observations from the Minnesota debate clarify the problems faced in relying on some technology assessment process. First, technology assessment is useful for determining whether to cover the technology, but is less useful for determining whether to give a particular patient access to the technology.<sup>160</sup> Second, technology assessment will probably not have clear answers for most controversial technologies absent rigorous clinical trials. The situation where procedures clearly work or do not work are likely to be the exceptions. Most high profile issues, such as the efficacy of prostate-specific antigen (PSA) tests for men and mammography screens for women under age 50, are likely to be in an ambiguous category, dominated by conflicting opinions.

## CONCLUSION

The media's influence on health policy seems clear, and may affect outcomes of individual litigation cases as well. Media scrutiny of health insurance is an omnipresent reality that insurers must consider in grappling with difficult coverage decisions. As the HDC/ABMT case study suggests, the media scrutiny has been harsh and unrelenting, but facilitated by the industry's inability to develop an effective counter-strategy. If past is prologue, more contentious insurance coverage decisions are sure to follow, including coverage for spiral CT scans screening for lung cancer, bariatric surgery (for obese patients), and any number of expensive "wonder" drugs.

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<sup>158</sup> See John J. Monahan, *Mitt, Ted Work Together to Save Mass. Bases*, WORCESTER TELEGRAM & GAZETTE, Mar. 3, 2005, at 2.

<sup>159</sup> *Id.*

<sup>160</sup> This respondent also argued that the world of making coverage decisions for purposes of reimbursement is much different than making decisions for a real patient. In real world decision-making, physicians are more likely to take risks.



Even if insurers deserve much of the adverse attention their decision-making processes have generated, it is critical to remember that they are not always wrong. More importantly, perhaps, poor execution of these decisions should not be viewed as acting with malevolent motives. The correct decision is not always obvious. Without doubt, insurers' decision-making processes should be more transparent. Indeed, Jacobson has argued previously that the lack of transparency is a major cause of the health insurance industry's poor public image. To reverse this image, the industry would do well to adopt the law's emphasis on open and transparent processes.

But the insurance industry is not the only institution that needs to reconsider its actions. The media have a responsibility to improve their medical reporting of new and exciting technologies and procedures. Americans demand the latest and greatest technology, seemingly unconcerned with the potential costs and consequences of reflexively adopting new technologies. It is incumbent on the media to restrain its initial enthusiasm for the latest discovery and to report on the potential limitations and side-effects. In the meantime, we need improved social mechanisms, such as technology assessment, to constrain the reflexive adoption by the medical community of novel technologies and procedures until their scientific efficacy has been proven.<sup>161</sup> Above all, we need a public dialogue over limits to health care interventions and a more realistic understanding of the costs and achievements of medical science.

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<sup>161</sup> See PETER D. JACOBSON, *MEDICAL LIABILITY AND THE CULTURE OF TECHNOLOGY* (forthcoming 2005).

