

BIOGRAPHICAL SKETCH**BARBARA GARVEY**

[Click here to read Senator Durbin's \(D-IL\) floor statement](#)



In May of 1994, Barbara Garvey and two of her girlfriends went to Hawaii on the vacation of a lifetime. Only a few hours after landing on the island she discovered large bruises on her body and immediately went to a local clinic for blood tests. The clinic transferred her to the oncology department of a hospital in Hawaii. She was diagnosed with 'aplastic anemia' and was transferred to the bone marrow unit. The doctor in Hawaii started a medical treatment plan and said a bone marrow transplant would likely be necessary.

After a few days of treatment, the Garvey's HMO decided Barbara would have to return to a hospital in Chicago for continued care and possible transplant. But the doctor in Hawaii said Barbara was not stable and should not be moved in her condition. The Garveys learned later that the first HMO doctor assigned to her case in Chicago spoke to the doctor in Hawaii and agreed that Barbara should not be moved in her condition. That doctor was removed from the case that same day and another doctor in the HMO said Barbara should be returned to Chicago. He never examined her or talked to the attending doctor in Hawaii.

Despite her Hawaiian doctor's recommendation that she not be moved, the HMO continued to refuse to keep Barbara in Hawaii for the medical treatment and/or bone marrow transplant. Her husband, David, was asked to call the HMO and try to get approval for treatment in Hawaii. He called and spoke with a nurse in the HMO's Utilization Review department who told him, after checking with her Supervisor, that Barbara had to be brought back to Chicago. If not, it would be considered a refusal of services and they would not cover Barbara's medical expenses, which were quickly adding up. Mr. Garvey was also told to put Barbara on a regularly scheduled commercial flight and send her back at personal expense. When asked if at least the HMO would pay for a private air ambulance ("medivac") the answer was "NO."

Barbara's condition left her with a weakened immune system and the inability to clot if she were to bleed. The commercial flight from Hawaii exposed her to all of the impurities of recirculated air, and to pressure changes. These may be harmless to healthy people, but proved to be deadly for Barbara.

Sometime between leaving Hawaii and returning to Chicago, she suffered a stroke (from bleeding in the brain), and a couple of days later she was diagnosed with a fungal infection. She died nine days after returning to Chicago.

Barbara Garvey was 55 years old. Along with her husband of nearly 35 years, she left seven children. She had six grandchildren at the time of her death; three more have been born in the four years since her death.

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PATIENTS' BILL OF RIGHTS (Senate - June 17, 1998)

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Mr. ROCKEFELLER. Mr. President, I have come to the Senate floor to talk about, as others have, something of fundamental importance to the people that I represent in my State of West Virginia, and that is equal treatment for all Americans with respect to health care. I am not just talking about Congressmen, and I am not just talking about coal miners or CEOs or custodians, I am talking about all Americans and all the time.

I want to talk about what I think is an urgent need here in Congress to pass legislation on the quality of health care, and that this legislation should apply to every single American. When enough of us recognize these needs, I am convinced we are going to enact legislation, and it is going to be called patient protection. It may have some other name. It may be modified, it may be expanded, who knows? But the need for it is undeniable, and it has to happen. Every single day that passes without the enactment of some kind of patient protection legislation is another day that millions of Americans, thousands of people I represent in West Virginia, are subject to the denial of needed treatments by insurance companies who are looking out for their bottom lines.

Every single day that we as a Congress fail to act on the Patients' Bill of Rights Act, if we want to call it that, is another day that Americans are left vulnerable to health care decisions made by people who are not doctors--in fact, doctors complain about this all the time--but who are, in fact, business professionals. Every day that we do not act, Americans are refused the specialty treatment they need and deserve. I am going to give two examples of this which I think are scary, and

which are very real. Make no mistake, if we do not respond and if we do not respond forcefully, more Americans are going to lose confidence in our health care system.

It is interesting to me, having observed health care now for quite a number of years, that it used to be it was only patients, or only consumers of health care who were worried about the cost of health care, the quality of health care, the problems of health care, the paperwork of health care. Now, the people who really are coming on board in this angst are physicians themselves and nurses and people who work in hospitals who have to deal with the realities of what the health care system has become in this country.

West Virginia is no exception. West Virginia may have some more problems than some other States, but we are no exception with regard to the need for patient protection. I constantly run into West Virginians when I am at home who complain to me--not at my invitation, but at theirs--about being denied the treatment they felt they were promised, or that they knew they were promised from plans, health care plans where they thought their premiums entitled them to something called quality health care and fair treatment.

One complaint I hear all too often is being denied specialty care. That is a very big deal. General practitioners can take care of a lot of problems, but sometimes you come to a point where you have to have more. Under most managed care plans, a patient's primary care physician may in fact refer, as the gatekeeper or whatever, a patient to a specialist, if the primary care physician determines that specialty care is necessary. That makes a lot of sense to me. Primary care physicians are in a very good position to

do that. That is a professional decision involving going to another professional. However, things may change if the specialist is not on the list often called the plan's network.

Let me explain. Suddenly, someone then comes from the administrative office, or from some other division, and may take over. Suddenly, the patient who, along with the primary care physician, is anxious for that patient to see a specialist because of some health problem, finds out that the executives, not the physician, but the executives in charge of the managed care plan, people who are not doctors, not medical providers, reserve the right to refuse payment for the specialist recommended by his or her original doctor. In fact, this is a frequent occurrence for people who have insurance companies that push their employees to steer patients to only the physicians listed within their plan.

That is not the way it is meant to work. Insurance companies do not always make the best medical choices because they are not trained in that business. They are trained in a different business. Too often motivated by their bottom line, which is understandable, and not often enough motivated by the patient's health care needs, many specialty referrals are refused. Now, I go to my examples and I hope my colleagues will listen.

I think of a little 6-year-old boy from West Virginia who became seriously ill. Concerned, his mother rushed him to the doctor's office, his doctor's office, in fact, where he was quickly diagnosed with diabetes. His primary care physician referred him to an out-of-plan pediatric endocrinologist; a specialist in childhood diseases, that is. That was the referral, to a specialist in childhood diseases. The specialist

placed this young child on insulin to control his condition. But when the child's primary care doctor referred him back to the specialist for a follow-up visit--which makes a lot of sense--the referral was denied, stating, '* * * service available with in-plan endocrinologist.'

That doesn't sound so bad, does it? In other words, go to the in-house, in-plan endocrinologist. So while it sounds like the child could get the care that was needed from the in-plan physician, the reality is that he could not get that health care for a very subtle but basic reason. The in-plan specialist was an adult endocrinologist, not a child endocrinologist, specializing in adult diabetes. But diabetes is not the same in children and adults, and there are different specialties for adults and for children in that field. The treatment is different. There is serious risks of developing future health problems when the childhood diabetes is not dealt with properly by a proper physician. The insurance company in this case was gambling, in effect risking this child's future health for the few dollars they saved by saying: Oh, you have to go to an in-plan doctor.

As bad as that case is--and I wish it were the only one, but it is not--I was recently told the story of a 14-day-old baby girl. Mr. President, 14 days old, this precious little child's health was already jeopardized by her health plan. What do I mean by that? This poor child was brought to her doctor 14 days after birth because of a urinary tract infection. Treatment of a urinary tract infection at that age requires an evaluation for urinary tract abnormalities. But the referral from the pediatrician to an out-of-plan specialist was denied, again saying services are available in-plan, an in-plan urologist. OK, if she could get the right treatment in-plan, that is what HMOs are for; right?

But she could not. She could not get the help because the urologist the plan would have had her see was, once again, an adult urologist. Am I picking here? Am I just being petty? No. The problem lies in discovering and treating urinary tract abnormalities which is vital to preventing serious and permanent kidney damage, and the appropriate specialist for such a situation is a pediatric urologist.

I have working in my office, thanks to the Robert Wood Johnson Foundation, a pediatric cardiologist. A pediatric cardiologist is different from an adult cardiologist. In other words, an adult and child are different and they require different specialists with different skills. It is a basic and important fact. Simply to say you have a urologist in-house is not to say that if that urologist deals with adult urology problems, that it is sufficient for a 14-day-old baby girl.

This decision by the HMO was based on having an adult urologist, which urologist did not have speciality training in pediatric disorders and, therefore, was not capable of caring sufficiently for an infant. Why? Because keeping her within the plan's network of doctors costs less.

This could work if they got their co before referring these there was no in plan physician

I understand business, and business is important, but this business of quality of health care treatment is very serious and very scary, and that is what we have to focus on when we are thinking about what we are going to do. These are our children, the most helpless and vulnerable of all of American citizens. They have no way of defending themselves. They depend on their parents, they depend on their communities to take care of them, and these people, in turn, depend on us in Congress to ensure that they are not taken advantage of, that games are not played with their health and the health of their children.

The time has come for us to pass a bill which guarantees certain commonsense protections for every single patient in America, young or old, rich or poor. This legislation--which we have the opportunity to pass, an obligation, I think, to enact this year, the Patients' Bill of Rights Act of 1998--will do exactly that.

I am interested in good health care for our people, Mr. President. I don't think it is a game, and I don't think it has anything to do with politics. I think it is a very, very serious consideration.

I thank the Presiding Officer and yield the floor.

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Mr. FORD addressed the Chair.

The PRESIDING OFFICER (Mr. Sessions). The Senator from Kentucky.

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Senator Jack Reed's Managed Care Floor Speech

May 6, 1998

MORGAN SMITH

Mr. President, children should not be left out of the health care quality debate. Children, like all Americans, deserve common sense consumer protections for their health insurance.

Managed care plays a valid role in our health care system, but all too often these days we hear a story about a child whose unique health care needs have not been met.

I would like to tell you about one such child. Morgan Smith was born in Rhode Island in November of 1993. Shortly after her fourth birthday, this past December, she was diagnosed with Rhabdomyosarcoma, a cancer that attacks any smooth muscle in the body, including blood vessels. Morgan's cancer developed in her brain, leaving her with a life-threatening brain tumor.

The people of Rhode Island are fortunate. We have a top rate children's hospital in our state. And the pediatric oncologists at Hasbro Childrens Hospital in Providence told Morgan's mother that she needed to take her daughter for a special chemotherapy treatment at New England Regional Medical Center in Boston. They directed her to that hospital because HASBRO did not have the expertise to treat her daughter.

At that point, her insurance company denied payment and asked that she get a second opinion. The second opinion said the same thing -- that Morgan needed the expertise of physicians in Boston. However, the HMO still refused to pay for the treatment necessary for her 4 year old daughter.

Ultimately, Mrs. Smith had to wage her own battle against the HMO, starting a letter writing campaign along with Morgan's doctors. I believe that the last thing the mother of a child with a life threatening illness has the time and energy to do is fight an HMO.

Meanwhile, Mrs. Smith took Morgan to Boston for the treatments, unsure how she was paying for it, but knowing that she couldn't afford to risk Morgan's health while she fought with the insurance companies.

Fortunately, this story has a happy ending. Close to a month after Morgan had started her treatment, the insurance company finally agreed to cover the procedure that all the medical professionals agreed was necessary.

Mr. President, we hear stories like this all too often. And when it comes to our children, we should not take risks.

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BIOGRAPHICAL SKETCH

JAMES ADAMS



[Click here to read Senator Cleland's \(D-GA\) floor statement](#)

James Adams is now 5 years old. But because of his parents HMO's rules, what happened to him in March of 1993, when he was only 6 months has changed his life forever.

James was suffering from a 105 degree fever. His mother took him to his HMO plan pediatrician, who diagnosed only a respiratory ailment and post-nasal drip. He prescribed only saline drops, vapriizer use, and Tylenol. James' mother was told not to worry, that high fevers in young children do not necessarily mean serious illness.

Later that night, his temperature was still rising and he was in great discomfort. James' worried mother called her HMO directly. The nurse on duty recommended bathing James in cold water. A pediatrician then placed a follow-up call, advising the parents to bring James to an HMO participating hospital -- 42 miles away.

On the way to the hospital, James suffered full cardiac and respiratory arrest, and lost consciousness. His parents couldn't wait to get him to the HMO hospital -- James needed care immediately. James' parents pulled into the closest hospital they could find -- 6 miles from their target destination. Upon his arrival at that hospital, doctors were able to return his pulse and breathing. But the circulation to his hands and feet was cut off, and never returned.

James suffered irreparable damage to his extremities. Both his hands and feet had to be amputated. The delay of care caused by driving almost an hour to an affiliated hospital had taken its toll.

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PATIENTS' BILL OF RIGHTS (Senate - June 02, 1998)

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Mr. KENNEDY. Mr. President, we are now in what should be one of our most productive and thoughtful legislative periods this year. Many important items are pending before the Senate, and there is no reason to believe that we cannot successfully address each of them. We must act to protect the nation's children from tobacco, and we must move forward on appropriations and authorization bills. But, there are many other important measures waiting to be brought to the floor. Patients across the country are urging Congress to enact the 'Patients' Bill of Rights.' I would like to take this opportunity to share with members of the Senate another tragic story that demonstrates the need for action.

This is a story about Mrs. Peggy Earhart of Sun Valley, California. At the age of 63, she was being treated by her HMO for arthritis. Her treatment required her to visit her doctor every six to eight weeks for cortisone injections. During a period of treatment, she noticed a mole on her ankle. She brought this mole to her doctors' attention, but her doctor reassured her that it looked fine and she need not worry about it.

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Initially, she trusted her doctor's judgment. As the mole changed shape and color, she brought these changes to the attention of her doctor, who looked at the mole again and assured Mrs. Earhart that it was fine. On the next visit, Mrs. Earhart once again pointed out changes in size and color, and again, the doctor did nothing.

Worried and exasperated, Mrs. Earhart requested a change of doctor. She filled out the necessary paperwork and waited--and waited, and waited. Six months later, the HMO finally responded, permitting her to see another physician. The first time she saw the new doctor, he examined the mole and immediately referred her to a dermatologist. The dermatologist took a biopsy and found that the 'mole' was in fact a malignant melanoma.

Further tests were ordered, which showed that the cancer had metastasized. It was then too late to treat Mrs. Earhart, and she died a year later.

As this tragic story shows, the heart of the issue is providing patients with access to needed health care--a guarantee that patients shall receive the care they paid for with their hard-earned premiums.

In talking about the rights of patients, it is no answer to simply say 'Let the Patient Beware.' Purchasing health insurance is not like buying a car, and it never will be.

Patients deserve to know that, if they notice something wrong and report it to their doctor, their health needs will be met. Mrs. Earhart should have been treated by the appropriate specialist, without the long delay that ultimately cost her life.

Mrs. Earhart should have had access to an appropriate review procedure that would have allowed her to seek outside help in time. Her family should have been able to hold the health plan accountable for its actions, and for the inexcusable delay that took her life.

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 Q&A: Battling With Your HMO

MANAGED CARE JULY 13, 1998 VOL. 152 NO. 2

Sol Feldman, 81

THE SITUATION After his HMO was sold, Feldman had to replace his regular hypertension drug with a lower-cost one

THE RESPONSE Within days his blood pressure skyrocketed. He switched to an HMO that covered his drug, but then the new plan changed its coverage too

THE OUTCOME Feldman, unable to pay for the drug, went on TV. Finally, a local physician gave him the drug free

Matthew Cerniglia, 13

THE SITUATION Standard chemotherapy didn't help cancer patient Matthew, pictured here in a black cap with his family. His doctors decided to try advanced treatment with a bone-marrow transplant

THE RESPONSE His HMO said the procedure was not a "medical necessity"

THE OUTCOME Matthew's father Raymond is trying to pay for the bone-marrow transplant himself. Bills to date: \$100,000

David Garvey, 59

THE SITUATION While vacationing in Hawaii, his wife Barbara, 55, was found to have aplastic anemia

THE RESPONSE Her HMO would not pay for a bone-marrow transplant in Hawaii and insisted she return to Chicago for treatment

THE OUTCOME Garvey flew his wife back at his own expense,

While Viagra provided a spark, the embers of discontent have been smoldering for some time. Back in 1993, when Hillary Clinton proposed her grandiose plan for curbing rising health-care costs and covering the uninsured, the American people made it clear that they didn't want the Clintons or anyone else in government telling them which doctors they could choose or what pills they could take. What most folks didn't realize was that if government didn't do it, somebody else would. That somebody turned out to be America's employers, working hand-in-glove with the insurance companies. Today 85% of all insured employees--up from 53% five years ago--have moved out of traditional fee-for-service plans, in which doctors call the shots and insurance companies pay the bills, and into managed-care plans, including health-maintenance organizations, or HMOs. Almost every aspect of medical care provided by HMOs is second guessed--not by the government, not by Hillary, not even by doctors, but by the bean counters.

Now, like battle-scarred veterans back from the medevac front, patients are sharing their war stories on TV, in letters to Congress, in chat rooms and home pages on the Internet. When Helen Hunt ranted against the heartless HMO that was making life difficult for her and her asthmatic son in the movie *As Good as It Gets*, audiences cheered so lustily that the health industry's professional association felt compelled to launch a counterattack. It produced an ad for viewing in movie theaters that claimed Hunt's fictional son would have fared better in an HMO than in a

his wife back at his own expense, and at some point during the flight, he says, she had a stroke. Nine days later she was dead

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David Pollard, 65

■ **THE SITUATION** Crippled by nausea and chest pains, Pollard called his HMO, which, after a day's delay, finally sent him to the emergency room

■ **THE RESPONSE** The HMO's doctors told him he had a bad case of indigestion

■ **THE OUTCOME** Two days later, Pollard was rushed to another hospital, barely able to breathe. Doctors there made the correct diagnosis: he had suffered a heart attack

Jim Hutchison, 55

■ **THE SITUATION** A minister who needed prostate surgery, Hutchison had a history of bad reactions to anesthesia

■ **THE RESPONSE** His health plan required admission to the hospital the same day as surgery, and in the rush Hutchison never had a chance to tell his anesthesiologist

■ **THE OUTCOME** The wrong anesthetic was administered, and his blood pressure dropped to dangerously low levels

Mary Betts-DuMonte, 49

■ **THE SITUATION** A car accident left Betts-DuMonte with severe neck pains and numbness in her hands and arms

■ **THE RESPONSE** Doctors at her HMO hospital treated her bruises but never, she says, X-rayed her or gave her an MRI

■ **THE OUTCOME** After two months, Betts-DuMonte finally got her MRI, which revealed several broken bones in her spine and ribs that had healed improperly

traditional health plan; the screenwriters "got the facts all wrong." The multiplexes, knowing where their customers' sympathies lay, didn't want to show it.

The truth is, Americans are probably as healthy today as they ever were, and are paying less for their health coverage. Thanks at least in part to managed care, vaccination rates are up, premature births are down, more women are getting mammograms than ever before and costs have fallen dramatically. Managed care saved between \$150 billion and \$250 billion last year alone out of total U.S. health-care spending of \$1 trillion. If things are really as bad as Hollywood and Washington say, the plan administrators wonder, why do more than three-quarters of their members say they are satisfied with their health care?

Good question. A TIME/CNN poll of 1,024 Americans conducted last week suggests that the country is of two minds about health reform. Although 85% responded that they were "very satisfied" or at least "fairly satisfied" with the quality of medical care they receive, 68% said they think traditional fee-for-service plans provide better health care than HMOs, and only 41% of those covered by managed care said they were "very confident" that their plan would pay for their treatment if they got really sick.

Getting really sick is what worries most Americans. They know how hard it can be to cut through the managed-care red tape for a pair of eyeglasses or a simple ear infection. What would happen, they wonder, if they or one of their loved ones became desperately ill and needed serious--and expensive--medical attention? Who would prevail if their medical needs ran smack into gate-keepers of an HMO focused primarily on reducing costs? The horror stories coming back from the front lines are not encouraging. A sampling:

■ When Raymond Cerniglia's 13-year-old son Matthew developed a rare and aggressive cancer, doctors gave him a 20% chance to live and started an

11-month course of chemotherapy. Cerniglia's HMO paid the bills at first. But when things took a turn for the worse and doctors ordered a bone-marrow transplant, the health plan refused to cover it. The new treatment, the administrators said, wasn't a "medical necessity," nor was it on their list of covered therapies. Despite a letter from an expert at the National Institutes of Health testifying that this was Matthew's best chance at life, the HMO would not budge. Today Cerniglia, a computer technician in McLean, Va., is trying to scrape together enough money to pay for the procedure himself. His son's bills already total \$100,000.

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■ Mary Halm, 38, of Chillicothe, Ohio, developed a severe case of endometriosis, in which extraneous uterine tissue permeated her abdomen and left her writhing in pain. Several operations paid for by her HMO failed to remove all the offending tissue. Then her primary-care physician told Halm about a specialist in Atlanta who had developed a novel technique for treating the disease. The HMO refused to refer her, saying there were plenty of specialists in Ohio who could care for her. (Name one, she said. They wouldn't.) Halm appealed the decision for nine months with no response. Finally, no longer able to bear the pain, she borrowed \$10,000 and paid for the procedure herself. The operation was a success, and the pain disappeared. But because she had taken matters into her own hands, the HMO won't reimburse her.

■ In 1994 Barbara Garvey, then 55, boarded a flight from Chicago to Honolulu. Once she arrived, Garvey noticed her body was severely bruised. A trip to the hospital produced a chilling diagnosis: aplastic anemia. She needed a bone-marrow transplant right away. Her son, who was a good match, was willing to fly to Hawaii for the operation. But her health plan, Rush Prudential HMO, had other ideas. "They insisted that I fly her back at my own expense" to be treated in Chicago, her husband David explains. "They told me that if I declined, I would be refusing services, and they wouldn't pay my bills." Believing she had no choice, Barbara boarded a commercial flight to the mainland. Somewhere in the air between Hawaii and Illinois, David says, his wife suffered a stroke; nine days later, she died. Garvey is suing the HMO. "They had a chance to be heroes or save money," he says. "And they decided to save money." Rush Prudential disputes Garvey's account; they contend that Barbara Garvey had noticed some bruising before she left on vacation and resisted going to the doctor before her trip.

How did America's vaunted medical-care system--with its helpful

nurses and doctors who made house calls--get to this point? The story begins back in the 1980s, when rising health-care costs, driven by an aging population, runaway malpractice awards and advances in high-tech surgical and diagnostic procedures, finally caught up with the employers who were footing the medical-insurance bills. Executives at General Motors, for example, reported in 1990 that they were spending more for health care than for all the steel that went into their cars and trucks. Medical care, which accounted for 9.3% of the total U.S. output of goods and services in 1983, had risen to 12.3% of GDP by 1993.

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FAX TRANSMISSION COVER SHEET

Date: July 13, 1998

To: Barbara Wooley

Fax: (202) 456-6218, and
(202) 456-6682

Re: HMO related matters

Item Sent: Correspondence dated July 13, 1998, and enclosures

1. Factual portion of Wallock Complaint
2. Factual portion of Yanuck Complaint
3. USA Today article re Scott case
4. L.A. Times article re Scott case
5. Factual portion of Frediere Complaint

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July 13, 1998

Via FAX #(202) 456-6218 and #(202) 456-6682

Barbara Wooley
Office of Public Relations
Washington, DC

Dear Ms. Wooley:

Per your request, I am sending information regarding the following four cases with brief summaries of each contained below. Supporting factual and news information is attached in the same order. Please give me as much advance notice as possible either way.

1. **Wallock Family**

Case Summary: Denied home healthcare to incapacitated mother and infant, Daniel, who was born with six cardiac defects.

Case Status: Case is in Arbitration.

Location: Santa Barbara, California.

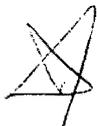
2. **Danielle Yanuck:**

Case Summary: 12 year old who was denied doctor recommended care to support her heart which was failing.

Case Status: No Litigation. Family in appeal, but litigation probably their only alternative.

Location: Ventura County, California.

Barbara Wooley
Office of Public Relations
July 13, 1998
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3. **Madison Scott**

Case Summary: A premature baby denied continuity of care and referrals to retina specialist now permanently blind although 95% preventable.

Case Status: Lawsuit filed.

Location: Orange County, California.

4. **Maurice Frediere**

Case Summary: Infant with a huge growth that took over his entire face and affected his breathing. Maurice was repeatedly denied doctor recommended referrals and surgeries and will endure permanent deformities because the procedure was denied as cosmetic in nature.

Case Status: Lawsuit just filed, June 1998

Location: Fresno County, California.

Very truly yours,

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Enclosures

Home Healthcare Memo to incapacitated mother & infant son with cardiac defects

1 LEONARD, DANA, and DANIEL WALLOCK.
2 10. Plaintiffs DANA WALLOCK, and LEONARD WALLOCK, individually, and DANIEL
3 WALLOCK, a minor, by and through DANA WALLOCK as his Guardian Ad Litem, at all relevant times,
4 were third-party beneficiaries of a contract between defendant PACIFICARE and plaintiff LEONARD
5 WALLOCK's employer, the University of California Santa Barbara. The contract between defendant
6 PACIFICARE and the plaintiff's employer, the University of California Santa Barbara, was intended
7 primarily for plaintiffs' and other employees' and their dependents' benefit.

8 11. As a result of plaintiffs' third-party beneficiary relationship to the contract between
9 PACIFICARE and plaintiff LEONARD WALLOCK's employer, The University of California Santa Barbara
10 and DOES 1 through 50, inclusive, plaintiffs have an enforceable contract right to the benefits promised by
11 the PACIFICARE contract attached hereto as Exhibit 1 and to be performed by defendants PACIFICARE,
12 MONARCH and DOES 1 through 50, inclusive.

13 12. Further, as a result of plaintiffs' third-party beneficiary relationship to the contract between
14 defendant PACIFICARE and plaintiff LEONARD WALLOCK's employer, The University of California
15 Santa Barbara and DOES 1 through 50, inclusive, and each of them, PACIFICARE, MONARCH, and
16 DOES 1 through 50, inclusive, owed plaintiffs a duty to act fairly, reasonably and in good faith.

17 13. In compliance with the terms of the policy issued to plaintiff LEONARD WALLOCK,
18 plaintiffs have exhausted any and all claims reviews and appeal requirements. Alternatively, any and all
19 review, appeal, administrative, grievances or complaint procedures are exhausted by law, are violative of
20 plaintiffs' due process rights, or would be futile or otherwise unlawful, null, void and unenforceable.

FACTUAL BACKGROUND

21
22 14. Plaintiff LEONARD WALLOCK is employed as the Associate Director of the
23 Interdisciplinary Humanities Center at the University of California Santa Barbara. He is enrolled as a
24 subscriber and a member of the Policy offered as health insurance by his employer via its contract with
25 defendant PACIFICARE.

26 15. Plaintiff LEONARD WALLOCK and/or his employer have paid all premiums due under the
27 Policy to defendant PACIFICARE and DOES 1 through 50, inclusive, at all relevant times and have
28 performed all their obligations under the policy.

Wallock

1 16. Plaintiff LEONARD WALLOCK is married to Plaintiff DANA WALLOCK. On February
2 19, 1995, LEONARD and DANA's daughter, RACHEL, died of an undiagnosed neurological disorder at
3 the age of five (5) months. In an effort to move past this tragedy, LEONARD and DANA decided to have
4 more children. On May 14, 1996, DANA gave birth to twin boys, MATTHEW and DANIEL, by Cesarean
5 section.

6 17. Although MATTHEW was born healthy, and continues to remain healthy, DANIEL was
7 born with six (6) different congenital heart defects (Dextracardia, Visceral Situs Solitus, Double Outlet Right
8 Ventricle, Severe Pulmonary and Subpulmonic Stenosis, Proximal Left Pulmonary Artery Stenosis, and
9 Atrioventricular Discordance) which had been diagnosed before his birth by prenatal ultrasound.

10 18. On May 17, 1996, three days after his birth, DANIEL underwent surgery to receive a Blalock-
11 Taussig shunt. He was quickly discharged from the hospital on May 24, 1996. Plaintiffs were told by
12 several PACIFICARE and MONARCH-supplied doctors that babies with cardiac defects frequently have
13 feeding and digestive problems, and that it was crucial for DANIEL to gain as much weight as possible in
14 order to maximize his chances of surviving his numerous planned future operations. Plaintiffs were also
15 told by PACIFICARE and MONARCH-supplied doctors that DANIEL would fatigue easily and would most
16 likely show little or no interest in feeding. Consequently, plaintiffs were told that DANIEL would need to
17 be fed very small quantities of formula at hourly intervals, twenty-four (24) times a day.

18 19. On May 22, 1996, DANA had to undergo surgery due to complications with her Cesarean
19 section. As a result, she was left with an open wound in her abdomen three inches in width for the first nine
20 (9) weeks of DANIEL's life, and unable to lift any amount of weight or pick anything up.

21 20. On May 24, 1996, the day DANIEL was discharged from the hospital, plaintiffs' doctor, Dr.
22 Stephen Abbott, asked defendants PACIFICARE and MONARCH to provide home health care to help in
23 the medically necessary cardiac care for DANIEL's survival and to assist DANA with her own personal
24 medical needs caused by her surgery and her open wound. Defendants PACIFICARE and MONARCH
25 approved one week of home health care consisting of eight-hour night shifts.

26 21. On or about May 31, 1996, DANIEL's condition showed no improvement, and still required
27 hourly feeding on a 24-hour basis. Despite the clear need for continued assistance, and despite another
28 request by Dr. Abbott, defendants PACIFICARE and MONARCH refused to authorize further home health

1 care.

2 22. Despite numerous further requests by plaintiffs and their doctors, defendants PACIFICARE
3 and MONARCH continued to deny approval for any further home health care.

4 23. As a result of defendants PACIFICARE and MONARCH's denials, plaintiffs were forced
5 to care for DANIEL by themselves. Plaintiffs were unable to do so solely by themselves, due to the open
6 wound in DANA's abdomen that prohibited her from helping, and were forced to hire nurses using their own
7 limited funds to assist with DANIEL's feeding. Plaintiffs had to hire less than qualified help because they
8 could not afford the costs of appropriate nursing care. Their own funds were quickly exhausted and they
9 were forced to borrow money from their family and friends and to use up their credit cards, totalling more
10 than \$20,000.

11 24. By August 1, 1996, DANIEL had stopped passively resisting his feedings, and instead went
12 into violent rages when fed any type of formula. DANIEL would shriek and cry for hours at a time and
13 began to tear out his own hair and claw at his own skin, at times drawing blood.

14 25. On August 1, 1996, Dr. Abbott again formally requested that defendants PACIFICARE and
15 MONARCH authorize home health care to assist with DANIEL's feeding. A representative from defendant
16 MONARCH promised Dr. Abbott that someone from defendant MONARCH would go to plaintiffs' home
17 to assess DANIEL's situation. No one from defendant MONARCH came.

18 26. On or about August 1, 1996, Dr. Ursula Henderson also contacted defendant MONARCH
19 on behalf of DANA, urging defendants PACIFICARE and MONARCH to provide home health care because
20 it was medically necessary in order for DANA to fully recover her health. The Wallocks' tragedy was again
21 ignored or intentionally dismissed.

22 27. On August 8, 1996, Dr. Abbott again requested that defendant MONARCH authorize home
23 health care to assist with DANIEL's care and feeding. Defendant MONARCH refused stating, "Home
24 health care is not a benefit of patient's policy" in the denial signed by defendant WILLIAM MELLER, M.D.
25 A representative of defendant MONARCH called DANA and told her there were no medical reasons to
26 justify assistance with DANIEL's feeding. Said representative callously stated, "MONARCH does not
27 provide the service of feeding babies."

28 28. On or about September 15, 1996, one of the nurses hired by plaintiffs, a Neonatal Intensive

1 Care nurse, after observing the difficulties DANIEL had in feeding, became convinced that DANIEL was
2 suffering from a stomach ailment in addition to his cardiac defects, and urged plaintiffs to take DANIEL to
3 see a pediatric gastroenterologist.

4 29. Plaintiffs DANA and LEONARD took DANIEL to a pediatric gastroenterologist, who
5 performed numerous tests, including an upper gastrointestinal exam, nuclear medicine tests, gastric emptying
6 tests, and an endoscopy. The tests revealed that DANIEL was suffering from multiple gastrointestinal
7 problems. Namely, DANIEL had gastric ulcers in his antrum, multiple erosions surrounding his stomach
8 lining, and extremely delayed gastric emptying of the stomach due to a spasming pylorus.

9 30. On October 4, 1996, DANIEL was re-admitted to Cottage Hospital in Santa Barbara, where
10 he was hospitalized for three weeks and fitted with an NG tube for feeding so as to allow his stomach to
11 heal.

12 31. On November 9, 1996, DANIEL was again hospitalized, this time for pneumonia brought
13 about by his months of digestive difficulties and the resulting trauma and fatigue.

14 32. On November 15, 1996, DANIEL was hospitalized for eight (8) days to replace his NG tube,
15 which had not alleviated his health problems. The NG tube was replaced by a G tube inserted surgically into
16 the stomach. During this hospitalization period, DANIEL experienced several respiratory problems which
17 caused the treating physicians to prescribe respiratory therapy ever four (4) hours. During this same
18 hospitalization period, the pediatric gastroenterologist determined that DANIEL needed to be continuously
19 tube fed by a pump for twelve (12) hours at night, and periodically bottle-fed during the day.

20 33. DANIEL was released from the hospital on November 23, 1996. DANIEL had to be taken
21 back to the pediatric gastroenterologist on three (3) consecutive days, November 25, 26, and 27, due to
22 complications with the G tube incision and tubing. DANIEL continued to suffer from projectile vomiting,
23 extreme stomach distention, diarrhea, wheezing, and deep coughing, and his care became more problematic,
24 which increased the emotional and financial burden on LEONARD and DANA, who were already at their
25 emotional and financial limits due to PACIFICARE's and MONARCH's repeated denials.

26 34. LEONARD and DANA WALLOCK, having lost their infant daughter only a year prior, and
27 now faced with DANA having an open three-inch wound in her stomach, one healthy baby requiring love,
28 attention, and feeding, and one ill baby, DANIEL, born with cardiac defects, who needed constant feeding,

1 love, attention, and observation, were repeatedly denied coverage and reimbursement for home health care,
2 even though it was a covered benefit under their policy, and were forced to borrow heavily on their credit
3 cards and to borrow heavily from family and friends, simply because defendants PACIFICARE,
4 MONARCH, McGINNIS, and MELLER decided to increase their profits at the expense of a family
5 desperately in need of medical care.

6 **FIRST CAUSE OF ACTION FOR TORTURE - NEGLIGENCE PER SE (VIOLATION OF**
7 **PENAL CODE § 206) BY PLAINTIFFS DANA WALLOCK AND DANIEL WALLOCK, by**
8 **and through his Guardian Ad Litem, DANA WALLOCK, AGAINST DEFENDANTS**
9 **PACIFICARE, MONARCH, McGINNIS, MELLER, AND DOES 1 THROUGH 50.**

10 35. Plaintiffs refer to paragraphs 1 through 34, inclusive, and incorporate the same herein as
11 though set forth in full in this Cause of Action.

12 36. California Penal Code section 206 states, "Every person who, with the intent to cause cruel
13 or extreme pain and suffering for the purpose of revenge, extortion, persuasion, or for any other sadistic
14 purpose, inflicts great bodily injury . . . upon the person of another, is guilty of torture."

15 37. Plaintiffs are informed and believe, and thereon allege, that the aforementioned conduct by
16 defendants PACIFICARE, MONARCH, McGINNIS, MELLER, and DOES 1 through 50, inclusive, of
17 repeatedly denying and refusing to authorize home health care benefits for the suffering, newly born, infant
18 DANIEL WALLOCK and his wounded mother, DANA WALLOCK, when home health care was, in fact,
19 a covered benefit under plaintiffs' Policy, was performed with the intent to cause cruel or extreme pain, and
20 was designed for a sadistic purpose, in this context, to maximize the companies' and doctors' profits while
21 sacrificing the health and wellbeing of mother and infant child. Defendants acted with the intent to cause
22 cruel or extreme pain because defendants were aware of plaintiffs' having lost an infant daughter, were
23 aware of DANA's three-inch wide open stomach wound, were aware of the hourly medically necessary care
24 that DANIEL required, and were aware that DANIEL, a newly born infant, began pulling out his own hair
25 and scratching himself hard enough to draw blood because he was in such pain, and defendants still persisted
26 in repeatedly denying plaintiffs' requests for home health care. Such illegal denials took place despite the
27 repeated attempts by the Wallocks' family doctors to request such medically necessary care to this mother
28 and infant child.

Wallock

No lawsuit yet

AT 11/01/97

heart therapy b/c psychological nature

7. As a result of plaintiff DEBORAH YANUCK's health care contract with the defendant, plaintiffs have an enforceable right to benefits promised by the defendant's contract attached hereto as Exhibit 1 (PPO contract) to be performed by defendant and Does 1 through 100, inclusive.

8. Further, as a result of plaintiffs contractual relationship with defendant BLUE SHIELD and DOES 1 through 100, inclusive, and each of them, defendants owed plaintiffs a duty to act fairly, reasonably and in good faith.

9. At some point in time relevant herein, presently unknown to plaintiffs but approximately 15 years ago, the plaintiffs purchased directly from defendants their health care contract (PPO contract) thereby creating a first party contractual relationship with defendant.

10. In compliance with the terms of the PPO contract issued to plaintiffs, plaintiffs have exhausted any and all claims reviews and appeal requirements. Plaintiffs have appealed on numerous occasions to defendants that the at-issue procedure is a covered benefit, citing the basis in facts and law. Alternatively, any and all review, appeal, administrative, grievances or complaint procedures are exhausted by law, are violative of plaintiffs' due process rights, or would be futile or otherwise unlawful, null, void and unenforceable.

FACTUAL BACKGROUND

11. Plaintiff DEBORAH YANUCK is self-employed and is enrolled as a subscriber and a member of the Policy offered as health insurance via his contract with defendant BLUE SHIELD.

12. Plaintiff DEBORAH YANUCK has paid all premiums due under the Policy to defendant BLUE SHIELD and DOES 1 through 100, inclusive, at all relevant times and has performed all of his obligations under the policy.

13. In the months leading up to September of 1997, DEBORAH YANUCK's daughter DANIELLE YANUCK, then age 12, gradually began to eat less and less, to the point where she was starving herself.

14. In September of 1997, DEBORAH YANUCK became so concerned about DANIELLE's continued weight loss that he made an appointment for her with his family's Blue Cross-provided pediatrician, Dr. Kenneth Saul. Dr. Saul diagnosed DANIELLE with acute anorexia nervosa, a disease which manifests itself in severe, self-destructive, suicidal tendencies, including compulsive self-starvation, and recommended that DANIELLE immediately see a nutritionist. Soon thereafter, DANIELLE began

yanuck

1 seeing Anne Stone, a nutritionist recommended by Dr. Saul.

2 15. Unfortunately, the nutritionist was unsuccessful in reversing the progression of DANIELLE's
3 disease, and DANIELLE was sent to a therapist who specializes in treating patients with eating disorders.
4 During a session, the therapist noticed that, besides her worrisome thinness, DANIELLE's lips were
5 alarmingly blue and her hands were red, which are symptomatic of impaired circulation due to starvation.
6 Because of her concern, the therapist sent DANIELLE back to Dr. Saul.

7 16. On November 12, 1997, Dr. Saul examined DANIELLE and became extremely concerned when
8 he observed that DANIELLE was suffering from bradycardia, an abnormally slow heart rate. DANIELLE's
9 resting heart rate was as low as 28 beats per minute, and fluctuated between 28 and 42 beats per minute. Dr.
10 Saul was so concerned that he immediately called Dr. Frederic Leong, a pediatric cardiac specialist. Dr.
11 Leong made an appointment for DANIELLE the next day.

12 17. On November 13, 1997, Dr. Leong examined DANIELLE and also observed DANIELLE's
13 bradycardia, noting that her resting heart rate was between 30-40 beats per minute, which was well below
14 normal and a significant cause for concern. Dr. Leong recommended that DANIELLE be admitted to
15 UCLA's Neuropsychiatric Institute (NPI) where she could be monitored and fed because her heart rate was
16 not stable enough to remain at home.

17 18. Plaintiff immediately began the process of admitting DANIELLE to UCLA's NPI. Plaintiffs
18 contacted UCLA, who in turn contacted defendant BLUE SHIELD. On or about November 14, 1997,
19 defendant BLUE SHIELD denied DANIELLE coverage for the treatment at UCLA. UCLA then told
20 plaintiff that because of defendant BLUE SHIELD's denial, UCLA would not admit DANIELLE to the NPI
21 unless plaintiffs paid UCLA \$14,000.00 upfront.

22 19. Plaintiff borrowed the necessary money to admit DANIELLE to UCLA-NPI, even though it should
23 have been covered by defendant BLUE SHIELD under plaintiffs' insurance policy, but was told on
24 November 15, 1997, that because the paperwork could not be completed over the weekend, UCLA would
25 not admit DANIELLE until Monday, November 17, 1997.

26 20. Plaintiff's pediatrician, Dr. Saul, was very concerned when told that UCLA could not admit
27 DANIELLE until November 17, 1997, and on November 15, 1997, after examining DANIELLE,
28 immediately had her admitted to Columbia/Los Robles Medical Center because of first degree heart block

yanuck

1 with extreme bradycardia. Because of her extremely slow heart rate, DANIELLE was immediately placed
2 on a heart monitor and had to be under constant observation during her stay at Columbia/Los Robles Medical
3 Center.

4 21. On November 17, 1997, DANIELLE was transferred from Columbia/Los Robles to UCLA's
5 Neuropsychiatric Institute. At the time of her admission, she stood nearly 5'7" yet weighed just over 90
6 pounds, which was less than 75% of the ideal body weight for her size. The admitting physician at UCLA,
7 Dr. Carol Pataki noted at the time of admission that DANIELLE's hospitalization was medically necessary
8 because she was suffering from malnutrition and sinus bradycardia, as well as anorexia nervosa.

9 22. DANIELLE remained in treatment at NPI until January 23, 1998, when she was able to return
10 home on a full time basis. Although her stay at UCLA enabled her to regain some of the critical body weight
11 that she had lost due to her acute anorexia nervosa, DANIELLE will need to see a therapist and a nutritionist
12 once a week for the foreseeable future in hopes of keeping her anorexia nervosa in check.

13 23. On March 12, 1998, defendant BLUE SHIELD gave its final denial of plaintiffs' request to have
14 BLUE SHIELD pay for DANIELLE's treatment at UCLA. BLUE SHIELD based its denial on its
15 conclusion that DANIELLE's treatment consisted of Inpatient Psychiatric Care, which it specifically
16 excludes from coverage, while ignoring the medical necessity of the hospitalization, including the fact that
17 DANIELLE had to be fed intravenously and placed on a heart monitor because the danger of her heart
18 stopping was so great. If any type of meaningful review had been done by defendant BLUE SHIELD, it
19 would have been clear that DANIELLE required immediate and medically necessary inpatient treatment,
20 treatment which defendant BLUE SHIELD should have properly covered under its insurance contract with
21 plaintiffs.

22 **FIRST CAUSE OF ACTION FOR NEGLIGENT REVIEW OF PLAINTIFFS' CLAIM FOR**
23 **BENEFITS BY PLAINTIFFS DEBORAH YANUCK AND DANIELLE YANUCK, by and**
24 **through her Guardian Ad Litem, DEBORAH YANUCK, AGAINST DEFENDANTS BLUE**
25 **SHIELD AND DOES 1 THROUGH 100.**

26 24. Plaintiffs refer to paragraphs 1 through 23, inclusive, and incorporate the same herein as though
27 set forth in full in this Cause of Action.

28 25. At all relevant times, defendants knew that plaintiffs would rely upon the accuracy, good faith,

Yanuck



Good story
Madison
Scott
right to
sue

THE NATION

Holding HMOs accountable

Patients may find that they have almost no legal recourse if they are harmed because of the policies or treatment of a managed-care insurance plan.

By Steven Findlay
USA TODAY

When something goes wrong with their medical care, many people think: I'll sue.

But a growing number of Americans who are covered by HMOs and other managed care health plans are finding that while they can sue, they probably can't win.

A legal loophole lets many health maintenance organizations avoid medical malpractice lawsuits because they claim they are part of an employer's health benefits plan, which under federal law can't be sued for malpractice. Because of that, a fierce debate over changing the law is under way in courtrooms, among consumers and medical professionals and in Congress and state legislatures.

"We get calls every day from people who are enraged at their HMOs and want to sue. We have to tell most that it may get them nowhere. And they are shocked to learn why," says Mark Hiepler, an Oxnard, Calif., health-care lawyer. The loophole was barely noticed when HMOs were in their infancy in the 1980s. But with the growth of managed care, about half the 180 million Americans enrolled in such health plans are now affected.

The consequences

Experts say the loophole is a classic example of unintended consequences. Its origins are in a 1974 federal law, the Employee Retirement Income Security Act (ERISA). It allows companies that set up pension and health benefits plans to avoid the hassle of having to comply with a different set of laws in every state in which they operate. But as HMOs and managed care organizations spread, they discovered that under some conditions, ERISA could serve as a shield against medical malpractice lawsuits.

Because of ERISA, HMOs can claim they are merely extensions of employee benefit plans and thus protected from state laws that have anything to



Blinded by regulations: Curt and Helen Scott of Santa Ana, Calif., blame infant daughter Madison's blindness on their HMO, which enforced rules that delayed Madison receiving a crucial eye exam.

do with health insurance. The law also makes it futile to sue in federal court. It doesn't allow plaintiffs to seek punitive or compensatory damages, as they can in state court. They can sue only to pay for the cost of the care resulting from medical negligence. This gives lawyers, who usually take their fee from a slice of the punitive award, little incentive to take on such cases.

Consumer, doctor and lawyer groups are pressing hard for a change in the law. Courts are weighing in, too, with new rulings that undermine or question the HMO protection. And state and federal lawmakers have begun to pass or propose laws to broaden consumers' rights to sue managed care insurers. Among the recent attempts to address the issue:

► In May, Texas became the first state to challenge the HMOs' shield. The Legislature passed a law giving consumers the right to sue their HMOs for medical malpractice. Similar measures are pending this year in Alabama, Georgia, Maryland, New York and New

Jersey. And consumer groups pledge to press the issue before state lawmakers in a dozen more states next year. But the Texas measure already is facing a court challenge because it conflicts with ERISA.

► Four federal appeals courts — in Denver, New York City, Philadelphia and Chicago — have ruled in the past two years that HMOs and other managed care health plans can and should, in some circumstances, be held liable for medical negligence.

► The Pennsylvania Supreme Court heard arguments in April in a case involving the malpractice culpability of U.S. Healthcare, an HMO based in Blue Bell, Pa. The court is expected to rule soon. Experts say it could be the first case of its kind to be appealed to the U.S. Supreme Court.

► Lawmakers in Congress have proposed several bills this year that would remove the legal shield HMOs claim.

► The Clinton administration has filed eight "friend of the court" briefs in malpractice cases in the past three

years. The administration supports giving consumers the right to sue HMOs in state courts.

► A presidential commission on consumers' health-care rights agreed the loophole was serious and pledged to address the issue in a report.

The debate also has spurred a re-evaluation of what medical malpractice and negligence are in an age when, some allege, HMOs and insurers, not doctors, are making medical decisions.

Lawyers for HMOs have argued successfully in the past that the health benefit decisions made by HMOs are not the same as doctors' medical decisions, so those health benefit decisions cannot constitute "malpractice."

"The effect of this is basically to let HMOs deny treatments or tests with impunity. They cannot be held accountable in a court of law," says Brian Welch, a Washington, D.C., lawyer who specializes in health-care law. "Congress certainly didn't intend that in 1974. ... It's a law run amok."

Curt and Helen Scott of Santa Ana, Calif., learned about all this the hard way. When their daughter Madison was born three months premature last year, an eye exam indicated she had the early stages of retinopathy, a condition that is usually correctable. Doctors assured the Scotts that there was no cause for alarm, and a follow-up test was scheduled.

Later, when the Scotts discovered the test hadn't been done, their HMO demanded that they see a primary care doctor before the test could be approved. That led to an eight-week delay.

It's no late, Madison Scott, who is now just shy of a year old, is blind.

Uphill battle

The Scotts are suing the hospital, the doctors, the HMO and the group that oversaw referrals for the HMO. But Hiepler, their lawyer, has told them they face an uphill struggle suing their HMO, which they note principally responsible for the final delay that led to Madison's blindness.

That's because Curt works at a large California company that has set up its own health benefit plan under ERISA.

While no one has statistics, health-care lawyers say thousands of people face the same situation. Legal, medical and consumer groups argue that managed care plans make medical decisions all the time — decisions that can result in harm to patients.

Carol O'Brien, a lawyer for the American Medical Association, says, "Whether it's a benefit decision or a medical decision, the harm done is often the same." Patients, she asserts, don't see the difference between having an HMO refuse to allow a medical test — one that could detect cancer, for example — or having test results misread by a doctor. "And there should be no legal difference either," O'Brien says.

Curt Scott says, "They need to change the law. Maybe that will help prevent for others the nightmare we went through."

Patients' Lawsuits May Be Best Cure for Health System

The more I've covered legislative deliberations on insurance and legal issues in Sacramento, the more the lawmakers have come to seem like pawns manipulated by the lobbyists.

Gradually, I've concluded that the lobbyists are the most important players. Greatly empowered by their ability to make campaign contributions, they call the shots, and when I want to find out what is going to happen, usually I ask them.

That's the case with California's health care, too. And it seems to be true in Washington as well.

Thirteen years after Congress adopted the Employee Retirement Income Security Act of 1974, the courts ruled that it preempted the states' ability to pass laws allowing patients receiving employer benefits to recover damages against HMOs.

It's become all too evident that the lawmakers can't be relied upon to get that reversed, despite rising public sentiment that the HMOs must be held accountable.

Indeed, efforts in Congress to guarantee patients' rights have gone nowhere. Meanwhile, proposed legislation in Sacramento for independent review of HMO treatment decisions is so weak it is opposed by consumer groups.

So, if the balance of power is going to shift from the HMOs to patients—and their conscientious doctors—it is probably going to come through new, imaginative lawsuits.

That's where the Madison Scott case may come in.

Madison Scott is a 21-month-old girl living with her parents on the Central Coast. She is blind and will remain so the rest of her life.

Born prematurely at St. Joseph Hospital



AN EQUAL CHANCE
KENNETH REICH

of Orange, she was afflicted by retinopathy of prematurity, an eye disease that can be a byproduct of the treatment premature babies receive.

ROP occurs in up to a third of preemies who survive. But total blindness is the outcome among only a small minority of this third. ROP can be successfully treated in most cases, if it is detected early enough.

The lawsuit brought by attorney Mark Hiepler of Oxnard alleges that professional negligence prevented Madison from obtaining such timely treatment.

Among the suit's allegations are these:

- Orange County ophthalmologist Florencio Ching wrote on a hospital report Oct. 1, 1996, that reexamination was important and should take place in 10 days to two weeks (or no later than Oct. 14). However, he didn't show up then, and no reexamination took place until Nov. 26.

- St. Joseph Hospital did not apprise Madison's parents of the seriousness of the situation.

- There were delays of several days by St. Joseph Medical Group in approving examinations, and by the Medical Group and Cigna HealthCare in approving emergency surgery that finally began Dec. 6, 1996. Several surgeries were performed, but they were too late to prevent blindness.

"Altogether, we had eight weeks of delays, and during most of this time, we weren't even told time was important," says Madison's father, Curt Scott.

Although California has a \$250,000 limit on malpractice awards, that applies to pain and suffering. In Madison's case, economic damages

Please see REICH, B11

LOS ANGELES COUNTY NEWS

REICH

Continued from B10
could run into millions of dollars more.

But probably the most important thing about this lawsuit is the theory attorney Hiepler, who has won several major lawsuits against HMOs, is trying to pursue against Cigna to get around the ban on lawsuits under the federal ERISA statute.

He hopes to show that Cigna was negligent in approving as part of its network doctors like Ching, and was responsible for payment arrangements rewarding doctors for not rendering treatment.

In so-called "capitation" arrangements, HMOs pay doctors an average amount for all patients, regardless of the treatments they prescribe. The more treatments, the less profit for the physicians.

If Hiepler's arguments prevail, the ERISA exemption may be largely swept aside.

In that respect, the biggest target of the Scott lawsuit is Cigna.

I wonder whether, in advertising so effectively to kill off President Clinton's proposed national health care system five years ago, the industry realized it was putting itself in such a hot seat.

When the defendants and their attorneys were contacted for their view of the issues in the Scott case, two attorneys, plus representatives of Cigna, were responsive.

They all contested the complaint on factual grounds, saying the Scotts missed an appointment with Ching on Nov. 12 that could have interrupted the spiral toward

Madison's blindness.

The Scotts insist that the appointment was not approved. The defense attorneys say the Scotts were told Nov. 8 that it was approved. That is obviously a matter that will be resolved at the trial.

Cigna HealthCare of Southern California made its chief medical officer, Dr. Chue L. Yuen, available, and she described an elaborate procedure whereby Cigna exerts great diligence in choosing its doctors and in reviewing them for retention every two years.

Although Yuen gave no statistics on what percentage are ever rejected, the Cigna presentation was going quite well until the firm's PR man, Jim Harris, remarked that Cigna, like all HMOs, is diligently regulated by the state Department of Corporations.

I had to smile at that. The Department of Corporations is notorious for its weak regulation.

Harris also released a statement defending the ERISA exemption against damage claims.

"Changing ERISA would be a drastic disruption of the U.S. system of employee benefits . . . and could lead employers to decide they cannot or will not provide health care benefits to their employees," it said. "This would leave many individuals without any health care coverage."

Hmmm. I thought. The HMOs don't know what thin ice they are on. If public antipathy to them rises much higher, even Congress and the Legislature might act against them, despite their lobbyists.

Ken Reich can be contacted with your accounts of true consumer adventures at (213) 237-7060, or by e-mail at ken.reich@latimes.com

MILLER & MILLER
TEL: 800-368-3828
JUL 13 1998
12:11 PM NO. 007 P. 13

Fresno Area Law Suit not begun. DADY

Parents' appealed. Although affecting the child's hearing - Denial. Cosmetic

10. Plaintiffs PIERRE FREDIERE, and PAM FREDIERE, individually, and MAURICE FREDIERE, a minor, by and through PAM FREDIERE as his Guardian Ad Litem, at all relevant times, are the direct beneficiaries of a contract between defendant PACIFICARE and plaintiffs

11. As a result of plaintiffs' contractual relationship with DEFENDANT PACIFICARE and FHP/TAKECARE and DOES 1 through 50, inclusive, plaintiffs have an enforceable contract right to the benefits promised by the FHP contract attached hereto and incorporated herein as Exhibit 1, and to be performed by defendants PACIFICARE, FHP/TAKECARE, VALLEY PRIMECARE, COMMUNITY HEALTH NETWORK, SANTE and DOES 1 through 50, inclusive.

12. Further, as a result of plaintiffs' contractual relationship between defendant PACIFICARE and FHP/TAKECARE and plaintiffs and DOES 1 through 50, inclusive, and each of them, PACIFICARE, FHP/TAKECARE, VALLEY PRIMECARE, COMMUNITY HEALTH NETWORK, SANTE, and DOES 1 through 50, inclusive, owed plaintiffs a duty to act fairly, reasonably and in good faith.

13. In compliance with the terms of the policy issued to plaintiffs PIERRE, PAM and MAURICE FREDIERE, plaintiffs have exhausted any and all claims reviews and appeal requirements. Alternatively, any and all review, appeal, administrative, grievances or complaint procedures are exhausted by law, are violative of plaintiffs' due process rights, or would be futile or otherwise unlawful, null, void and unenforceable.

FACTUAL BACKGROUND

14. In 1997, plaintiffs PIERRE AND PAM FREDIERE, were insured by defendant FHP/TAKECARE, an HMO, under an individual conversion policy, and have personally paid all premiums due under the policy to defendant FHP/TAKECARE and DOES 1 through 50, inclusive, at all relevant times and have performed all their obligations under the policy.

15. Plaintiff PIERRE FREDIERE is, and at all relevant times was, married to Plaintiff PAM FREDIERE. On March 9, 1996 PAM gave birth to a 6.05 pound, 20 1/2 inch baby boy named MAURICE. MAURICE was born with a "shadow" on his left cheek and bottom lip. At MAURICE'S one week exam his pediatrician, Dr. David Bergdahl, noticed that the abnormality was getting darker, and Dr. Bergdahl identified it as a "port wine stain."

16. In April of 1996 the abnormality on MAURICE'S face continued to get darker and began to swell.

Frediere

1 By May of 1996 the mark continued to grow and darken rapidly. At this point PIERRE and PAM became
2 very concerned about their infant son, and the HMO provided physicians seemed to be unable or unwilling
3 to diagnose, treat, or even refer MAURICE to a specialist.

4 17. Motivated by their growing concern for MAURICE's well being, and through their own diligence,
5 PIERRE and PAM were directed to David Apfelberg, M.D. Dr. Apfelberg specializes in birthmarks on
6 infants. On May 14, 1996 he diagnosed MAURICE with an extensive cavernous hemangioma of the left
7 cheek, lower lip, and floor of MAURICE's mouth and tongue.

8 18. A hemangioma is a red-purple growth caused by an abnormal distribution of blood vessels in the
9 skin. Hemangiomas cause various complications requiring treatment, including obstruction of the upper
10 airway, ulceration and bleeding, persistent soft-tissue deformity, and/or high-output congestive heart failure.

11 19. Dr. Apfelberg was immediately concerned about an abnormality in the tissue located at the back
12 of MAURICE'S throat, because a hemangioma at that location can cause a blockage of the airways resulting
13 in a slow and excruciating death by strangulation. Dr. Apfelberg then arranged for MAURICE to see Dr.
14 Anna Messner at Stanford Medical Center that day. Dr. Messner performed an ear, nose, and throat
15 evaluation and confirmed that there was a problem with the airway. Dr. Messner insisted on immediate
16 treatment and on May 15, 1996 began MAURICE on a steroid called Prelone to control the rapid swelling.

17 20. When MAURICE became 6 months old Dr. Apfelberg urgently recommended a series of four life
18 saving surgeries to be performed on September 9, 1996, February 20, 1997, April 27, 1997 and August 18,
19 1997. These surgeries were doctor recommended, medically necessary, and contractually covered under the
20 FREDIERE's policy with DEFENDANT FHP/ TAKECARE

21 21. According to Dr. Apfelberg, the purpose of these surgeries were to arrest the alarming growth of
22 the tumor, to cause shrinkage, and to lessen the severe facial and neck deformity. In addition, several of the
23 procedures done under anesthetic indicated respiratory obstruction caused by the disease.

24 22. Despite that fact that this critical surgical intervention had helped MAURICE, DEFENDANT
25 FHP / TAKECARE denied the last two urgently needed, medically necessary surgical procedures.

26 23. DEFENDANT HMO FHP/TAKECARE by and through their agent COMMUNITY HEALTH
27 NETWORK denied MAURICE these medically necessary, doctor recommended, contractually covered
28 surgical procedures because they said the surgeries were cosmetic, and that they could provide the service

Frediere

1 by their in network providers rather than by a non-contracted provider.

2 24. Concerned for their infant son's well being, PIERRE and PAM appealed this decision to
3 DEFENDANT FHP/TAKECARE on April 12, 1997. In her letter, PAM explained that the surgery being
4 requested by MAURICE's physicians and the family was not for cosmetic purposes, but that the procedure
5 addressed a life-threatening medical need. PAM also pointed out that Dr. Apfelberg's expertise and surgical
6 technique are unique and are not provided by doctors inside the network.

7 25. Despite the FREDIERE'S appeal for this medically necessary, doctor recommended procedure
8 for MAURICE, on June 18, 1997 DEFENDANT FHP/TAKECARE upheld its original denial of treatment.

9 26. PAM FREDIERE was told by Dr. Gerald Brown at FHP/TAKECARE that an in network doctor,
10 Stephen Zuniga, M.D., could perform the surgery. PAM FREDIERE contacted Dr. Zuniga and was
11 informed that he did not perform the type of surgery MAURICE needed.

12 27. At this point PAM and PIERRE had Dr. Apfelberg send yet another letter to DEFENDANT
13 FHP/TAKECARE explaining why the requested two surgeries would be effective in helping to manage
14 the enormous swelling, reduce the risk to the airways, and insure MAURICE's safety.

15 28. According to Dr. David Apfelberg the surgeries for MAURICE, which were denied by
16 DEFENDANT FHP/ TAKECARE, were in fact medically necessary, and not purely cosmetic. Dr.
17 Apfelberg specifically stated, "the continuing succession of surgical procedures including the third and
18 fourth surgical procedures were done for reconstructive and not cosmetic purposes. They were medically
19 necessary because clinical observation demonstrated that the hemangioma was continuing to grow and to
20 extend into new areas. The treatments were designed to arrest this growth and cause some involution and
21 shrinkage of the hemangioma. In addition, it became apparent to us as we watched this child that there was
22 a growth retardation and the patient also had evidence of cardiac problems secondary to the abnormal
23 circulation through the hemangioma. The treatments were intended to improve both the growth retardation
24 and to help the circulation to diminish the load on the heart. In addition, the deformity was becoming larger
25 and extending into new areas and the laser surgery was intended to arrest this further growth. These
26 procedures were medically necessary and reconstructive and appeared to be needed on a semi-urgent basis.
27 I would not consider them cosmetic."

28 29. MAURICE'S HMO pediatrician tried to get FHP/TAKECARE to approve the last necessary

1 surgery. Unfortunately, for MAURICE and his parents FHP/TAKECARE continued to deny the surgery.
2 PIERRE, and PAM understood the medical necessity for MAURICE to have these surgeries, and were
3 individually forced to bear the financial responsibility of ensuring their child's safety since
4 FHP/TAKECARE would not. As a result of FHP/TAKECARE's delay and denial, PIERRE and PAM had
5 to borrow funds, and incur massive credit card debt at very high interest rates, in order to pay for the
6 surgeries MAURICE desperately needed on his grossly enlarged face.

7 30. In addition to the medical concerns about the hemangioma, there was also concern about
8 MAURICE's failure to thrive. MAURICE had very little significant growth in weight and height. On or
9 about May 1997 Dr. Bergdahl, their local HMO pediatrician, noticed that MAURICE's hemangioma had
10 expanded into the right side of his face, having previously been only on the left side, in the parotid gland.

11 31. In March 1998 Dr. Blei confirmed that there was a significant high flow component within the
12 left parotid area, a vibrating heart murmur, and a high output state with aortic runoff all due to the
13 hemangioma. It was therefore determined that MAURICE needed yet another embolization of the high flow
14 lesion. After a nine hour surgery and a two week hospitalization, including eight days in the pediatric
15 intensive care unit, MAURICE made a noticeable improvement in his weight gain.

16 32. PIERRE AND PAM FREDIERE have had to struggle every step of the way to get the proper,
17 medically necessary treatment for their young son, MAURICE.

18 **FIRST CAUSE OF ACTION FOR BREACH OF CONTRACT BY PLAINTIFFS PIERRE**
19 **FREDIERE, PAM FREDIERE, AND MAURICE FREDIERE by and through his Guardian Ad**
20 **Litem, PAM FREDIERE, AGAINST DEFENDANTS PACIFICARE, VALLEY PRIMECARE,**
21 **COMMUNITY HEALTH NETWORK, VALLEY PRIMECARE MEDICAL GROUP, INC.,**
22 **COMMUNITY HEALTH NETWORK, CENTRAL VALLEY PHYSICIAN PARTNERS,**
23 **MEDICAL GROUP, INC. dba SANTE COMMUNITY PHYSICIANS IPA MEDICAL**
24 **CORPORATION, AND DOES 1 THROUGH 50.**

25 33. Plaintiffs refer to paragraphs 1 through 32, inclusive, and incorporate the same herein as if they
26 were set forth in full in this Cause of Action.

27 34. Plaintiffs PIERRE FREDIERE, PAM FREDIERE, AND MAURICE FREDIERE have had
28 continuous health insurance coverage from FHP/TAKECARE through an individual conversion policy. On

USA TODAY

USA TODAY • WEDNESDAY, AUGUST 5, 1993 • 3A

THE NATION

Holding HMOs accountable

Patients may find that they have almost no legal recourse if they are harmed because of the policies or treatment of a managed-care insurance plan.

By Steven Findlay
USA TODAY

When something goes wrong with their medical care, many people think: I'll sue.

But a growing number of Americans who are covered by HMOs and other managed care health plans are finding that while they can sue, they probably can't win.

A legal loophole lets many health maintenance organizations avoid medical malpractice lawsuits because they claim they are part of an employer's health benefits plan, which under federal law can't be sued for malpractice. Because of that, a fierce debate over changing the law is under way in courtrooms, among consumers and medical professionals and in Congress and state legislatures.

"We get calls every day from people who are enraged at their HMOs and want to sue. We have to tell most that it may get them nowhere. And they are shocked to learn why," says Mark Hiepler, an Oxnard, Calif., health-care lawyer. The loophole was barely noticed when HMOs were in their infancy in the 1980s. But with the growth of managed care, about half the 180 million Americans enrolled in such health plans are now affected.

The consequences

Experts say the loophole is a classic example of unintended consequences. Its origins are in a 1974 federal law, the Employee Retirement Income Security Act (ERISA). It allows companies that set up pension and health benefits plans to avoid the hassle of having to comply with a different set of laws in every state in which they operate. But as HMOs and managed care organizations spread, they discovered that under some conditions, ERISA could serve as a shield against medical malpractice lawsuits.

Because of ERISA, HMOs can claim they are merely extensions of employee benefit plans and thus protected from state laws that have anything to



Blinded by regulations: Curt and Helen Scott of Santa Ana, Calif., blame infant daughter Madison's blindness on their HMO, which enforced rules that delayed Madison receiving a crucial eye exam.

do with health insurance.

The law also makes it futile to sue in federal court. It doesn't allow plaintiffs to seek punitive or compensatory damages, as they can in state court. They can sue only to pay for the cost of the care resulting from medical negligence. This gives lawyers, who usually take their fee from a slice of the punitive award, little incentive to take on such cases.

Consumer, doctor and lawyer groups are pressing hard for a change in the law. Courts are weighing in, too, with new rulings that undermine or question the HMO protection. And state and federal lawmakers have begun to pass or propose laws to broaden consumers' rights to sue managed care insurers. Among the recent attempts to address the issue:

► In May, Texas became the first state to challenge the HMOs' shield. The Legislature passed a law giving consumers the right to sue their HMOs for medical malpractice. Similar measures are pending this year in Alabama, Georgia, Maryland, New York and New

Jersey. And consumer groups pledge to press the issue before state lawmakers in a dozen more states next year. But the Texas measure already is facing a court challenge because it conflicts with ERISA.

► Four federal appeals courts — in Denver, New York City, Philadelphia and Chicago — have ruled in the past two years that HMOs and other managed care health plans can and should, in some circumstances, be held liable for medical negligence.

► The Pennsylvania Supreme Court heard arguments in April in a case involving the malpractice culpability of U.S. Healthcare, an HMO based in Blue Bell, Pa. The court is expected to rule soon. Experts say it could be the first case of its kind to be appealed to the U.S. Supreme Court.

► Lawmakers in Congress have proposed several bills this year that would remove the legal shield HMOs claim.

► The Clinton administration has filed eight "friend of the court" briefs in malpractice cases in the past three

years. The administration supports giving consumers the right to sue HMOs in state courts.

► A presidential commission on consumers' health-care rights agreed the loophole was serious and pledged to address the issue in a report.

The debate also has spurred a re-evaluation of what medical malpractice and negligence are in an age when, some allege, HMOs and insurers, not doctors, are making medical decisions.

Lawyers for HMOs have argued successfully in the past that the health benefit decisions made by HMOs are not the same as doctors' medical decisions, so those health benefit decisions cannot constitute "malpractice."

"The effect of this is basically to let HMOs deny treatments or tests with impunity. They cannot be held accountable in a court of law," says Brian Welch, a Washington, D.C., lawyer who specializes in health-care law. "Congress certainly didn't intend that in 1974. ... It's a law run amok."

Curt and Helen Scott of Santa Ana, Calif., learned about all this the hard way. When their daughter Madison was born three months premature last year, an eye exam indicated she had the early stages of retinopathy, a condition that is usually correctable. Doctors assured the Scotts that there was no cause for alarm, and a follow-up test was scheduled.

Later, when the Scotts discovered the test hadn't been done, their HMO demanded that they see a primary care doctor before the test could be approved. That led to an eight-week delay.

It's too late. Madison Scott, who is now just shy of a year old, is blind.

Uphill battle

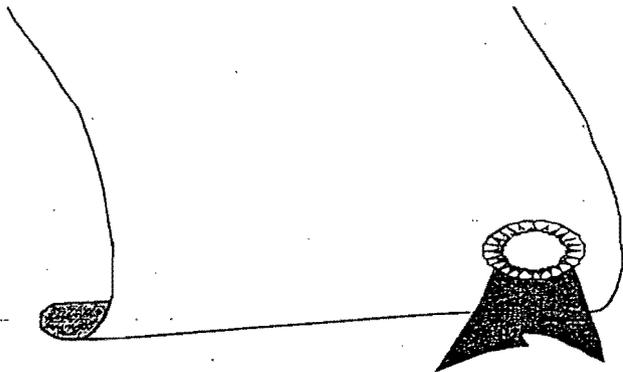
The Scotts are suing the hospital, the doctors, the HMO and the group that oversaw referrals for the HMO. But Hiepler, their lawyer, has told them they face an uphill struggle suing their HMO, which they hold principally responsible for the final delay that led to Madison's blindness.

That's because Curt works at a large California company that has set up its own health benefit plan under ERISA.

While no one has statistics, health-care lawyers say thousands of people face the same situation. Legal, medical and consumer groups argue that managed care plans make medical decisions all the time — decisions that can result in harm to patients.

Carol O'Brien, a lawyer for the American Medical Association, says, "Whether it's a benefit decision or a medical decision, the harm done is often the same." Patients, she asserts, don't see the difference between having an HMO refuse to allow a medical test — one that could detect cancer, for example — or having test results misread by a doctor. "And there should be no legal difference either," O'Brien says.

Curt Scott says, "They need to change the law. Maybe that will help prevent for others the nightmare we went through."



Voluntary Acceptance of ERISA Restrictions

I _____ hereby accept all the restrictions of patients with private sector, employer-paid health care, including forgoing my right to recover damages when a health maintenance organization (HMO), managed care company or health insurance company has harmed myself or my family -- no matter how egregious the company's negligence, how willful or malicious their obstruction of medically-necessary treatment or how serious our injuries may be.*

(signature)

(date)

Name:

Address: _____

City: _____ **State:** _____ **Zip:** _____

****I recognize that this waiver imposes upon my family and myself the same limits on recovery that most working Americans must accept involuntarily as private sector employees.***

ERISA Casualty Of The Day

May 6, 1998

Consumers for Quality Care

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

Insurer Told Her To Reuse Disposable Colostomy Bag For Five Days



Michelle Leasure
Baltimore, MD

I am a disability advocate and work for an agency that not only serves the disability community, it is staffed by people with disabilities. I have several disabilities, one of which is an incontinent ostomy. I do not have control over my bowels, and must wear a colostomy bag to contain my waste. Under Maryland law, ostomy supplies are 100% covered by insurance agencies.

When my employer changed insurance providers on September 1, 1997, I could no longer get the supplies I required to live. I have had my ostomy for three years and this was the first time I had ever had problems. I fought with my insurer for two months before I received any supplies, and at that time the supplies were incomplete. Many of the doctor-prescribed items were denied as unneeded, so I was forced to purchase them myself.

At the time, my salary was \$500 a year above the poverty level and I soon found myself in financial trouble as a result. When the few supplies I got at that time ran out, my co-workers and myself went back to battle with my insurer, and it was January before I received more supplies, again not all that I needed.

I was told by my insurer that I was expected to use disposable bags for five days each. Now pardon me for being so graphic, but it's necessary. I work in the public arena, and I was expected to (and this is verbatim) "wash the

bags out in the public restrooms that I frequent, walk (I use a wheelchair) to the sink with my ostomy exposed, and finish washing the feces out into the sink, then reattach it to my flange." It would be the same thing as asking a mother to empty a diaper, rinse it out in the sink and reapply it to her baby for five days.

I have systemic lupus, so I also have a compromised immune system. To even ask anyone, let alone a person with immune problems, to use public restrooms in such a fashion, is sheer and absolute insanity.

In mid-April I finally received a full month supply of ostomy products, but I had been out from work for 2 1/2 months, living in my bathtub because I had not had the supplies for that long. I even spent a week in a nursing home as a result of this and had another stroke requiring a hospital stay because of the stress from this battle.

I am a person who could get the medical benefits I require from Medical Assistance if I were to quit work and go on welfare. The bizarre thing is, I want to work--and I am paying into the system, but cannot get the services I'm entitled to and work so hard for.

I was supposed to have corrective surgery to fix the bilateral spinal implants that have "fell out" of their socket and are currently free-floating in my right side. I actually have to push them back inside my body several times a day and night. My insurer has only one doctor they will allow me to see that can do the work on the implants and he is unavailable to see me until the end of May. That is just to see him--I have no idea if he will then be able to schedule the surgery then, or if I will have to wait another six months. I cannot stand the discomfort much longer.

I have been told that because of the ERISA loophole my insurer is protected from legal liability for delaying and denying the medical care that I so badly need. I am convinced that if I were able to hold my insurer legally accountable I would be getting more attentive care.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

Statement by Rep. Pete Stark
Press Conference with the Consumers for Quality Care
July 13, 1998

The most important component of managed care reform is to hold health plans accountable for their medical decision-making.

There are certainly high-quality managed care plans in this country that provide appropriate care to their patients up front. However, the unfortunate reality is that as long as there is no serious financial consequence to denying appropriate care, many health plans will continue to do so — such behavior is simply in their financial interest.

Some 125 million workers are in health plans that are protected by ERISA. ERISA provides a shield that protects health plans from being held financially responsible for damages caused by their denial of benefits. Changing that component of ERISA is vital to ensuring meaningful managed care reform.

That is why I am proud to be here today with the Consumers for Quality Care. For the past nine weeks I have been sending to all the Members of the House the daily horror stories compiled by the Consumers for Quality Care of people hurt under today's ERISA liability limitations.

I have a compilation of these reports and copies are here today for anyone who would like to review them. One such story may be an anecdote, but this daily drumbeat of people killed or maimed by managed care plans — with the plans facing no consequences for their actions — proves that this is a national epidemic that needs to be addressed.

As these reports show, ERISA limits damages that can be collected by people in employer-provided health plans to the value of the benefit they were denied — and this limitation causes great harm and suffering to the injured individuals and their families.

To provide an example, if a plan denies a woman a mammogram because the plan doesn't believe it is necessary — even though the plan clearly covers mammograms for women — and that woman is later found to have advanced breast cancer that could have been detected and treated if she had been given the mammogram the plan had denied, the only damages she can obtain from the health plan are the costs of that original mammogram. Even if the plan's actions caused that woman's death, the cost of the mammogram is all her family can recover!

The fact that health plans are causing such harm to people and are seeing no consequence to those actions, is wrong and unjust. If a doctor or hospital were to treat a patient in the manner described in any of these cases, that doctor or hospital would be sued for medical malpractice. If health plans are going to be in the position of making medical decisions, they must be held similarly accountable. It makes no sense to do otherwise.

That is why the ERISA liability provisions of HR 3605, The Patients' Bill of Rights, are a fundamental component of meaningful managed care reform. You will note that the Republican managed care proposal - which has yet to be introduced - will not include these protections. That's just one of the missing components of their sham "reform" bill. We must not allow this Congress to pass legislation that avoids repairing this fundamental problem of today's health care system.

Again, I am proud to be here today to make the case that changing ERISA liability cannot be left out of a real managed care reform bill.

As a doctor who ran afoul of managed care, I find it fascinating to hear the explanations of health maintenance and other managed-care organizations for the low opinion the public has of them. For example, the California Association of Health Plans, my state's trade group for H.M.O.'s, blamed "a couple of stories being repeated over and over" for their bad image.

The trade group's comment was in response to my victory two months ago in a suit that was one of the first to test new laws in various states, including California, that protect doctors from being punished for ordering appropriate tests and for spending additional time with their patients. Ever since the jury's verdict, my office has been flooded with calls from doctors and patients recounting their own horror stories — and I have yet to hear the same one twice.

I have been a practicing pediatric gastroenterologist in San Diego for more than 25 years. Before the advent of managed care, I had a reputation for being a thorough and careful diagnostician. But as managed care became more powerful and as patients were turned into "cost units," my medical group, now affiliated with various H.M.O.'s, began to criticize my thoroughness as amounting to "overtesting," insecurity or indecisiveness. The board expressed concern that I would jeopardize future referrals to the group by managed-care organizations, which were con-

Thomas W. Self has been a pediatric gastroenterologist in San Diego for more than 25 years.

cerned with keeping down costs.

When I explained that the tests were appropriate in all cases and that I needed to spend adequate time evaluating each of my patients, my comments were brushed aside. Pressures on me to see more patients increased. In the outpatient clinic, it

There's a reason people are wary of H.M.O.'s.

was not uncommon for a nurse to rap on the door during a patient exam and unceremoniously call out, "You're running behind."

Two of my colleagues in the gastroenterology unit resigned from the group, leaving me as the sole obstacle to the "new phase" of medicine. In the ongoing attempt to force me out, too, secretaries were asked to keep notes of my statements and activities without my knowledge. Finally, on July 14, 1995, I found a terse termination letter on my desk.

After I was fired, and while I was setting up a new practice across the street, the group's staff told my patients that I had left the state, or that I did not accept their insurance, or that something terrible had happened that they could not talk about. My patients later told me that they felt abandoned and were confused and frightened by the loss of continuity of care when I was terminated. When it became clear that my patients were in distress and that I would not survive in solo practice if this interference and defamation

continued, legal action became necessary.

As disturbed as I was by what had happened to me, I was shocked by what came out at the trial. The smoking gun of the case came when a letter written to the president of my medical group by a top official of a managed-care organization surfaced during the discovery process. It pointedly warned that the organization did not wish its patients to be referred to me because I ordered too many "costly tests" and because I was a "provider" who "still doesn't understand how managed care works." If the president could not solve this problem, the letter insinuated, patients would be sent elsewhere. Within a month, I was secretly written out of the budget for the coming year, and about three months later, I was dismissed.

It also came out at the trial that while the younger doctor hired to replace me had generated enormous revenue in a short period and was commended by the medical group for doing so, he was involved in several medical incidents, including the death of one child and serious injury in two others. The medical group reached an out-of-court malpractice settlement, the doctor's privileges at the hospital were dropped, and he is no longer with the group.

After a three-month trial, the jury found that the reason for my termination was to save money for the managed-care organization and my group. The jurors relied on California Business and Professional Code 2056, whereby a doctor may not be dismissed for advocating appropriate care for patients. They also awarded defamation damages because of the untrue and disparaging

remarks the medical group circulated in an effort to discredit me. (The verdict will not be appealed, because the medical group quickly settled before the punitive damages phase of the case.)

From the enormous public and press attention given to the verdict in my case, it is clear that many Americans are unhappy with managed care. Despite all the political noise about reform, H.M.O.'s still hold the high cards. In California, for example, a committee in the State Senate recently approved a bill that would allow a health plan to choose its own reviewer to consider the appeals of patients who had been de-

Focus too much on your patients and you get a pink slip.

ned coverage for particular tests or procedures. The measure would also not require the H.M.O. to pay for treatment the reviewer recommends and would exclude from review any treatment that costs less than \$2,000.

Patients continue to be denied vital diagnostic tests and procedures because H.M.O.'s and other managed-care groups bring pressure on doctors to whittle down costs. It is also discouraging that, in my experience, H.M.O. business executives seemed to expect and receive timely treatment for their children rather than have to wait for the tedious and lengthy treatment authorizations that regular H.M.O. plan members must endure. Also, in two instances, I was told to do whatever was necessary, with no thought given to cost, by the executive whose children were being treated.

Don't misunderstand — I am personally not against the concept of managed care, but rather against the evils it can generate. A well-organized managed care system can prevent the disparity of treatment where one H.M.O. authorizes even acupuncture and biofeedback while another balks at allowing procedures like bone marrow and organ transplants. H.M.O.'s must allow independent and objective reviews of cases rather than rely on cursory checks by doctors who are eager to placate their powerful H.M.O. customers.

Surveys show that patients' faith in health maintenance organizations and in doctors has badly eroded. This inherent distrust of doctors and their

recommendations can only undermine the traditional physician-patient relationship, which is so vital to successful treatment.

After the verdict in my case, I received a congratulatory letter from a well-known pediatric surgeon in California. The rewards of being a doctor, he wrote, are "largely measured in identifying what is best for a patient and then having the opportunity to do what one believes is correct and best for that patient." If medicine will need this doctrine under all circumstances, then the tendrils of greed inherent in managed care will not be able to find fertile soil in which to take root and grow. □

Note to Readers

The Op-Ed page welcomes unsolicited manuscripts. Because of the volume of submissions, however, we regret that we cannot acknowledge an article or return it. If manuscripts are accepted for publication, authors will be notified within two weeks. For further information, call (212) 556-1831.

JULY 13, 1998 — NEW YORK TIMES

PHOTOGRAPH BY JAMES HAMILTON FOR THE NEW YORK TIMES

**Woman On "Inside" of Health Care Benefits
Learns The Hard Way About Being On "Outside"**



Judy Lerner
Studio City, Ca.

I was a principal with one of the largest benefits consulting firms in the world. As an "insider" in the world of employee benefits for twenty years, I was a defender of the "system" until I found out the hard way about the abuses in the managed care industry-- I lived it.

On June 21, 1996 I fell down the stairs at home, fracturing my right leg in three places, dislocating my right ankle, and fracturing my left foot. After undergoing emergency surgery, I emerged with casts on both legs and five pins and a plate in my right leg. I spent nearly three months confined in my third-floor bedroom, totally immobile. The physical torture alone and the long road to recovery would have been enough of a burden to bear; but my medical plan and my employer turned it into a nightmare.

My health care plan denied payment for medically necessary ambulance transportation to my doctor's office for follow-up care even though I could not get into a normal vehicle, had to be carried down the stairs, and had coverage under a medical plan whose legal plan document says it pays for transportation in an emergency or for medical necessity.

Three weeks after my accident, my health care plan also tried to cut off my home health care, even though I was immobile and totally dependent on trained assistance for every bodily function, medical need, and activity of daily life. A few weeks later, my home health benefits were actually terminated, forcing me to pay for them myself. My health care plan contended that I should be able to go up and down three flights of stairs on crutches---even though I had casts on both legs, suffered from vertigo, and initially became injured by falling down the stairs!

I have continued to appeal without success these outrageous denials of medical

benefits that go against the very provisions of the plan itself, as well as against the orders and opinions of all my treating health care providers.

And to make matters worse, my employer's actions when I returned to work aggravated a chronic illness I have, rendering me incapacitated. But to no surprise, my employer also has denied my long-term disability benefits-- even though I was approved for Social Security disability (the strictest disability standard to meet). Medical and disability benefits are expensive and my employer loses nothing by delaying and denying them.

Unfortunately, ERISA precludes me from seeking compensatory or punitive damages. Unbeknownst to the public at large, in today's health care environment, if an employer or its benefit plan denies care improperly and the patient is irreparably damaged or even dies, the only action available is a suit for the amount of benefits denied; legal fees are not even guaranteed - even if the plaintiff succeeds.

The majority of employees in this country have some form of employee benefits coverage that by and large they don't understand. In "normal" situations, more and more people are having trouble getting their expenses paid under their benefit plans; in cases of serious accident, catastrophic disease, and chronic illness, the problems in getting benefits paid are staggering.

No matter how egregious the violation of law or good faith, benefits law does not allow an employee to sue the employer or its benefits plan for damages--even if denied medical care results in irreparable bodily harm or death. People in this country need straight talk about what to expect from their benefit plans and how to get what they deserve: they need the story their employers will never tell them.

The ERISA Loophole must be challenged and changed or more and more individuals will find themselves trapped in a no win situation that leaves them with nowhere to turn and the health care industry immune from legal responsibility for denying or delaying medically appropriate care.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.



Baby Blind Because of HMO Denials



Madison Scott
Orange County, California

Madison Scott was born premature, but otherwise healthy. Today she is permanently and completely blind. Her parents, Curt and Helen Scott, claim the HMO they counted on to care for her was more worried about saving dollars than it was about saving her sight. Yet, because the Scotts receive their health care through their employer, they have no remedy against their HMO.

Madison was born three months premature. She was at extreme risk for a condition known as Retinopathy of Prematurity or ROP. Extra care is required to protect the vision of premature newborns because the extra oxygen they receive after birth can cause blindness if not properly monitored. ROP is very treatable if monitored closely and treatment stops the disease if started early enough.

Madison was examined by a pediatric ophthalmologist six weeks after her birth for signs of ROP. However, he - like her other HMO doctors who received financial incentives to delay treatment - didn't discuss the seriousness of Madison's condition with her parents or perform the

exam needed to determine her treatment. Nor did the doctor tell Madison's parents that Madison could go blind if proper care and monitoring wasn't done.

Later, the HMO delayed approval of the referral for the test, and consequently, Madison wasn't seen by the eye specialist for weeks. When the ophthalmologist finally saw her, the examination revealed that the ROP disease had progressed significantly. It was only then that Madison's parents were told that their daughter had a disease that causes blindness. Her condition was so serious that the doctor set an appointment for the same day with another eye specialist. That specialist told Madison's parents that the disease had progressed to the last stage and immediate surgery was required to try to save their baby daughter's sight.

Madison's parents decided to take her to a specialist outside of the HMO for a second opinion, to the Jules Stein Eye Institute at UCLA. The doctor from the Institute told them that he wanted to do surgery on Madison the next day in order to try to save her sight. Her parents called their HMO for approval of the emergency surgery. The HMO refused to give approval for the last opportunity to save Madison's vision.

After five failed surgeries, over the course of 3 weeks, doctors told Madison's parents that 3 month old Madison was completely and permanently blind.

Her parents cannot seek damages against their HMO for Madison's future medical bills because ERISA preempts state law causes of action for damages. Pending federal legislation would restore the Scotts' state court remedies.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day
May 11, 1998



**Consumers for
Quality Care**

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At-Risk Mother Not Admitted To Hospital Loses Baby, Has No Remedy



Florence Corcoran
Slidell, Louisiana

Florence Corcoran tragically discovered that the ERISA loophole stripped her of her rights and remedies to protect herself under state law. Her case has become the most frequently cited precedent used by HMOs hiding from state lawsuits.

Corcoran was faced with a high-risk pregnancy. Her obstetrician ordered her hospitalized, as she had been successfully in a previous high-risk pregnancy. Yet her managed health care company, United Healthcare, overruled her doctor and denied the hospitalization, even though they had a second opinion agreeing with the doctor's advice. Instead Corcoran's insurer ordered home nursing for only 10 hours each day.

During the last month of Corcoran's pregnancy, when no nurse was on duty, the baby went into distress. Denied the

monitors and care of the hospital, the baby died.

Because Corcoran received her health insurance through her employer, the ERISA loophole freed her insurer from liability. Mrs. Corcoran's wrongful death action in Louisiana state court, alleging medical malpractice, was preempted.

Fifth Circuit Court of Appeal Judge Carolyn Dineen King ruled in the case that "the basic facts are undisputed," but "the result ERISA compels us to reach means that the Corcorans have no remedy, state, or federal, for what may have been a serious mistake." She continued, saying ERISA "eliminates an important check on the thousands of medical decisions routinely made. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decision making."

"If I go out on the street and murder a person, I am thrown in jail for murder and held accountable," said Corcoran. "What's the difference between me and this clerk thousands of miles away making a life decision which took the life of my baby and she gets off scot-free and keeps her job. They don't get held accountable. And that's what appalls me. I relive that all the time. Insurance companies don't answer to nobody. Nobody knows about ERISA."

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day

May 12, 1998

Consumers for Quality Care

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Disabled & Denied



Jane Gabrilove
Santa Monica, CA.

In June of 1994, I sustained an injury to my back and neck when I fell on slippery floor outside of my place of employment. The ramifications of that fall still totally dominate my life -- physically and financially. For the last three years, I have been disabled and will shortly undergo a second surgery on my neck. I was depending on the long term disability insurance I had paid for through my employer to provide me with the *only* income I had...but because of a legal loophole of ERISA, the insurer brazenly refused to fulfill their contract with me.

ERISA allowed the insurance company to throw me into financial crisis, to siphon what energy the injury hadn't already taken, to "insure" that I had no viable legal recourse - and to further "insure" that the insurance company has no legal responsibility.

My insurance company has deliberately violated the terms of their agreement with me, unnecessarily delayed the processing of my claim for six months, continually withheld requests for important information, ignored repeated phone calls, faxes and mail, withheld moneys owed to me, and when finally dispersing some moneys due, did not explain the withheld money nor provide an itemization for the withheld money.

It was not until I enlisted the help of from a state legislator, a United States Representative, and the New York State Department of Insurance that I was able to get any of the money due me or any appropriate response at all from my insurance company.

My insurance company knows that because of the ERISA loophole, a dissatisfied policy holder can only do so much legally to them. Moreover, the recourse for a person like myself is extremely limited.

For example, when I went to file suit in Federal Court against my insurance company, I was told by a well-

reputed law firm that I would have to pay attorney fees while the case went through the lengthy process of trial, and if I won a judgment, ERISA would shield my insurance company from having to pay punitive damages or legal fees. My insurance company would only be responsible for the amount owed for medical bills.

Worse yet, if I were to lose, I would be responsible for paying both my insurance company's legal fees and my own. So they told me that they could not help me, nor did they know of a law firm who would. They said they received many calls like mine...and they wished me luck.

I am persistent in fighting this matter because it seems clear to me that ERISA protection is influencing my insurance company's claims processing and payout behavior. In other words, they have no incentive to process and payout in an appropriate manner because they are protected from prosecution by ERISA.

In my case, my insurance company managed to hang on to my benefit money for nearly a year! And during that time, they kept that money invested and profited from that investment, while they threw me into financial crisis. I had to drain my savings and borrow money from my family. I have not only been disabled, weak and in excruciating pain, but have had to live in constant worry because my insurance company was blithely "stonewalling" me. I have spent hundreds of hours trying to contact them and petitioning for help.

Contrary to what it would seem to offer, ERISA affords no realistic legal redress for my insurance company's behavior. In fact, ERISA enables insurance companies to defraud policy holders with the assurance that they cannot be exposed or held responsible for their behavior in any meaningful way.

I worry that many injured and disabled people cannot put forth the effort or have the knowledge I have to fight this battle. Many people with ~~valid~~ insurance suffer physically and financially from the negligence that ERISA encourages. Had I not persistently battled with my insurance company every step of the way by writing letters, documenting every transaction, faxing to numerous places, copying every hard copy paper, enlisting Congressional support, sending countless certified letters to all people and companies involved, I would not have been financially or medically aided.

I have now spent four years contending with this laborious and time consuming process. Had I gotten my disability insurance through my personal insurance agent I would of at least had legal recourse.

I believe the ERISA loophole must be changed in order for insurance companies to behave properly. Under the current ERISA protection, the insurance companies have no incentive to do so.

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HMO Refuses Expensive Tests, Wife Does Own Research To Diagnose Ailing Husband



Frank Dutcher Azle, TX

As Told By Deanna
Dutcher:

From 1986 my husband
Frankie did line
construction and took
out electrical

transformers. Polychlorinated Biphenils or PCB's, a
toxin, are found in these transformers and because of
their health risk, must be replaced through attrition or
when they are leaking. Liver dysfunction is a
recognized symptom of PCB exposure.

My husband's health problems started in 1988,
when Frankie began to have infrequent black-out spells.
By 1993 he was waking up with occasional nausea and
dizziness, sometimes vomiting before he went to work.
He had some swelling in his hands too.

We went to our family doctor and the tests showed
elevations in his liver enzymes which meant that there
was possible liver damage. The doctor never told us that
at the time and just put Frankie on an anti-depressant,
but his symptoms continued.

In 1995 Frankie had lost an unexplained 28 pounds
in one month and woke up one morning vomiting
violently. He went to his doctor and the tests revealed
that those 1993 enzyme levels were worsening...it was
the first we knew of them. Frankie was referred to a
specialist who did a physical exam and asked about our
family history. Due to Frankie's symptoms, exam and
discussion, the doctor expressed that he felt "it was very
important that Mr. Dutcher have a liver biopsy as soon
as possible." Yet, once the doctor realized which
insurance provider we had, he abruptly changed his
diagnosis. In short, the doctors response was, "Let me
tell you, you have bad insurance... dis-incentives
through your HMO restrict the care given to patients on
their plan." He suggested we report back to their our
doctor and have him order a CAT scan.

After explaining to the new physician the history,
symptoms and previous doctor's diagnosis, the
gastroenterologist claimed he did not believe the problem was
related to the liver. Instead, the doctor felt his problems
concerned the stomach and proceeded to test for ulcers. When
the tests returned negative, we took out a \$2,000 loan and
went out of the HMO's network. On May 27, 1996 we finally
received a diagnosis. The doctor did a physical exam, blood
work and a CAT scan and informed us that "there were indeed
other possible causes for fatty liver, toxins or certain drugs
being among those causes."

Once the test results were back, our new doctor informed
us that Frankie had "some very serious health problems
including an enlarged heart and hardening of the arteries."
Moreover, the doctor felt that "these conditions in a man of
31 years old warrant immediate attention."

With that diagnosis in hand, we changed HMO providers
and started a new cycle of problems with our new HMO. Our
new HMO sent us to two more doctors, one of which claimed
"there was no other possible cause for his condition other
than his weight."

We learned more about the symptoms of PCB exposure,
and pointed to those same symptoms in Frankie. But the
doctors were more adamant that the PCBs were not the
problem. Basically, if there are classic signs of liver damage
in someone and you know that there is a direct pathway to
PCB for that person, it would make sense to check out the
liver.

We have been the victims of managed care. Everything
we have learned about Frankie's condition has come from
outside our HMO network and has come at our own expense.
We have been denied and delayed care and services, delayed
and denied prescriptions, canceled by our primary doctor for
requesting care, denied appropriate care, and finally even lied
to in order to cover these problems up. We have been
completely ignored in our attempts to complain to the HMOs
involved.

I believe our HMO knows we have no legal remedy for
denied or delayed care because of the ERISA loophole. Until
HMOs are able to be held accountable for denied or delayed
care, I am convinced that more people like Frankie and I will
continue to suffer at the hands of managed care.

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Denied Mental Health Care Leads To Death Of Depressed Boy



Bill Schriever
Cypress, Ca.

As Told By His Mother, Mary

My husband and I took my son to the HMO doctor on three separate occasions, requesting a referral for psychiatric care. Under the terms of my coverage with my HMO, mental health care is covered for 20 visits for "crisis intervention."

To this day, I am unable to determine what my HMO deems to be a crisis. However, my son was failing school, had performed self-mutilation on his arms by burning and carving himself, used drugs and alcohol, and had several encounters with the police, which were becoming more serious. This certainly felt like a crisis situation to me.

We asked for a referral for eighteen months. The first two times we were brushed off by the doctor with the explanation that he was acting like a normal teenager. Realizing the need for treatment, we took him to a counseling center on our own. Bill's treatment was based on a sliding scale, and we soon realized that he was not getting the kind of professional experienced care necessary. Instead, his counselor was a displaced aerospace worker who was changing careers and performing his internship at this center. We really needed an experienced psychiatrist with a history of successfully treating adolescents.

I called the HMO doctor and again asked for a mental health referral. The doctor told me that my HMO would only approve a referral in the event of a suicide attempt. (Assuming at least some suicides attempts are successful, this probably does tend to save my HMO money.) He stated that he had as a patient a teenage girl who was raped and requested a mental health referral and the HMO would not approve care for her, so they would not approve care for my son.

The doctor prescribed Luvox for him. I do not know much about psychiatric medications, however, I was concerned that the cost was a factor in prescribing this particular medication instead of the more common Prozac. I understand that patients using Prozac may feel relief sooner

and therefore may be more inclined to continue treatment. My son decided to quit taking Luvox after twenty days because he did not feel any affect from it.

We were left on our own with no where to turn and my son's condition deteriorated rapidly. In one of his final incidents, he became very agitated and he called the police. My son told me he was going to have them come over and shoot him. He made a lot of statements about having the police kill him. When the police finally took control of the situation and took him into custody, they were very adamant about Bill needing mental help. Bill and I agreed, but told them I had been unsuccessful in getting him any through my HMO.

While in custody he was seen by a court ordered psychiatrist. She said my son should be considered a suicide risk and should be treated for depression. She said he needed to be in an environment where he could get intensive counseling and was in need of more counseling than he could get in a community environment.

Against our concerns, Bill was sent to the California Youth Authority. I was assured they had good security and that he would be segregated from the more dangerous offenders. Ten days later he was in a fight and died of a brain hemorrhage. I saw him the day before he died for two hours and he looked good. He was joking and asking about the dog, etc. I left thinking that things were going to turn out okay after all. His autopsy notes that he was on Prozac. They never discussed this with me so I don't know for how long, but I wonder if this is the reason he seemed to be doing better.

I personally don't think my son would have ended up dead if he could have had the proper medication and counseling much sooner in the process. Because my son received his health care through my employer, we cannot hold our HMO accountable for denying our son the mental health care he so badly needed. Our HMO is protected from legal liability through the ERISA loophole. ERISA shields HMOs that deny or delay medically appropriate treatment for individuals who receive their health care through their employer. Until HMOs are held accountable for their actions they have no incentives to authorize expensive treatment even if it may be medically necessary

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Delayed Surgery Leads To Death of Heart Patient



Honora Wempren

La Mesa, CA

As told By His Daughter Patricia

Even though I have been in nursing nearly 25 years and have worked directly with cardiologists for the last 12 years, I was unable to protect my father from his HMO and get him the care he needed.

Most people of my father's generation continue to hold physicians in high regard, and believe that they will be honest enough to provide them with the best medical care and advice that is currently available. Most are unaware of the fact that some physicians are willing to compromise medical care in order contain costs for the HMO and secure for themselves a financial bonus in the process.

My father was thrilled to have a pension benefit of health care coverage for his retirement years. Unfortunately he did not understand that HMOs and traditional health care are not the same.

My father had a medical condition known as Aortic Stenosis. In an elderly individual, the aortic valve may calcify and narrow. As the valve continues to narrow, it becomes increasingly more difficult for the heart to pump blood out to the rest of the body. Eventually the heart begins to fail, and irreversible heart damage can occur if surgery is not performed in a timely manner. Long term survival and quality of life are significantly reduced when surgery is delayed - as it was in my father's case.

My father had a heart murmur indicative of aortic stenosis for at least 12-15 years. There is a strong family history of stroke and heart attack and my father suffered a heart attack when he was in his fifties. He had long standing high blood pressure, and had a pacemaker. Despite this significant history of heart disease, his HMO chose not to follow him with a heart specialist.

In February of 1995, it was noted on a routine referral for a pacemaker check, that his heart rhythm had changed. This is the first clue that his heart was beginning to show signs of strain from the narrowed valve. Physicians who have since reviewed his medical records say that his aortic valve was severely narrowed at this point and further testing should have occurred.

I tried several times to contact his HMO physician to discuss his case, but he did not return my phone calls for over a month. When he did finally call, his message on the answering machine was so intimidating that I was concerned that if I called back my father would not be treated appropriately.

In November of 1995, my father complained to his physician that he was short of breath, felt rotten, and couldn't walk anymore. The physician decided to schedule my father for a procedure to correct the irregular heart beat that was discovered back in February. One would have thought that it would have been scheduled right away, but no, the surgery was scheduled for January of 1996!

Unfortunately, my father's health continued to deteriorate. He could barely walk or pick-up objects, even talking was an effort. I took him to the emergency room, hoping he would receive the urgent care he needed. But after waiting 4 hours in the emergency room, we were sent home--with no treatment. The next day surgery was discussed, but still our HMO was insisting it be done in January. We prayed that my father would make it through the holidays.

On January 2, 1996 my father underwent a procedure to correct his irregular heartbeat. His health did not improve. Days later he was back in the emergency room, his lungs and liver were congested with fluid and his legs were swollen to twice their normal size.

I found out that my HMO had a patient care advocate and I contacted them and told them the entire situation. They were unable to tell me where I could go for help or who I should complain to. To be sure, they were useless. I have nothing but criticism for that department.

My father was finally admitted to the hospital, and 10 days later underwent open heart surgery. But, it was too late, his health never improved. According to a physician who reviewed my fathers chart, the battle was lost between February and December of 1995. His surgery had been delayed until irreparable heart damage had been done. He never fully recovered from his surgery because of complications that set in and he soon passed away.

Because my father received his health care through his employer, his HMO is protected by the ERISA loophole. This loophole, shields HMOs from legal liability when they delay medically appropriate treatment. Until HMOs are held accountable for the medical decisions that they make, they will continue to deny and delay expensive treatments that cut into their profits and their bottom line. They have nothing to lose because ERISA is their goose that lays the golden egg.

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ERISA Casualty Of The Day

May 18, 1998

Consumers for Quality Care

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HMO Will Not Authorize Removal of Leaking Breast Implants



Diana McNair
Joshua, TX

I have been struggling with my HMO since 1990. Every action that I have had to take is like taking a 4 year old to the dentist for a filling. I have not been able to do anything as easy and carefree as the HMO makes it sound in their sales pitch and in their handbook.

In May of 1985, I had a double mastectomy followed by silicone breast implants which were reconstructive in nature and were subpectorally positioned. A year after the initial surgery, the left breast implant had shifted and was moving upward in position. This required reconstructive surgery using the same breast implant. That same implant is now moving downward, leaving my nipple pointing upwards.

My doctor and I believe the silicone breast implants are slowly poisoning me. I have suffered numerous miscarriages and believe the toxicity level is killing these babies in my uterus. My requests to have the implants removed by my HMO have gone unheeded, even as it imperils my health and well being.

In 1990, I started having stiff joints in my elbows, fingers, and most prominently, in my knees. This condition severely limits my daily activities, including on my worst days, difficulty in standing up and down. My HMO doctor merely recommended that I use BenGay for the stiffness. There was no connection made between the stiff joints and my implant problems.

In 1992, I faced the possibility of infertility, as I attempted pregnancy repeatedly, to no avail. After achieving pregnancy in 1992, I miscarried shortly thereafter. I underwent much testing and infertility work and finally conceived in 1994. Since then, I have had 5 more miscarriages, three of which reached the stage of a heartbeat, only to miscarry in the 12-15th week. My doctor and I believe the difficulty in getting pregnant and the 5 miscarriages are due to the toxicity level built up in my body from the silicone implants. There are many testimonials from other women who have the silicone implants and report the same predicament. Once the implants were removed, the women were able to conceive and carry a baby to birth with no problems. This is my biggest concern for wanting the breast implants removed.

In 1994, I started noticing discoloration and skin rashes on my face, upper chest and arms. The rashes developed into what I call scaly, little bumps that never go away. Additionally, in 1994 I was diagnosed with Chronic Fatigue Syndrome. Again I believe that both of these symptoms are related to the toxic nature of my breast implants.

Lastly, I have been having a burning sensation under my breast implants. It feels like they are falling out of place. The pain goes all the way through me to my shoulder blades. I desire that these breast implants be removed for the sake of my health and well being, not for cosmetic purposes. Yet, my HMO denies me coverage of this procedure by claiming that it is aesthetic in nature. Despite the many medical examinations whereby my symptoms are routinely linked to the breast implants, I am still denied coverage.

Due to the fact that I get my insurance through my employer, my HMO is protected by a federal law called ERISA (Employee Retirement Income Security Act) which voids state protection laws. The ERISA loophole shields HMOs and insurers from paying damages when they deny medically appropriate treatment for patients who receive their health care through their employers.

I have requested the surgery four times from my HMO, only to be denied each time. I have submitted documentation and medical exam results to substantiate that my claim is for medical purposes rather than cosmetic reasons.

This is absolutely the worst nightmare of my life and it is ridiculous the extent to which I have had to go to get the service and product that I pay for every month.

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May 19, 1998

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HMO Fails Cystic Fibrosis Patient



Melody Louise Johnson, 16
Norco, California
R.I.P.

The serious disease of a child is one of the most stressful occurrences in a family's life. While Melody's family should have been devoting all of their time and energy to helping Melody deal with her disease, they were spending hours fighting with HMO bureaucrats on the phone.

Melody had Cystic Fibrosis (CF). CF is the number-one genetic killer of children and young adults in this country. In 1955 few children lived to attend elementary school. Today, with consistent, aggressive, and quality care the median age of survival for individuals with CF is 31 years.

Due to Melody's pre-existing condition, her HMO required that she have secondary insurance even though their HMO said that all of Melody's medical needs would be covered. So the Johnsons took no chances and kept a secondary insurance policy with the state-run California Children's Services (CCS). If her HMO chose not to cover a procedure, then CCS would be there as a safety net. All CCS needed was a letter of denial from Melody's HMO.

The Johnsons had numerous problems from the beginning. They were told that all pre-existing care costs were covered and that Melody had been put on "Medical Alert" at their HMO. According to the Johnsons, both proved to be false. On several occasions they utilized urgent care facilities and were shocked to discover that the doctors had no experience or knowledge of Cystic Fibrosis. "What is Cystic Fibrosis anyway?" one doctor asked.

The Johnsons could see that Melody was deteriorating and they continually asked for a referral to a Cystic Fibrosis Center. They were not only denied the referral but were told that Cystic Fibrosis did not require a specialist. Incidentally, if you have a child in a CCS plan, the state requires that a child with Cystic Fibrosis be seen by a certified Cystic Fibrosis Center once a year because the disease is so complex to manage.

According to the Johnsons, when Melody was finally seen by a specialist, the doctor advised the Johnsons that she needed an operation for a hernia and a "tune-up." That is, Melody needed her lungs treated prior to surgery as she was decompensated. The Johnsons requested that the surgery be done at a Cystic Fibrosis Center, because of the dangers involved. But their HMO insisted that it be done at one of their group hospitals. The Johnsons were concerned. The operation should have been done by a Cystic Fibrosis Team.

And the problems continued. The Johnsons said they were denied follow-up visits with doctors after surgeries and hospital stays. Melody's specialist's decisions were overridden by utilization review boards, and her primary doctor's referrals to specialists were overridden by the office manager in charge of referrals. In one case, the HMO covered the medicine that Melody needed, but not the needles to deliver it. "We only cover needles for Diabetes" they were told by an administrator. After three weeks of daily phone calls requesting a letter of denial, so they could get the needles through CCS, their HMO finally agreed to cover the needles.

The Johnsons did the best they could in making sure that Melody's medical needs would be taken care of. Unfortunately Melody died at the age of 16. The ERISA Loophole shields Melody's HMO from having to pay damages for delaying and denying the medically appropriate treatment because Melody was insured through her father's employer.

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A Simple Test Would Have Saved His Hearing



Kyle, 3
Bakersfield, Ca.

As told by his mother:

Our son, Kyle, got his health care through his father's employer. In 1992, Kyle began having ear problems when he was 6 months old. Because it took our HMO so long to get the specialized treatment he needed, Kyle is now "maimed" for life. Besides the horror of a lifetime of hearing loss, Kyle will continue to be monitored every year for potential problems that could develop.

We first became concerned about our HMO because the corrective measures the doctors were taking were not working. After approximately 9 months of similar treatments, we requested Kyle be sent to an ENT specialist as a "tube" candidate. A "tube" is a teflon tube that is surgically inserted in the ear to allow for drainage of infected fluids. We were told the HMO didn't like to do tubes anymore, that tubes were "over prescribed". For 9 more months, the HMO kept Kyle on a ritual of antibiotics. He was finally referred to an ENT when it was noted that his eardrum had ruptured.

The specialist confirmed that Kyle definitely needed tubes and went through the necessary paperwork to schedule him for surgery. During the surgery, the polyp was removed and sent for a biopsy. PE tubes were placed in both ears. After 10 days, Kyle's right ear began to bleed.

A CAT scan then would have provided conclusive evidence of a cholesteatoma - severe infection that destroys the bone in the inner ear. Instead, the HMO chose to withhold that test.

For 3 months, a new doctor continued with ear drops and aspiration. He finally concluded Kyle must have had an allergic reaction to the "metal" tubes the first doctor placed in the initial surgery. He scheduled another surgery to remove and replace the PE tubes. (The new doctor did not request copies of any of Kyle's records from their old doctor's office to support his theory).

After several months we finally came to the conclusion our son was not getting the necessary treatment he needed to resolve his problems. We advised our doctor that we were changing HMOs and, at that point, the doctor suggested that we do exploratory surgery to determine what was going on in Kyle's ear. The doctor said that was what he recommended we tell the new HMO.

After discussing Kyle's history with their ENT at the new HMO, lab tests were performed and a CAT scan was scheduled. The CAT scan disclosed a cholesteatoma. Kyle was immediately referred to a head and neck surgeon in Oakland. Kyle's surgeon explained the cholesteatoma was caused by a number of different things and he couldn't pin point the exact cause, but that chronic ear infections was one of the causes.

At the age of 3 Kyle was scheduled for another surgery. The doctor called us from the operating room and told me the surgery would last 3-4 hours. After 7 hours of surgery, the doctor came out and explained that because the cholesteatoma had been undetected for so long it had done extensive damage to the middle ear. They had to do a radical mastoidectomy, which included removing all of the bones (with the exception of the stapes) in his middle ear. We now had to hope for a 70% chance of success on this procedure and anticipate another surgery in a year to attempt to reconstruct the middle ear.

We are now facing another surgery for our son and are anticipating "significant" hearing loss as he reaches adolescence. Because of the ERISA Loophole, the first HMO is shielded from legal liability for withholding medically appropriate treatment. The few dollars the HMO saved by withholding a CAT scan could have led to meningitis or even killed Kyle. Until HMOs are held accountable for denying or withholding care, there is no incentive for them to perform tests that could lead to expensive treatments.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day
May 21, 1998

**Consumers for
Quality  Care**

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

AIDS Patient Denied Coverage Retroactively Has No Remedy



John McGann
Houston, Texas
R.I.P.

“Any type of insurance that came be taken away at a moment’s notice is the equivalent of having no type of insurance at all”

When John McGann was diagnosed with AIDS, he turned to his employer's health plan, which covered him for \$1 million in health benefits. But when he filed his first claim for AIDS-related treatment, the insurer informed him that his benefits would be capped at \$5,000, retroactively.

The retroactive change was against state law. But since McGann was insured through his employer, the state's consumer protection law was nullified by the ERISA loophole.

McGann went to court claiming discrimination, but lost. The judge claimed ERISA's broad scope did not prohibit the retroactive elimination of coverage even though the benefit change "may stem from prejudice against AIDS..." The ruling leaves insurers with an extraordinary degree of immunity from discriminatory and dangerous denials of treatment for people with costly, life-threatening illnesses.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day

May 22, 1998

Consumers for Quality Care

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org



Matt Scwabe
Davenport, IW

On July 9, 1991, Matt was accidentally shot by a friend, leaving him a quadriplegic. As a result, Matt's medical needs were extensive. Every two to four hours he needed attention: catheterization, suctioning of his breathing tube, adjustment of the breathing equipment, medication, bowel care, tube feeding--what some hospitals consider acute care.

Confidant that that their health plan would abide by the plan's promise of 100% coverage for doctor-ordered home nursing, Matt's family brought him home after nearly a year of hospitalization and rehabilitation. Soon after, they received a letter from a lawyer who represented their health plan. it read:

"...In the Company's opinion, Matthew is now custodial. Therefore, we are not required to provide in-home nursing services. However, we are not terminating the benefit now, but rather are decreasing nursing services over a period of time until the benefit is terminated..."

As the hours of nursing care were reduced, Matt's mother, Mary Peterson, slept by her son's bedside with an alarm clock set to go off every few hours. She soon would have to provide all of Matt's care, 24 hours a day, seven days a week. "It was like we were on death row," Matt's stepfather, Clair Peterson, said. "Every two weeks they'd cut away four more hours of care for Matt. With each passing day, with each passing minute, our family was being pushed closer to zero hours. And we could not find out who made this decision, and why. Who was responsible? Who was 'The Company?'"

The Petersons sought help from their Congressman, Rep. Jim Leach, who contacted the Iowa Insurance Division. A staff attorney responded to Leach's inquiry:

"This (health) plan is self-insured and subject to the provisions of ERISA. Consequently, our division could not be of assistance to Matthew even though we would like to be. This case illustrates how ERISA prevents our division from being of service to our bosses--the people of Iowa."

In a written plea to their health plan, the Petersons begged company officials to reconsider their decision "When we hit zero hours, you have effectively chained Mary to Matthew for the rest of her life and told her to do what you'd never ask a nurse to do: pull 24-hour shifts the rest of her life."

The Petersons filed a lawsuit and argued that all medical evidence indicated that Matt needed skilled nursing care--the kind their health plan seemed to guarantee--just to stay alive. Without it, he would die.

Their health plan's defense was based largely on its assertion that Matt needed only custodial care--care that is not designed to improve the patients condition--which was not covered. Interestingly, the company's definition of custodial care was not inserted into the policy until 14 months after Matt's accident and just 15 days before the case went to trial.

Because of ERISA, the Petersons did not have the option of a jury trial, and the case was heard by Judge Charles R. Wolf, in Davenport's US District Court.

In a May 29 letter to the court, the health plan's attorney described to Judge Wolf how ERISA protected the firm from the Petersons' claims of bad faith (a point that the judge said "added nothing" to the discussion of why benefits were being denied) and that the Petersons' health plan required them to settle disputes through arbitration. The attorney quoted from this provision at length, but failed to mention that this language had been inserted into the plan on May 28, *the previous day*.

After several weeks of trial, Judge Wolf sided with the Petersons, ordering their health plan to "pay in full all of Matthew's necessary costs of care to the present date." However because of ERISA, the Petersons were not entitled to any punitive damages: the company responded with an appeal.

"It was amazing to see the lengths to which our health plan was going to avoid its obligation," Mary Peterson said. "I naively thought there was some kind of integrity behind the promises they had made."

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

May 20, 1998

**PATIENTS WITHOUT REMEDIES DUE TO ERISA
LOOPHOLE, LAUNCH CASUALTY OF DAY CAMPAIGN**

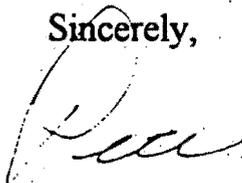
Dear Colleague:

Consumers for Quality Care has launched a campaign to lift the ERISA protection from managed care plans, so that patients who have been injured by plan actions can obtain help.

Attached are the first several weeks of examples of ERISA's "Catch 22"--failure to provide needed care and protection against legal action. The stories of ruined lives are evidence of why we must act to make plans more responsible.

Whether it is the Norwood or the Dingell bill, we need to include ERISA reform in whatever Managed Care Consumer Protection bill we pass this year.

Sincerely,



Pete Stark
Member of Congress

Denied Medical Tests Leads To Tumor Growing Unchecked



**Paige Lancaster
Virginia**

Eleven year-old Paige Lancaster's HMO delayed giving her important medical tests for her frequent headaches, letting a tumor grow unchecked for four years. According to the Lancasters, the HMO had an incentive program in place to pay bonuses to physicians who avoided "excessive" care.

In 1991, Mrs. Lancaster took Paige to their HMO, because of her daughter's frequent headaches and nausea. For the next four years, Paige repeatedly visited the HMO's pediatricians for the headaches, but she was never once referred to a neurologist or given any other diagnostic test to understand the causes of the headaches. Finally, in May 1996, after Paige's school psychologist wrote a letter to the HMO urging the

company to perform diagnostic tests to understand the debilitating headaches, her HMO doctors ordered tests. They discovered a right frontal tumor and cystic mass over 40% of Paige's brain. A week later, she underwent surgery. However, because of the tumor's size and maturity, the surgery was unsuccessful, requiring Paige to undergo several more surgeries and radiation therapy.

Unfortunately, when the Lancasters tried to hold their HMO responsible for the delayed care, and to recover their costs, they found their case fell under the ERISA loophole. The District Court of Eastern Virginia had no choice but to dismiss the Lancasters' claims for negligence and fraud against the Kaiser Corporation.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

Debilitating Pain is Treated With The Urgency Of A Common Cold



Lillian Jefferies
Sun City, Ca.

My medical problems began in 1997, when after suffering from severe sciatica pain (nerve condition), I underwent a hip replacement surgery on the advice of my doctors. Since that surgery, my condition has severely deteriorated. I have spent 95 percent of my time with my leg and foot elevated in order to be even minimally comfortable. I sleep less than four hours per night, and I am in unrelenting pain, which has been treated with continuing and frequent changes in, and additions to, medications. I am dependent on others to perform all but the most basic tasks for me, yet I spend hours on costly telephone calls trying to get the attention I need. To date, my condition remains undiagnosed; although I have been told repeatedly that I have undergone "successful" surgery.

Throughout my medical treatment, I have experienced persistent problems with my HMO. My grievances include stalling of treatment and tests, access to specialists, as well as extremely poor customer service overall.

The negligence began when my doctor recommended that I undergo three epidural injections to be administered in 2-week intervals. My HMO requires treatment requests to be submitted and authorized before a doctor can treat a patient, creating delays in treatment. Instead of the HMO approving all three at once, each individual session required new forms to be submitted and further delays between injections. This delay resulted in my epidural injections to be given in intervals longer than the two weeks recommended by my doctor.

My chronic pain ensued so I was tested for a suspected blood clot. Not only was I treated rudely by the desk clerk when trying to get an appointment, but I

was virtually forgotten about while awaiting her test results. Had I not persistently phoned the lab, I most likely would not have heard from them.

On March 31, 1996, my doctor requested an authorization for me to be seen by a neurologist. Pending the HMO's authorization, I was forced to wait a month for an appointment. When I finally got in to see the neurologist, I was flatly informed I had been given the wrong forms and was told to reschedule. This stress caused a rapid and recorded rise in my blood pressure.

Eventually, I was given an exam and the doctor concluded that I had a pinched nerve somewhere in my body and that a more comprehensive examination would be required. The doctor assured me that he would immediately process the request.

Throughout my involvement with my HMO, I have experienced frustration every step of the way. Departments are seriously understaffed causing delays in treatment, and doctors are so overburdened that patients must wait three weeks or more for appointments and are required to pick up and deliver x-rays and doctor authorizations, even when they are ill and have limited mobility. Furthermore, patients are asked to verbally convey findings of one doctor to another rather than direct doctor to doctor communications.

Therapists and anesthesiologists are not provided with treatment plans or results of diagnoses, nor are caregivers providing the patient with copies of all authorization forms as prescribed by law.

I am concerned by the lack of knowledge and apathy to pain management resulting in high narcotics dosages. I also question the excessive delays due to the need for all recommendations for treatment from specialists be approved by primary care doctors, and then by the provider staff. Why make referrals to specialists whose medical expertise can be questioned and countermanded by non-specialists or even nonprofessionals?

The HMO is protected by a federal law called ERISA (Employee Retirement Income Security Act). The ERISA loophole shields health maintenance organizations from damages when they delay and deny medically appropriate treatment for patients who receive their health care through their employers, like me.

I am dismayed and disgusted by this pervasively callous disregard for timely and effective patient care. Something is wrong when a painful and debilitating condition is treated like a common cold.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

Following Doctor's Advice Leads to Denied Coverage



Dallas George
Davenport, IA

Dallas George was on heart medication when he switched jobs in 1990. When he decided to take the new job, Dallas made sure his new employee health plan would cover future costs related to his previous open heart surgery.

On February 12, 1990, he began experiencing chest pains. Two days later, he was undergoing coronary bypass surgery with prior authorization from his new insurer.

"We got the pre-approval, had the operation, then four months later the bills started coming in. That's when they came up with this argument that they were denying my claims based on a pre-existing condition."

The insurer claimed the second surgery was an extension of treatment initiated with the

first operation, as evidenced by the pills George had been taking ever since his first surgery. By following his doctor's advice and taking the pills, George had forged a link of treatment between two operations that were years apart--- and had given the insurer a reason to deny coverage.

Because of ERISA, Dallas George and others in his situation can't get damages against insurers who refuse to pay their bills. Future employers aren't likely to offer them insurance, and insurers that do collect premiums can deny coverage with impunity.

"It's a hell of a fix to be in for someone who thinks he has insurance" George says.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

May 26, 1998

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

When I Needed Hope, My HMO Gave Me A Denial



Bill Beaver
Pollock Pines, CA.

One morning in 1993 I was out running and I began to have problems with one of my legs. I went to my HMO to have it checked out but was told it was nothing serious. But my leg problems persisted. I began to have trouble walking and I could no longer run. Five months later, my HMO concluded that I must have had a stroke on the morning when I first noticed my leg problem. In my mind though, I just didn't fit the profile of a stroke victim.

My problems with my legs and nerves worsened over the next two years and my HMO wasn't able to develop any remedy. After more extensive testing, doctors finally discovered that my problems were due to a deadly brain tumor that had been misdiagnosed two years earlier. I had difficulty understanding this new diagnosis and why it had taken so long to come to light.

They told me the tumor was inoperable and predicted that I would live two years at best. They told me normally they would perform a biopsy of the tumor to confirm the diagnosis and order treatment, but in my case the procedure was much too risky and would most likely leave me paralyzed, comatose or dead, and regardless of the findings there were no known treatments that could prove beneficial.

Essentially they were saying take two aspirin, go home, and die. What was taken from me that day was hope. In a very few minutes I was cast from the herd, of no more use to the well being and future of my peers. I felt like a sickly gazelle left as

prey outside the protective circle because it is not economically feasible to do otherwise.

I could not believe there wasn't anything that could be done. I spent many years acquiring and teaching positive outcomes from negative circumstances. I could not give up.

My wife and I drafted a list of family and friends to find some answers, our army of faithful I called them.

One afternoon I received a telephone call from my sister-in-law. While sitting in a waiting room she read an article about a young man who had the same condition as me and was being treated successfully at John Hopkins Hospital. The article went on to reveal the compassion and competence exhibited by John Hopkins and how they have earned the distinction of being the leader in health care and wellness.

I used all of my savings and began traveling to this prestigious teaching hospital. They contradicted the opinion of my HMO doctors by performing a biopsy and recommending radiation therapy for treatment, and then the doctors at John Hopkins convinced my HMO to administer the radiation treatment.

More than three years have passed since I was given a death sentence from my HMO and I am grateful for the fortunes during this time. While I am not well, I now have a good chance to get well. I do not know what the situation would be if I had the best possible care from the onset.

I do know that my HMO still refuses to pay for my life-saving treatment at John-Hopkins. The Employment Retirement Income Security Act (ERISA) makes it impossible for me to collect damages from my HMO for denying me my life-saving treatment. The ERISA loophole must be closed so that HMOs that make medical decisions to withhold care can be held legally liable for their cost cutting decisions.

There is no incentive for an HMO to give treatment to a patient that only has a small percentage of a chance to live. When I needed hope, my HMO gave me a denial. When I needed support, my HMO gave me the door. Until HMOs are forced to give quality care, they will continue to deny costly treatments that can prolong, or in my case, even save a life.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

May 27, 1998

CASUALTY OF DAY #2

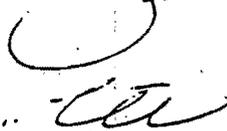
Dear Colleague:

Consumers for Quality Care has launched a campaign to lift the ERISA protection from managed care plans, so that patients who have been injured by plan actions can obtain help.

Attached are the four latest examples of how ERISA plans fail to provide needed care, but are protected against legal action. The stories of ruined lives are evidence of why we must act to make plans more responsible.

Whether it is the Norwood or the Dingell bill, we need to include ERISA reform in whatever Managed Care Consumer Protection bill we pass this year.

Sincerely,



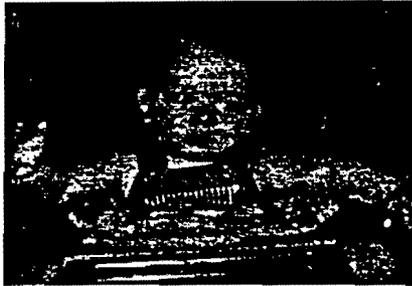
Pete Stark
Member of Congress

ERISA Casualty Of The Day
June 4, 1998

**Consumers for
Quality  Care**

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

**Untreated Infant Dies Due To HMO Clerical Error.
Family Has No Remedy**



Chad Aitken
Woodland Hills, CA
R.I.P

As Told By His Mother Heather

To have your life fall apart when one piece of the puzzle comes out is very devastating. This is what happened to my family when my HMO refused to see my son, Chad, after a routine vaccine.

Chad died because of denied care by my HMO. He was just one in a number of children and adults who are getting hurt by the managed care industry because they are treated like a number, not a human.

The difficulties began when I took my 5 1/2 month old son in for a checkup. Chad was given vaccine shots at this appointment which caused a subsequent reaction. I called my HMO and requested they see Chad again, because of a reaction to the shots. At this time, the pediatrician became hostile with me and accused me of having used their facilities for six months without insurance. I was confused by this accusation because I had just had the baby five months ago, and another one of my children had a minor operation, and no one had mentioned our insurance coverage before to us.

Although we had been members of my HMO for over five years, the doctor told us that we had been coming in under fraudulent circumstances and refused to see my son. This accusation was due to a clerical mix up on our insurance coverage dates through my husband's ex-employer.

Refusing treatment after an invasive procedure like drug injections is not only unethical, it is unconscionable. If doctors administer treatment, they are supposed to follow through with the job-not

leave it half way. When my son was refused treatment, I did what my HMO told me to do by giving Chad breathing treatments for asthma. This breathing problem was directly related to Chad's adverse reaction to the vaccine shots. But without my HMO seeing and treating Chad for this reaction, what could have been prevented, became fatal. Chad Aitken senselessly died on August 8, 1995. The microscopic report clearly indicated that the cause of death was due to Chad's reaction to the vaccine shots.

We feel the take over of the medical profession by HMO administrators is a threat to the health and safety of everyone-young and old. It is apparent the HMO industry is only concerned with wealth, not health. I have heard so many horror stories because my HMO was too busy and it did not matter to them what happened to patients. I trusted this facility to take care of my children. As a mother and a human being, I thought I was doing the right thing. I never thought my HMO would abandon us.

My life without my son has been devastating and I wouldn't want to see another parent go through the same nightmare as we have been put through.

Because we received our health care through our employer, we can recover no damages against our HMO. ERISA, the Employment Retirement Income Security Act, contains an unintended loophole that prevents me from seeking damages against my HMO for denying Chad the care he needed. This law must be changed. In the long run, my HMO probably saved money now that Chad is dead.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

HMO Stonewalling Costs Woman Fertility



Connie Barcliff
Santa Barbara, CA.

In November of 1996 I had a physical exam with my long-time physician. We discussed my symptoms and his exam confirmed that I have a condition called endometriosis. This is when the lining in the uterus overgrows, and makes pregnancy nearly impossible. Since my doctor is not contracted with my HMO, I called my primary care physician and he did another thorough exam and confirmed the diagnosis. He then prescribed medication which I have been taking since December of 1996.

In February of 1997 my primary care physician then referred me to an OB-GYN specialist who was also contracted with my HMO. He too confirmed the diagnosis and recommended I have surgery to take care of the problem. He recommended a follow-up with invitro-fertilization.

In March of 1997, my primary doctor's office called and told me that my HMO had denied the claim for surgery. The office manager also told me that my doctor could no longer help me because he had dropped my HMO as of March 1st. She suggested that I call my HMO directly.

I called my HMO and talked to a Member Services Representative. I was told that the best course of action was to re-submit the claim to a Review Board. I waited a month and in the middle of April called my HMO.

In May, I spoke with a lady from Member Services. She told me my HMO had once again denied the claim due to the "way my doctor had worded the diagnosis." Although she never told me the doctor's wording, she did say that the claim was for follow-up invitro-ertilization treatments which she said were not covered by my policy.

I next called my union which provides my insurance coverage. The union representative reviewed my benefit package with me, and in fact, *I do have* invitro-fertilization coverage.

On May 7, 1997, I spoke to another Member Services Representative and told her everything that had happened. She assigned me to a different primary care doctor and requested that I go to him to get another referral to see a specialist. In a perfect world, that specialist would again submit a diagnosis to my HMO, and then my HMO would again review the claim.

When I called my new primary care physician, I was told he no longer was accepting patients from my HMO. Urrrrh!!!

Again I called my HMO and spoke to the same Member Services Representative. She said she would find yet another primary care physician, however she informed me there was none practicing in the Santa Barbara area. She said she could assign me a doctor an hour to the north or 50 minutes to the south. I declined both, and requested an HMO doctor in Santa Barbara area, even if that doctor practiced outside of the medical group.

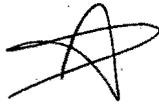
This ordeal lasted 8 months and I have never received written correspondence from my HMO regarding why my HMO claims have been denied. I am at a complete loss about how to deal with the run-around I have received. My repetitive requests to speak to supervisors at my HMO have been stone-walled and I cannot understand my HMO's negligence, especially in view of the fact that the procedure I need can be performed on an out-patient basis.

My experience tells me that my HMO operates in a way that leaves their injured so upset and frustrated that the person either gives up or seeks another medical care provider. Because I get my health care through my employer, the ERISA loophole shields my HMO from damages for delaying and denying this medically appropriate treatment.

I had to take care of my medical condition and time was of the essence if I ever planned to have children. (To this day I have been unable to conceive.) I wish to see the ERISA loophole closed and HMOs to be held accountable so that the consumer has a remedy when they are faced with the kind of stalling tactics that were employed by my HMO in my case.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day
June 2, 1998



**Consumers for
Quality  Care**

phone: (310) 392-0522
web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

Child With Brain Tumor Denied Access to Specialist



Sarah Pedersen

San Mateo, CA

As told by her mother, Brenda

Sarah was born with a brain tumor. When Sarah was three her doctors began a course of aggressive treatment, including brain biopsies and chemotherapy. While Sarah's body struggled to fight her disease, her father and I fought the HMO to provide her with appropriate care.

Her neurosurgeon knew Sarah needed the expertise of a doctor specializing in brain tumors in children. But the HMO saw Sarah as a diagnosis, not a child. "What difference does it make, cancer is cancer." I was told when asking for an appropriate referral. Like all HMOs, ours had a list of preferred providers, and there was no one on the list specializing in tumors like Sarah's. Referring Sarah to a doctor in the plan, an HMO representative told me, "We're not giving you second best, we're giving you what's on the list."

I'm a nurse and know my way around the medical establishment, and it still took me months to get Sarah the care she needed. Sarah's dose of Vincristine, a common chemotherapy drug, was denied once by a clerk at the HMO because she didn't know the computer code of the drug. People with no medical training are making decisions about the medical treatment you receive, regardless if your doctor knows best.

Once Sarah finally got to the right doctor, her chemotherapy began. Everyone knows

chemotherapy causes severe nausea and vomiting. The same HMO that paid a CEO \$895 million in a merger, denied Sarah a \$54 prescription to quell her nausea and vomiting because it was "too expensive."

The HMO won. They didn't care about Sarah and wished she'd just go away. Her father and I were lucky enough to be able to switch insurance plans in the middle of a medical crisis. Because Sarah obtained her health care through her father's employer, the HMO cannot be held legally accountable for denying or delaying valid medical care because of an unintended loophole in a federal law called ERISA. Until this loophole is closed, HMOs will have no incentive to aggressively treat the sickness in our society.

Sarah is eight now and doing well, but she still has a tumor and continues to be monitored. I wish to see changes in our health care system that puts patients before profits. Until then, others will continue to suffer at the cost-cutting hands of the HMO industry.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

HMO Denies Heart Patient Access to Cardiologist, and Hospitalization For Drug Treatment



Stephen Keller
Pacifica, CA.

I have a condition called "atrial fibrillation" which is an irregular rhythm of the heart. I take medication to control this. I have had this condition for 10 years.

Three things happened to me while I was insured under an HMO that I consider to be medically dangerous decisions. First, my wife called the office of my MD to inform them I was having an attack of atrial fibrillation. The office told her that the doctor was booked up and couldn't see me. We went to my cardiologist instead. (We pay for an individual health plan because my cardiologist who I have been going to for 8 years wasn't on the HMO plan) If we were medically uneducated or didn't have enough money to pay to see the cardiologist, I would not have had any medical attention at all when my heart was beating irregularly.

Second, my cardiologist wanted me to change medication to a drug called Cordarone. He told me that I would be hospitalized for about five days while I took a very high dose of the drug to build it up in my system. I would then take a lower dose daily. The HMO refused to pay for the hospitalization. As a result, I had to take a lower (but still quite high) dose at home over a longer period of time.

During the first two weeks I was unable to go to work as my wife had to watch me for side effects of the drug. After the dose was lowered, I could go to work, but could not drive; a co-worker had to pick me up to go to work. All in all, it was 6 weeks

before I was lowered to the maintenance dose and could resume normal activities.

Third, during the period when I started on Cordarone, I had several attacks of fibrillation. On one occasion it was late at night, so my wife took me to the emergency room. They put me on a heart monitor a couple of hours, then sent me home while my heart was still beating irregularly. In the past, on another health plan, the hospital had admitted me for observation when I went to the emergency room. I believe that they sent me home because they knew the HMO plan would dock them under the capitation agreement. This happened more than once when I was under the HMO plan.

I have been lucky so far, but the law needs to be changed to make HMOs more accountable for the cost cutting decisions that they make. I get my health care through my employer so I fall under what is called an ERISA Plan. ERISA, the Employment Retirement Income Security Act, shields my HMO from damages if they make a cost cutting move that maims or kills me. If I could find a lawyer to represent me, I would be able to collect only the cost of the care that was denied me. However, lawyer fees are not even guaranteed under ERISA, so finding representation would be difficult too.

ERISA works like a bank robber who gets caught robbing a bank and the only penalty they have to face if they get caught is returning the money they've stolen. No jail time...nothing. If that was the law, many people would give up their day job and take advantage of such a lax system. This is what is happening within the HMO industry under ERISA. HMOs know there is no legal recourse if they deny or delay expensive tests that may lead to expensive treatments. They have no incentives to go the extra mile or even just give standard care.

The ERISA loophole must be closed and HMOs must be held accountable for the decisions they make.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

June 5, 1998

CASUALTY OF DAY #3

Dear Colleague:

Why we need to provide malpractice protection for those in managed care plans:
the horror stories continue....the anecdotes pile up and prove a national problem.

Following are the latest Casualty of the Day reports from the Consumers for
Quality Care.

Sincerely,



Pete Stark

Member of Congress

June 12, 1998

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email: cqc@consumerwatchdog.org

HMO Delays Care for Cancer Patient



William Pratt
Vacaville, CA.

As Told By His Wife, Patricia Pratt

My husband, William Pratt, was diagnosed by his HMO with acute pancreatitis and treated for a year and a half. On January 26, 1995 he died of cancer.

In the weeks before his death we experienced things that I did not believe could happen in our country.

When William was first told he had cancer, we were told by his physician that an oncologist would examine William that morning and work out a treatment plan. He waited for 10 agonizing hours for this doctor to show up. Her office kept telling him she would be there, but after she failed to show up his physician released him from the hospital.

It turned out to be eight days before the HMO could get him into see a specialist, and we will never know if that delay would have made any difference.

While he was in the hospital, there was a failure to provide adequate pain relief during his hospital stay. In fact, the on-call physician discontinued pain medication that had been ordered by his primary physician.

There were inadequate staff and poor housekeeping conditions. And there was a failure to provide comfort and compassion to the patient and the patient's family.

Substandard medical care is just as devastating as a major illness, and far too costly. The laws must be changed to protect the patients rather than protect the HMOs. ERISA, the Employee Retirement Income Security Act, contains a little known loophole that prevents people like us, who receive their health care through their employer, from seeking damages against their HMO.

For a year and a half my husband was in almost constant pain. All of us in his family are still suffering. This is not an isolated incident...it is happening far too often.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 11, 1998

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HMO Denies Treatment Skinless Girl Has No Remedy

Francesca Tenconi, 11
Oakland, California

Eleven year old Francesca suffers from Pemphigus Foliaceous, an auto-immune disease in which the body's immune system becomes over active and attacks the protein which adheres the top layer of skin to the body. Francesca's parents had to battle with their HMO to insist upon appropriate diagnosis and medical care.

According to Donald Tenconi, Francesca's father, Francesca's medical and insurance ordeal began in December 1995, when at the age of 11 she developed what was diagnosed as a skin rash. By March, the condition had spread and become worse. By late April, the condition was so bad she could not attend school. During this period, several requests were made for referral to specialists outside the HMO. These requests were denied.

Finally, on May 8, 1996 (almost 6 months after the first appearance of symptoms), the HMO sent biopsies to out-of-network doctors and finally obtained an accurate diagnosis. The

diagnosis was Pemphigus Foliaceous. Even after receiving the diagnosis, the Tenconi's HMO still insisted on treating the disease primarily with its own doctors. It was not until February 1997, over one year after the symptoms first appeared, that the HMO finally agreed to allow Francesca to receive care at Stanford Medical Center, which possessed the doctors capable of providing the best care available in the San Francisco Bay Area.

Explaining the prolonged and unnecessary pain of lying down without skin on your back for over one year, Donald said "If you feel this pain you will shed tears of pain, the same pain that Francesca shed night after night, week after week, for many months."

Because Francesca received her health care through Donald's employer, the HMO claims that ERISA shields it from damages for delaying and denying medically appropriate treatment.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 10, 1998

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HMO Refuses To Pay For Life Saving Surgery



Betty Woolfson

Stockton, CA

As Told By Her Daughter, Sarah Jones

HMO enrollees who get an outside doctor's opinion had better have deep pockets to pay for medical help they need. So far, a dispute between outside doctors and my mother's HMO has cost our family more than \$15,000 in legal fees. My mother is in critical need of life-saving surgery that has already been postponed three times because her HMO refuses to pay for it.

The dispute between my mother and her HMO arose when the HMO's doctors recommended a course of treatment that world-renowned neurosurgeons at UCLA Medical Center believe will endanger her life. We wanted a second opinion because my mom has an artery in her brain the diameter of a golf ball that is calcified and brittle and full of blood clots. It has caused her to go blind in one eye. At any time she could completely lose her sight suffer a massive stroke, or die.

The estimated cost for the surgery and treatment UCLA doctors recommend is \$150,000. Advance payment is required. UCLA doctors believe my mother's condition is serious and that surgery must be performed as soon possible.

Initially my mom's HMO stated there is no appeal process. Finally, someone explained

there was no "complaint department" only a "customer satisfaction department."

Unable to reach an agreement with the HMO, we had to take our case to Federal Court where my mother, a middle aged, lower income woman with no connections was given the responsibility to convince top specialists to take a day off from brain surgery to fly 500 miles to testify on her behalf. She was unable to persuade the experts to come to court. The HMO suggested we enter into the arbitration process which by law insists that each side pay their costs when an HMO is involved, regardless of who wins.

By the sheer fact that HMOs have endless financial resources this makes it a cinch for HMOs to prevail. When this process bankrupts the patient, forcing them out of their HMO, it is often taxpayers that end up picking up the tab, saving the HMO from having to shell out for expensive medical procedures.

Sadly, our story is not unique. ERISA, the Employment Retirement Income Security Act, contains a loophole that allows HMOs to sidestep accountability for denying or delaying medical care. If this loophole were closed now, families like ours would not have to suffer financial and emotional ruin to get adequate medical help for our loved ones.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 9, 1998



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**HMO Denies Patient On Vacation Treatment
Women Suffers Stroke Flying To HMO, Dies**



(Barbara)

**Barbara Garvey
Chicago, Illinois
R.I.P.**

Chicago resident Barbara Garvey, 54, fell seriously ill during a Hawaiian vacation due to an adverse reaction to her arthritis drug, prescribed by her HMO doctor.

The doctors in Hawaii correctly diagnosed her condition and advised the Garveys that she needed a bone marrow transplant immediately. Then the physicians cautioned the couple that Barbara shouldn't travel back to Chicago for this transplant since this would increase the risk of her suffering a cerebral hemorrhage or infection during air travel. Barbara's HMO review doctor back in Chicago concurred with the Hawaiian doctors.

However, HMO bureaucrats told Barbara's husband David that the HMO would not be responsible for her treatment if she remained in Hawaii and that she should return to Chicago.

En route to Chicago, Barbara suffered a stroke that paralyzed her right side and left her unable to speak.

When she arrived in Chicago, she was admitted to St. Luke's Medical Center, where she died nine days later of a cerebral hemorrhage and other complications.

The HMO then attempted to use a legal loophole to avoid all responsibility. That loophole is contained in a law known as the Employee Retirement Insurance Security Act of 1974 (ERISA) which was enacted well before the era of managed care and was intended to provide workers with benefits protections. The HMO claims that because Garvey received her health care through her employer the Garveys cannot receive damages for Barbara's death. HMOs have been using ERISA, in many cases successfully, to shield them from accountability when they tie doctor's hands and direct patient's care leading to injury or even, in the case of Barbara Garvey, death.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 8, 1998

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**Cancer Patient Denied Liver Transplant
Living out HMO Death Sentence**



**Judith Packevicz
Saratoga Springs, NY**

A woman suffering from a rare form of metastatic cancer of the liver is being denied life-saving treatment by her HMO. The HMO will not pay for a liver transplant recommended by her oncologist with the support of all her treating physicians – causing the woman to live out a death sentence.

Judith Packevicz has struggled against the slow-growing cancer and now faces imminent death if the transplant is not performed. Her quality of life, according to a lawsuit filed May 27, 1998 in Federal Court, Northern District of New York, is "indescribably miserable both physically and mentally." Her son, Thomas Dwyer is a ready, willing and able donor. 13 friends of the family have also volunteered to donate a part of their livers. The recommended treatment is available at Mt. Sinai Hospital in

New York City and will cost an estimated \$345,000.

Ms. Packevicz is the mother of four children, stepmother of three and a grandmother of nine. A well-known figure in Saratoga Springs, she was an active and successful singer in a Sweet Adeline quartet until her illness forced her to stop last year.

The suit was brought under the Employee Retirement Income Security Act (ERISA) which applies to employee benefit plans. Ms. Packevicz purchased the health care through her employer. Under ERISA, she can recover no damages, only the cost of the procedure denied in the first place.

The HMO denied the recommended transplant on the grounds that it allegedly "does not meet the medical standard of care for this diagnosis." No explanation of why the recommended transplant allegedly fails to meet community standards was provided in the correspondence.

The lawsuit, filed under ERISA, seeks a temporary restraining order, preliminary injunction and permanent injunction requiring the HMO to pay for Ms. Packevicz's cancer treatment. It argues that "community standards in the State of New York do not mandate slow, certain, miserable hopeless, excruciating and inhumane death in plaintiff's case where there is a medically recommended reasonably feasible alternative a few dollars away." Ms. Packevicz's physicians assert a very high probability of survival with significantly improved quality of life if the transplant is performed.

Under ERISA, should Packevicz die before receiving her transplant, the HMO is liable for no costs at all.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

June 10, 1998

CASUALTY OF DAY #4

Dear Colleague:

Following are Casualty of the Day reports for the week of June 8 from Consumers for Quality Care.

If any one of us suffered this kind of treatment, we'd be screaming from the rooftops. It is time to end the ERISA shield against malpractice relief and help ensure that managed care plans pay more attention to the quality of the care they provide.

Sincerely,

Pete Stark
Member of Congress

ERISA Casualty Of The Day

June 19, 1998

Consumers for Quality Care

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email: cqc@consumerwatchdog.org

Pensioner's Health Care Taken -- Has No Remedy Under ERISA



Casey Patelski
Iowa

Casey Patelski was a dedicated employee of a leading aerospace manufacturer for 28 years. He helped to design spacecraft and directed U.S. astronauts at Mission Control in Houston. His future appeared secure when he retired in 1992, as he had been promised generous lifetime health benefits.

Six months later, even though he had been guaranteed it in writing, that promise was broken. His former company announced that it would no longer pay for non-union retirees' health coverage, and Patelski lost his health care coverage. Betrayed, a wheelchair-confined Patelski now faces his future unsure, and frightened.

Because he had put faith in his employers' promise of lifelong benefits, he and his wife now find themselves without a budget for major medical bills.

"It doesn't take a rocket scientist, which I happen to be, to realize that I am going to have continuing medical costs," he says. "I am afraid that any medical emergency could financially bankrupt me and my family."

As it stands, ERISA is the only federal law pertaining to employee health plans and pension benefits. Unfortunately, it supersedes state insurance law and answers to almost no regulation. In addition, any claims against the company by Patelski are preempted by ERISA and would be removed from state to federal court. Once in federal court, Patelski would be unable to recover any damages.

"Because ERISA does not set standards for health benefits, employers are free to do whatever they want," former United States Senator Howard Metzenbaum, D- Ohio, said. "Despite years of promises, employers can put clauses in their health plans, literally overnight, breaking original promises and reserving the right to terminate benefits."

Casey Patelski is one of the growing numbers of retirees who are learning the terrifying truth that, as a result of ERISA, these promises are empty. Instead of beginning his golden years of retirement peacefully, he now faces the grim reality of having no health benefits to speak of.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 18, 1998

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no DISCUSS Treatment

Cancer Patient Denied Treatment With Highest Recovery Rate



**Edward Mycek
La Quinta, CA**

In November of 1997, I found out that I had prostate cancer. After discussing treatment and recovery options, my doctor advocated surgery to remove the prostate. I decided to get another opinion. After consulting with a new doctor at Loma Linda University Medical Center, I decided on a Proton and 3-D Conformal Radiation treatment. The new physician and his staff concluded that I was an excellent candidate for the treatment.

1. The tumor was encapsulated
2. My P.S.A. count was low
3. The results of the bone scan were propitious
4. I am only 54 years old.

The doctors at Loma Linda Medical Center then contacted my insurer, which said that it would pay for the full treatments. In fact, my insurer called back to inform me that the insurance policy covered these treatments and they'd notify the medical center that the procedure had been authorized. The authorization never arrived at the medical center.

Worried about the delay of my care, I called my insurer, who told me that they had reversed the decision. The company claimed that Proton and 3D Conformal Radiation was "experimental and investigational."

Loma Linda then faxed factual information to my insurer which explained that the procedure was not experimental nor investigational. Since June 1996, Medicare, and many other insurance companies, have accepted this procedure. The medical center doctor also wrote a letter that discussed the different recovery rates: for Proton radiation the recovery rate is 98% versus 83% for surgery.

After several stressful weeks, I was still denied help. I asked my insurer what other treatments were covered. They responded by saying "they could not say, it would be practicing medicine." After being passed back and forth, like a ping-pong ball, I couldn't wait any longer. On February 17, 1998, after paying "up front," I began my first of 44 radiation treatments. This a financial burden on our family. Today, I have completed all 44 radiation treatments, and I am due for a check up next week. I am scheduled with Loma Linda for follow-ups through 2004.

After all is said and done, I still feel that I have been denied needed care by an agent 3000 miles away, seated at a desk and appointed by the company to ~~decide~~ the quality of care I receive.

I have worked for this well known company for almost 32 years and this was the first major claim I made. Because my insurer is protected by "ERISA", I can recover no damages against them. I do not have the resources to pressure my insurer to provide better care. Is this "ERISA" law a fair and just medical/insurance law to employees? Not by any means.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 17, 1998

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**Heart Patient's Access To Cardiologist Stone-walled
Dies Due To Mis-Managed Care**



Glenn Nealy
New York
R.I.P.

According to a court case filed by the Nealy family:

In March 1992, Glenn Nealy, 35 years old and the father of two young boys, was notified by his employer that there would be a change in his health care coverage and that he could elect coverage under one of three plans. Glenn chose a managed care company after receiving assurances from its agents that the plan would enable him to continue treatment of his unstable angina and would allow him to see his cardiologist. The doctor was treating Glenn with a complete drug regimen including nitrates, calcium blockers, and beta blockers.

On April 2, 1992, at the direction of the managed care company, Glenn went to the office of a participating primary care physician for the purpose of obtaining a "referral" for follow-up treatment by his cardiologist. However, the managed care doctor refused to see Glenn until he had a valid company card. On April 3, Glenn returned to the primary care doctor's office with a copy of his enrollment form, which the company advised would be accepted by their primary care provider. Again, the primary care doctor refused to see Glenn. Between April 2 and April 21, Glenn contacted representatives of the managed care company

to obtain a valid card, and it issued two incorrect and invalid cards to Glenn.

On April 9, 1992, the primary care doctor met with Glenn, but refused to give a referral to the cardiologist, professing no knowledge of procedures for allowing referrals. The doctor renewed Glenn's angina medications, but Glenn was unable to fill the prescriptions because the company provided incorrect and invalid information to Glenn's pharmacy. Between April 9 and May 18, Glenn repeatedly tried to get the insurer to authorize follow-up care by his cardiologist. On April 29, the insurer, in violation of its previous assurances, formally denied in writing Glenn's request for follow-up visits with his cardiologist, because they had "a participating provider in the area." On May 15, after being repeatedly denied authorization to see his cardiologist, Glenn obtained a referral from his new doctor to see a "participating" cardiologist with the managed care company on May 19. On May 18, Glenn died from a massive heart attack, leaving behind his wife Susan, and his two sons.

Unfortunately for the Nealys, Glenn received his health benefits through his employer. Under ERISA, the only legal remedy available to an injured patient is the cost of the benefit delayed or denied. Susan Nealy cannot recover economic losses -- such as lost wages or salary -- or non-economic losses. Because Glenn never incurred any medical expenses, the managed care company cannot be held responsible for any costs and Susan Nealy has no remedy for the wrongful death of her husband.

The District Court for the Southern District of New York had no choice but to dismiss Susan's claims for the breach of contract, misrepresentation and wrongful death.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day
June 16, 1998

**Consumers for
Quality  Care**

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Woman Denied Fertility Benefits Retroactively



Linda DeBenedictis
Norwood, Massachusetts

Unfortunately, I had received my health care through my husband's private employer in the mid 1980s. We were unable to conceive a child. I had been covered by the insurance company for invitro fertilization services in the past. But in 1986, invitro fertilization was suddenly listed as an excluded benefit – only after I applied for a claim. We believe we were the only couple using the benefit and that is why the insurer terminated it.

Through discussions with an employee insurance representative we were led to believe that our coverage would be continued since we had been approved in the past. As it turned out, our future claims were denied. We appealed to the Massachusetts Division of Insurance. After months of frustration and dozens of letters and phone calls, we learned about the "ERISA" laws which allowed my husband's employer to legally stop paying

for our treatment retroactively. We had absolutely no remedy under the law.

In 1988 Massachusetts passed a law mandating fertility coverage. We were still excluded because self-insured "ERISA" plans don't have to comply with state mandates. The Massachusetts Division of Insurance wrote us a letter stating that "the plan is not subject to any of Massachusetts mandated insurance benefits, including infertility benefits."

We learned about "ERISA" the painful way. It's critical for consumers to understand the limitations, risks, and lack of redress under self-insured ERISA plans. Most of us learn about it after the fact. It's time to stop the abuses and protect consumers by reforming the "ERISA" laws.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

Collapsed Boy -- A Cardiac Risk -- Told To Take Gatorade, Dies



**Alexander Giles, 9
Houston, Texas
R.I.P.**

Alex Giles' managed care plan doctor failed to give him crucial cardiac tests and to refer him to a cardiologist, resulting in the needless death of the athletic nine-year-old, according to a lawsuit filed by his family. Bridget Giles, Alex's mother, claims the health plan's doctor ignored obvious symptoms that require routine tests which could have saved Alex's life. The company maintains that all claims against it are preempted under ERISA and should be removed to federal court where no damages are available. The company is trying to appeal the case.

According to court documents:

The health plan doctor saw Alex twice, less than two months before his death. At the first appointment in 1995, the company's physician noted that Alex had fainted on three occasions while playing basketball, including one episode resulting in an emergency room visit. Fainting during exertion is a serious medical indication that should have been evaluated immediately because it suggests a cardiac-related problem. Not only did the health plan doctor fail to order any tests, but he also failed to obtain an appropriate history of Alex's condition. The doctor did not even take Alex's blood pressure, pulse, or respiratory rate.

The managed care doctor should have recognized the potential seriousness of Alex's condition and referred him to a pediatric cardiologist. Instead, Bridget Giles was simply told to give Alex Gatorade.

Two weeks after the first visit, Alex fainted again. A day later, he saw the same plan doctor. On this subsequent visit, the company's doctor again failed to gather an adequate history of the condition and took only Alex's blood pressure. The doctor did order a blood test and planned to do an EKG, but he never followed through with the test.

Two weeks later, at the frantic demand of Ms. Giles, the plan doctor relented and referred Alex to a pediatric ear, nose and throat doctor. The specialist referred Alex to a pediatric neurologist. Unfortunately, the original plan physician failed to follow Alex's condition and never obtained the critical cardiology consult which would have saved Alex's life. Alex's cardiac condition went untreated and he tragically died shortly afterward undiagnosed.

If the managed care company has its way in court and removes the case under ERISA, Ms. Giles will be unable to recover any damages for her son's delayed care and wrongful death from the plan. Since Alex died before getting his treatment, the managed care company, under ERISA, can be held liable for nothing in the case of Alex Giles.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

BILL THOMAS, CALIFORNIA, CHAIRMAN
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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

June 17, 1998

CASUALTY OF DAY #5

Dear Colleague:

Following are Casualty of the Day reports for the week of June 15 from Consumers for Quality Care--more proof of the need to hold all health plans, including ERISA plans, liable for medical misconduct.

Sincerely,

Pete Stark
Member of Congress

June 26, 1998

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HMO Misses Diagnosis & Denies Referral, Endangering Woman's Fertility



Charla Cooper
San Francisco, CA.

I originally went to my HMO for what I thought were some fairly routine gynecological tests. Two years later, exhausted from battling them for correct care on any level, I have probably lost my fertility due to the HMO's negligence.

My healthcare problems involve two diagnoses both of which were totally mistreated by my HMO. I have a pre-cancerous cervical condition called "high grade dysplasia," which can easily turn into cancer. Fifty percent of high grade dysplasia cases progress to invasive cancer, and I am in a high risk category because of my family history of cancer. Instead of treating this condition proactively, as it should be, my HMO did not return my phone calls, scheduled procedures 3 months after

they were needed and returned test results up to two months after the tests were performed.

I still have the pre-cancerous condition since it would require an expert surgeon to operate in order to avoid damage to my cervix. However, despite acknowledging their mistakes, the HMO steadfastly refused to pay for care from an expert surgeon.

My even more traumatic diagnosis involves "premature ovarian failure," which probably means I will not be able to have my own children. However, the really maddening thing is that the HMO totally missed this diagnosis until it was too late. Had the HMO done the appropriate tests when I first saw them, I would still be able to have children. But the HMO denied the tests, probably for reasons of cost, and now it is probably too late. I understand from other physicians that this particular negligence is costing many ~~women~~ their fertility.

Because I received my health care through my employer, my HMO can claim, under ERISA, that I am not entitled to damages against them for their denials of fertility coverage.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 25, 1998

phone: (310) 392-0522
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Delayed Benefits Costs Man His Testicles

Frank Wurzbacher

Covington, KY

According to court documents:

Frank Wurzbacher, a retiree, had surgery for prostate cancer and was taking monthly injections of a drug called lupron to keep the cancer from returning.

In January of 1995, a new insurer took over as the third-party administrator of his retiree health plan. It announced it would pay only 80% of the allowable charges for his treatment, rather than the 100% it had been covering.

The change would cost Frank \$180 a month, a charge he could not afford. After several months, Frank's doctor said he could not continue to provide the injections without recovering his costs.

The one alternative Frank's doctor gave him, and the one that would be covered in full, was castration.

After making several calls to his insurer and having no luck getting the company to change its mind about the injections, Frank took his doctors advice.

Frank had the surgery on September 18, 1995. When he got home, there was a notice waiting in the mail from his insurance company saying they would go ahead and pay the full cost of the injections.

The insurance company had actually decided more than a month before that it would cover Frank's injections in full. But administrative snafus, including failure to enter the information in the insurance company computer, kept the information from Frank despite his repeated inquiries.

Frank asked for compensatory damages from his insurance company, alleging negligence under state law, among other things.

A federal district court dismissed the complaint, ruling that Frank's claims are preempted by ERISA. "The court finds that this case is based on a denial of benefits claims which is clearly preempted by ERISA," the Court said.

Frank has no recourse and will get no compensation for this tragedy.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 24, 1998

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*Consumer
& Care*

HMO Fails Bone Cancer Patient



Shirley Moore
Union City, CA.
R.I.P

As told by her daughter Norma Lowe

In January 1997, my mother went to her HMO with pain in her right ribs and a heavy cold. After a chest X-ray was taken, the doctor diagnosed lung cancer. What the HMO's doctor failed to diagnose was that my mother also had bone cancer. Mom asked the doctor why she was having so much pain on the right side since the lung cancer is on the left. The HMO doctor looked at her X-ray and said she had a cracked rib, yet the written report says "evidence of an old fracture."

The HMO's doctor did not make any further investigations despite my mother's complaints of rib pain. A course of treatment was decided upon, consisting of chemotherapy and radiation therapy. Mother had to be hospitalized on more than one occasion during her chemotherapy treatment. For example, during one chemotherapy treatment she was given too much intravenous fluid which caused her to go into congestive heart failure. We were very disappointed to note that the doctor treating her cancer never visited her while she was in the hospital to check on her.

After the chemotherapy, mom was referred to a non-HMO hospital to receive radiation

therapy. The doctor at this hospital requested a bone scan be performed as he was concerned about my mother's complaints of rib pain. This bone scan was performed at the original HMO on April 24. No one called us from the HMO to tell us the results!

My mother returned to the other hospital a week later where the non-HMO doctor presumed we had been informed of the results of the bone scan. He was shocked to learn we had not, especially since the scan showed that my mother had bone cancer. We found this lack of communication to be totally and completely unacceptable.

We then made an appointment to see our HMO doctor on May 5. We were told that my mother did not have the HMO's coverage. We tried to explain there was a clerical error and that my mother was covered. Even after we gave the name and number of a person who could verify this, they insisted we pay for the visit. We were embarrassed and humiliated in full view of other patients.

Our HMO doctor then scheduled a CAT scan for my mother. The results of the scan showed that the cancer had spread and was going to continue to. However, the HMO doctor failed to diagnose a cancerous cyst on my mother's spinal cord. She was crippled as a result of this cyst.

My mother succumbed to the cancer on October 28, 1997.

We are very dissatisfied with the continuity of care provided to our mother by her HMO. We are especially upset about the lack of pain management she received. Cancer that affects the bones is extremely painful, yet they failed to give her proper pain medication on numerous occasions. We wanted to be assured by the HMO that necessary medical care be given to our mother, and that she would be treated in a caring, courteous and professional manner. We feel the care was substandard and our mother was misdiagnosed and improperly treated.

Unfortunately, my mother received her health care through her employer, so the HMO is protected by a loophole in the federal ERISA law. Therefore, we are unable to recover damages. If the HMO feared such damages, maybe they would have been more concerned about my mother's care.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 23, 1998

phone: (310) 392-0522
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**HMO Denies \$110,000 Surgery Recommended By HMO's Doctor
Patient Forced Into Debt**



Debra Moran
Winfield, IL

My managed care nightmare began in July of 1995 when I developed pain in my hand, wrist, elbow, shoulder and neck. The pain proved to be a symptom of Brachial Plexopathy and Thoracic Outlet Syndrome – two related conditions that impair circulation and neural transmission. As the conditions worsened, the pain grew. But I continued to get the run-around from my HMO, which refused to refer me to the right specialists and denied coverage for the surgery that my HMO primary care physician deemed medically necessary.

In fact, I had to learn about my condition through my own research and an out-of-pocket evaluation by a specialist in Virginia. When this specialist confirmed diagnosis of the circulation and nerve damage, I returned to the HMO and asked for a referral to her. They took five months to deny the referral and I received no treatment in the interim. My pain grew worse. I could not cook, clean, go to work or feed myself.

After two and a half years of stonewalling by my HMO, the nerve in my neck and shoulder was scarred and destroyed. The out-of-the-HMO network specialist in Virginia recommended surgery to repair the nerve and restore circulation. The HMO denied payment for this \$110,000 procedure, claiming it was not medically necessary, even though my pain was medically documented and my primary care doctor in the HMO concurred with the specialist. I mortgaged our future and our house, as well as our 401k, to pay for this surgery.

Today, I am well. The nerve and circulation damage is healing. The HMO would only pay for hack and cut surgery that would have cut into my neck, left me scarred and in pain, and taken years to recover. I would have never been better because the nerves were damaged and could not be left alone.

Until this day, my HMO refuses to pay for the procedure that saved my career and my quality of life. Because I receive health care through my husband's employer, the HMO will never have to pay more than the cost of the procedure they were supposed to pay for in the first place. [And ERISA's standard for proving an "arbitrary and capricious" denial to recover even those costs is much higher than the "medically necessary" standards under state law.]

Due to ERISA, the HMO will never have to pay damages for the pain they have caused or even my wage loss. If the HMO knew they would have to pay damages, I don't think they would ever have treated me this way. I thought I had more rights, but instead I am paying huge credit card finance fees to pay off this procedure.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

June 22, 1998

phone: (310) 392-0522
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email: cqc@consumerwatchdog.org

**Cancer Patient Dies From HMO Delays
Has No Remedy**



**Phyllis Cannon
Oklahoma City, Oklahoma
R.I.P.**

Phyllis Cannon's health insurer delayed her medically appropriate cancer treatment for three months. By that time her cancer had developed beyond treatment, and she died weeks later.

In 1991, Phyllis Cannon was diagnosed with acute myeloblastic leukemia. When she went into remission, her doctor urged that she undergo an autologous bone marrow transplant (ABMT). Yet her HMO delayed authorization for three months, by which time the cancer had returned and Mrs. Cannon could no longer benefit from the treatment.

Her HMO claimed that Cannon's bone marrow transplants would be

"experimental," yet this procedure was a covered benefit under Cannon's policy. She died just weeks later. Because Mrs. Cannon received health insurance through her employer, the ERISA loophole prevented the HMO from paying a price for its delay and gave Phyllis' husband, Jerry Cannon, no remedy for his wife's death.

Judge John Porfilio, of the Tenth Circuit Court of Appeal, noted the problem of ERISA's broad preemption of remedies for wrongful death, stating that "Although moved by the tragic circumstances of this case, and the seemingly needless loss of life that resulted, we conclude that the law gives us no choice but to affirm" that Mr. Cannon has no remedy for his loss.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

June 23, 1998

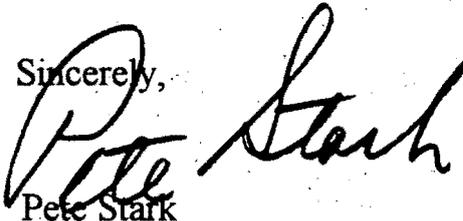
CASUALTY OF DAY #6

Dear Colleague:

Enclosed is the 6th week of examples of why we need to amend the laws protecting HMOs against malpractice complaints.

These are moving and dramatic examples of why reform of ERISA must be part of managed care reform.

Sincerely,



Pete Stark

Member of Congress

July 2, 1998

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**HMO Fails To Take X-ray, MRI or CT Scan
For Patient Who Suffers Neck Fracture in Auto Crash**



**Mary Betts-Dumonte
Alameda, CA**

I am a former paralegal and office manager. I have traveled the world. I was an all around athlete -- I skied, played tennis, golfed, and scuba dived. On September 11, 1994, I was in an auto accident in which I incurred a severe head injury after my head hit the windshield. I was immediately taken by ambulance to the county hospital.

Because I was an HMO member I was transferred the next day to my HMO where I was admitted to the surgical service. Despite having suffered severe trauma, and despite having symptoms which suggested that I had suffered nerve damage and possibly a broken neck, the HMO's records show that they failed to take a single x-ray, MRI or CT scan of my neck.

During my stay, I complained about accelerating problems with my hands and excruciating pain, complaints essentially ignored by my HMO. At the conclusion of my five day stay at the HMO, I strongly protested that I was in too much pain to be discharged and that I

could not use my hands. My complaints were dismissed, and I was discharged against my wishes and sent home in a taxi without any home care.

The HMO did not diagnose my broken neck until the end of November 1994. Two and a half months after my accident, despite the fact that I was in terrible pain during that entire period, an MRI was finally done in late November. It demonstrated that I had between 8 and 11 fractures in my neck, including two vertebrae that were completely broken up; what are called ring fractures. Further, I was not fitted for any type of brace to support my neck until three weeks later. I was told to drive home that same day in spite of the fracture and obvious instability.

I had a major operation to stabilize my neck on January 19, 1995 including the bolting of a plate into my neck. However because of the long delay in diagnosis, I suffered permanent injury to my hands which make me unable to work and causes me chronic pain. I believe if I had been promptly and properly treated most or all of my disabilities and pain could have been prevented.

Unfortunately, because I receive my health care through my employer, my HMO claims it is protected by the federal ERISA law. Even though, as a result of their lack of providing vital care, I am suffering from chronic pain and unable to work, I have no means to recover damages from my HMO. The ERISA law must be changed in order to make these HMOs accountable.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 1, 1998

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**Patient With Congestive Heart Failure
Told That He Has Stomach Gas By 1-800 HMO Clerk**



**David Pollard
Rancho Cordova, CA**

As told by his wife Mary Ann Pollard

My husband David, who is 63 and has a 15 year history of diabetes, woke up on Good Friday this year complaining of not feeling well. He told me he had woken during the night feeling ill and "drained", and had an episode of violent vomiting. Over the next two days he did not feel any better and started to feel short of breath. We called our HMO's telephone advice line and related David's symptoms, including his breathing problems. We were advised David had a "bad stomach" and told to buy over the counter antacid. After a day and a half, it was apparent it was not working and David was feeling more out of breath. At night he had to sit up to sleep, as he could not catch his breath lying down.

We called the HMO telephone advice line again. This time we were advised to go to the HMO's Emergency Room. David had an EKG taken by a technician, his lungs were listened to, and he related his symptoms. We were told

David was suffering from gas, and that there was a stomach bug going around. He was advised to keep taking the antacid.

Another day passed and David was no better. His shortness of breath increased. We again called the HMO advice line. We were on hold for an hour and then disconnected. We called back and eventually spoke to someone, and were again advised that David should carry on taking the antacid.

The next day, when David woke from a nap, he got up to walk, but found he could only take a few steps, as he could hardly breathe. We called 911. When the paramedics arrived they immediately listened to David's chest and told him that he could not breathe because his lungs were filling with fluid. They took him to the hospital where he was seen by another doctor who told him he had congestive heart failure and kidney failure. They stated that he had a heart attack the first night when he was vomiting violently.

David was then admitted to the hospital. It was determined that he needed triple bypass surgery. David had the surgery and is now recuperating. Now we are left in a position of not being able to trust those who we should have the most trust in, our HMOs. We are now extremely wary of everything the HMO does.

Because David receives his healthcare through his employer, he is subject to the ERISA loophole. We are denied the ability to get damages. The ERISA loophole must be closed so that the HMOs can be held responsible.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day

June 30, 1998

Consumers for Quality Care

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web: www.consumerwatchdog.org
email: cqc@consumerwatchdog.org

HMO Refuses To Authorize Heart Bypass Surgery: Patient Saddled With \$50,000 In Bills



Hal Reidell
Lakeport, CA

As told by his wife Linda Reidell

Hal is an HMO member and has a history of hypertension and diabetes. He was raking leaves one day when he suffered chest pains. We called our family doctor who recommended we go to the nearest Emergency Room (not an HMO hospital). There my husband was examined by a cardiologist who wanted to perform an angiogram, and called our HMO to advise them of his condition. Our HMO refused to authorize an angiogram. They advised us to go to their hospital in Santa Rosa, which we did. Some tests were done at the HMO hospital, but no angiogram.

When the tests were complete, the doctor said we should go home or stay in a motel overnight and come back in the morning, as Hal did not meet the criteria for admission. I called our cardiologist and related these events. He stated emphatically that Hal needed an angiogram and hospitalization. Our cardiologist spoke to the HMO doctor, to no avail. As we proceeded to leave the ER, Hal began to experience chest pain again. He sat down near the entrance and I tried to get him help. The doctor would not see him.

Disgusted, we drove home. The next morning we spoke to our HMO's cardiologist who claimed Hal had refused treatment and would not authorize any further tests. The conversation with the HMO cardiologist was so frustrating that Hal began having acute chest pain and turned ashen. We went to our local hospital. We again called our HMO to authorize treatment and they again refused. An EKG showed that Hal had a heart attack! An angiogram was performed by the hospital. It showed Hal had five blockages in his heart and needed triple bypass surgery. Our cardiologist called our HMO and asked them to authorize the surgery. They refused. The surgery was performed the next day and proved to be a success, and Hal continues to enjoy a good quality of life to this day. However, we now have approximately \$50,000 in medical bills.

In order to recover the costs of Hal's care, we began our HMO's arbitration process. We struggled to get a hearing for over five years. Meanwhile, we were being sued by two medical providers for the outstanding bills incurred. We initially contacted our HMO's administration to try and resolve this issue. We were shuffled between health plan administration, our personal doctor and our HMO's "patient advocate" before we could begin the arbitration process. We requested a copy of Hal's medical records; it was eight months before we received a complete set. We feel our HMO did all it can to delay the arbitration process and deliberately frustrate us in our search for redress.

Finally, we went to arbitration with our HMO. In spite of the fact that the HMO denied Hal care in a critical condition, the arbitrator dismissed our case. Because Hal received his health care through an employer, the ERISA loophole allowed the HMO to avoid accountability. The arbitrator found that ERISA preempted our claims of fraud and negligent misrepresentation.

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ERISA Casualty Of The Day

June 29, 1998

Consumers for Quality Care

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HMO Denies Quadriplegic Child Vital Therapy & Chance to Walk



Ethan Bedrick
Raleigh, NC

Ethan Bedrick was born January 28, 1992. During the delivery, there were complications and he was asphyxiated. As a result, he suffers from severe cerebral palsy and spastic quadriplegia. Hypertonia from the quadriplegia impairs the motor functions in all four of his limbs.

Without proper treatment, the hypertonia can get much worse. The hypertonic muscles must be stretched regularly, to avoid shortening and inflexibility. Therefore, Ethan was put on an intense regimen of physical, occupational and speech therapy to help him throughout his development.

When he was 14 months old, Ethan's HMO unexpectedly cut off coverage of his speech therapy, and limited his physical and occupational therapy to only 15 sessions per year. This sudden change was the recommendation of an HMO doctor who performed a "utilization review" of Ethan's case. The HMO has a doctor perform a "utilization review" to look for places to cut off or reduce unnecessary services, and thereby reduce the cost to the HMO. The reviewing HMO doctor called Ethan's pediatrician who told her that Ethan had a 50% chance to be able to walk by the age of 5. The reviewing HMO doctor decided this prognosis was of "minimal benefit" for further therapy, and so

Ethan's coverage was cut. The HMO doctor never even met personally with Ethan, his family, or his regular doctors during the review.

The denied coverage was finally reviewed a second time in October 1993. This time the HMO affirmed its position with a second HMO doctor. Though several months had passed since the initial review, the new HMO doctor did not update Ethan's file or contact any of his physicians. Instead, he relied only on his general knowledge and a single New England Journal of Medicine article on physical therapy and child development. The article was published in 1988, four years before Ethan was even born!

In addition, the second HMO doctor further denied Ethan prescribed therapeutic equipment, including a bath chair and an upright walker. It was claimed that they were merely "convenience items", not to be covered by the HMO.

In 1994, exhausted of options, the Bedricks filed suit in state court against the HMO. The HMO had the suit removed to federal court where they would be shielded by the federal ERISA law.

The federal circuit court concluded in 1996 that the HMO's decision to restrict Ethan's therapy was "arbitrary and capricious", as their doctors' opinions were groundless and riddled with conflict. The court also ruled that the HMO's guidelines do not require "significant progress" as a precondition to providing medically necessary treatments.

The court even stated, that "it is as important not to get worse as it is to get better. The implication that walking by age five... would not be 'significant progress' for this unfortunate child is simply revolting."

Still, because of ERISA, the Bedricks are left with no means of restitution for Ethan's therapy loss, and face the future with only limited care and equipment for him. The HMO will pay no damages.

Over the period of reviews and litigation, Ethan lost three critical years of therapy that will cost him for life.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

July 1, 1998

CASUALTY OF DAY #7

Dear Colleague:

Enclosed are the Casualty of the Day for week #7, showing why Congress needs to enact legislation to make managed care plans accountable for malpractice.

These are tragic stories--and the anecdotes clearly mount up to a National problem.

Sincerely,

Pete Stark
Member of Congress

July 10, 1998

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HMO Ignores Cancerous Mole Delays Change of Doctor



Peggy Earhart
Sun Valley, CA
R.I.P.

As Told By Her Husband, Montague Bancroft

My wife was 63 years old and was being treated at her HMO for arthritis. This treatment involved her seeing her doctor once every six to eight weeks for cortisone shots (a steroidal anti-inflammatory drug.) During this period of treatment, she noticed a mole on her ankle. She brought this mole to her HMO doctor's attention and her doctor reassured her that it looked fine and she should not worry about it.

Initially Peggy trusted the doctor's judgement. However the mole changed shape and color. Peggy brought these changes to the attention of her doctor. The HMO doctor gave the mole a cursory look and again reassured my wife that it was fine. On the

next visit my wife once again pointed out changes in size and color. Again the HMO doctor paid no more than lip service to my wife's concerns.

Worried and exasperated, my wife requested a change of doctor. She filled out the necessary paperwork and waited, and waited, and waited. Six months later the HMO finally responded, permitting my wife to see another physician. The first time she saw the new doctor he examined the mole and immediately referred her to a dermatologist. The dermatologist took a biopsy and found that the "mole" was in fact a malignant melanoma.

Further tests were then ordered. Unfortunately it was determined that the cancer had metastasized. It was too late to treat Peggy and she died one year later. What is particularly harrowing about my wife's experience is that she attempted to be a partner in her care, pointed out a potential problem, and yet was thwarted by the reluctance of the HMO bureaucrats to refer her to a specialist.

HMOs have no incentive to perform tests that may lead to expensive treatment. The federal ERISA law shields my HMO from damages for Peggy's death. As the law stands now, HMOs are basically not accountable to anyone except their shareholders.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 9, 1998

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HMO Denies Surgery, Patient Told Problems Are In Her Head



**Shannon Schmid
Cornelius, OR.**

In August, 1991, I sustained injuries to my jaw. I went to my HMO for help because I was in excruciating pain. I finally wound up at my HMO's dental clinic in March, 1992. I was given conservative treatment and the wrong type at that. In April, 1992, I sustained a further injury to my jaw and neck. I went to the HMO's emergency room where I was told I was not severely injured. I went back to the HMO two more times: they kept telling me my neck was not hurt. In August 1992, I was referred to a doctor who ordered a series of tests the results of which showed that I had "bilateral closed lock non-reducing anterior disk replacement," meaning my jaw and neck were hurt and I needed extensive surgery.

On October 29, 1992 I had surgery. Only exploratory surgery was performed, not the more extensive surgery I needed. The HMO failed to discover, confirm and fix my problem that was identified in the tests that were performed. I kept contacting the HMO as I was still in pain. My HMO tried to convince me that my problems were all in my head and referred me to a psychiatrist.

Frustrated by my HMO's unwillingness to treat me further, I went to another doctor

outside of the HMO in November, 1992, even though I had no money. This doctor recommended surgery to repair injured discs in my neck. He was of the opinion that the procedure performed by my HMO would not reveal the extent of my problems. He communicated this information to my HMO doctor.

Again I asked my HMO for more tests on my jaw and neck but was refused. I asked for an official second opinion. I was refused. I was referred to a neurologist who recommended anti-depressants! I continued to demand more tests and treatment. Finally an MRI was ordered in January, 1993. This MRI showed that I needed further surgery and treatment. My HMO agreed to surgery but again only performed the same limited procedures they had done earlier.

At this point I left my HMO. I had the extensive surgery performed elsewhere. After this surgery my jaw felt like new. Further treatment and tests showed that I also had neck injuries which needed further surgery. If my HMO had performed an MRI immediately all of my suffering could have been avoided. I have had to travel to California to get appropriate medical and surgical treatment. The specialist I saw in California confirmed that if I would have had appropriate treatment when I first saw my HMO, most of the subsequent problems, pain and anxiety could have been avoided.

It took my HMO a year to release my medical records. I have been put through hell. Most people trust HMOs until they get sick, need medical treatment and can't get medical care.

It needs to be known that these HMOs can skirt liability through a loophole in the federal ERISA law. Until legislation passes to close the ERISA loophole, people with cases like mine will have no remedy for a lack of proper treatment and misdiagnosis by their HMO.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 8, 1998

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email: cqc@consumerwatchdog.org

HMO Denies Care for Brain Damaged Boy Family Forced Deep In Debt

**Steven Pressly
Fort Worth, TX**

As told by mother Carol Pressly

In June, 1997, my husband, Jimmy, and I knew we had to do something to save the life of our 15 year old son, Steven, after we learned he had suffered brain damage from using inhalants.

Steven was examined by our HMO physician and he was immediately admitted to the local children's hospital. The physician told us that Steven would die without immediate treatment in a facility specializing in treatment of teenagers.

The doctor made an immediate referral to a facility that had a contract for treating the HMO's patients. The HMO's representative told us not to worry, that everything would be taken care of.

The next day, the doctor insisted that we take Steven directly from the hospital to the treatment facility and, because of his condition, if we even stopped at home to pick up a change of

clothes for Steven, the doctor would make a report to Child Protective Services.

We immediately drove Steven to the facility and he was admitted. The following day we received a call telling us that the HMO would not pay for the treatment and that we would need to pay \$7,500 cash for the first month of the treatment Steven needed to save his life.

We borrowed the money, a total of over \$35,000, to personally pay for Steven's treatment, and are now heavily in debt. The HMO continues to deny payment claiming that Steven didn't receive treatment for substance abuse, which was covered by the policy; but for emotional problems, a benefit which is not covered.

We have been unable to hold the HMO legally accountable, because the HMO has relied on the ERISA loophole to avoid liability in such cases.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 7, 1998

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Women's
Specialist
Class

HMO Refuses Cancer Treatment For Top Performing Employee



**Janice Bosworth
Simi Valley, CA**

As told by husband Steve Bosworth

In September 1989, my wife Janice discovered a lump in her breast. She made an appointment with her HMO doctor specifically to request a mammogram. He declined, citing her young age. I returned with her to her doctor in October and simply told him to order the test. The referral was not forthcoming until January 1990. By February 1990, we had not heard from him, so my wife called for the mammogram results. She was told that there was some calcification, but that was all. We then got a copy of the report and submitted it to another doctor, who then suggested a biopsy be performed.

The biopsy showed malignancy and metastases. A mastectomy was performed immediately, along with 6 months of chemotherapy. At the end of the chemotherapy treatment, things seemed to be fine.

Within a year the cancer returned. Since the metastasis was in the liver and my wife's chance of survival was poor, her oncologist suggested that we look into a bone marrow transplant with high dose

chemotherapy. She told her employer, our HMO, of her predicament and they assured her that they would pay for the treatment.

While we were at the hospital for an evaluation, our HMO's medical director called to speak with the hospital's doctor. The medical director explained that the HMO would not pay for any treatment. He also stated that the hospital's physician could not say anything to us about treatment protocols, but instead tell us that nothing could be done and that they should send us home.

We already knew about the treatment protocol since the hospital's physician had already outlined it to us. We were also informed that if the initial treatment was a success, the hospital would recommend the Bone Marrow Transplant. For the next four months, we fought with our HMO, trying to get an answer as to whether they would pay or not. They stalled and stalled, until finally the hospital said that, with time running out, they would do the procedure without cost. At this point our HMO told the hospital that if they did the transplant, the HMO would cancel all the contracts they had with the hospital. The hospital ended up losing their HMO contracts.

After the Bone Marrow Transplant, Janice did well for about two years. Unfortunately, her cancer resumed and at that point nothing helped. Janice died on May 10, 1994.

Even though Janice had been promised by our HMO that they would cover the treatment, we were left to the merciful hands of the hospital. Our HMO would not even cover their own employee's care! Because of ERISA, the HMO can effectively use Janice's employment with them against her, preventing me from recovering damages.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

ERISA Casualty Of The Day

July 6, 1998

Consumers for Quality Care

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HMO Prevents Pacemaker Replacement, Patient Dies Waiting



Robert Biddison
San Fernando, CA
R. I. P.

According to court documents:

Robert Biddison had a tumor successfully removed from his brainstem in 1974, leaving him suffering from "central sleep apnea." The apnea caused impaired breathing. Robert had to voluntarily lower his diaphragm with each breath, which he could not do when he was asleep.

An extremely rare condition, the apnea required Robert's referral to one of the few hospitals that had expertise in the field. He had a pacemaker installed, with a battery receiver outside of his body.

Unfortunately, the receivers are known to fail every 3 to 7 years, putting the patient at risk during sleep with the threat of an ill-timed failure.

Robert had three successful replacements of the receiver at the original hospital, over the 20 years following the original surgery. However, Robert changed from fee-for-service insurance coverage to an HMO in 1992.

In 1994, Robert went to his HMO to inform them that he was experiencing the symptoms he recognized as impending receiver failure. He asked to return to the original hospital for a replacement. His doctor made the request to the HMO. A single reviewer, ignoring the standard formal review procedure, made a cost-driven decision to deny the request. Robert was referred to an HMO-contracted doctor who knew little more about the apnea than his primary HMO doctor. The HMO never requested any medical history from Robert's original

hospital. The primary HMO doctor never advised the new HMO-contracted doctor as to Robert's medical history, especially his previous three replacements at the original hospital. The HMO-contracted doctor even acknowledged later that, had he known, he would have also recommended a transfer to the original hospital.

It is routine procedure to put a patient with a failed receiver on a respirator, yet the new HMO-contracted doctor instead recommended a sleep study. Not performed for over a month later, this study proved useless, as Robert and his original hospital were already well familiar with his symptoms. Finally, the HMO doctor relented that a new receiver was needed and put in a request to order one. The authorization was never granted and Robert Biddison died in his sleep from oxygen deprivation caused by failure of his pacemaker on November 21, 1994.

Robert's parents are left with the struggle of trying to get the HMO to take responsibility for providing Robert standard care. Because Robert received his health care through his employer, his HMO claims it is protected by ERISA, and that Robert's family is entitled to nothing.

Robert's parents have claimed that the HMO failed to comply with the statutory requirement of providing quality health care. The HMO's position essentially asserts that because of ERISA, they are above all state statutes and regulations governing HMOs.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

July 9, 1998

CASUALTY OF DAY #8

Dear Colleague:

Enclosed are the Casualty of the Day for week #8, showing why Congress needs to enact legislation to make managed care plans accountable for malpractice.

This week's casualties are particularly moving. I ask you to put yourself in the place of these families and imagine how you would feel. We will soon have a chance to vote on this issue and at last provide some protection for our constituents.

Sincerely,



Pete Stark
Member of Congress

July 17, 1998

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Patient Suffers Irreversible Nerve Damage After HMO Transfers Her To Four Hospitals In Three Days

**Ariday Dearmas
Miami, FL**

According to court papers:

Ariday Dearmas was injured in an auto accident and taken to her HMO's hospital for treatment. At the hospital, Ariday did not receive the treatment she needed, because there were too few doctors participating in her plan.

Consequently, her HMO transferred her to a new hospital that purportedly contained more of their doctors. Here, too, Ariday was delayed adequate treatment, because of a lack of the HMO's "in-network" doctors. And the story was the same at the HMO's third hospital. So they sent her to a fourth. Ariday's HMO had transferred her to four of its hospitals in three days!

Because of the transfers to these different HMO hospitals, and the limited

availability of providers participating in her plan, Ariday experienced delays in her treatment. As a result, she sustained irreversible nerve damage.

Ariday attempted to bring a case against the HMO for the negligence of its patient care coordinator, in evaluating Ariday's condition, and for violating "anti-dumping" statutes, in transferring her to the various hospitals. However, the HMO had the suit removed from state court to federal court, where the Court ruled ERISA preempted her negligence claims. Because Ariday's employer supplies her healthcare, she lost her remedy.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 16, 1998

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HMO's Lack of Referrals Leads To Patient's Loss Of Legs



**Misac Negosian
Sunland, CA**

According to Mr Negosian's report:

In February 1993, Misac Negosian suffered an arteriosclerotic aneurysm, or stroke, leaving him with a limp in his left leg. Misac requested referral to a cardiologist, neurologist, and cardiovascular disease specialist, but his HMO primary care physician instead called the stroke an "accident" caused by the stress of his loss of employment. He was never given any blood thinners or an angiogram test.

Then in May 1996, Misac suffered a major blood clot in his left leg and had to go to the hospital. The HMO refused to pay for the ambulance transport, so Misac had to use a private service. After three hours at the HMO hospital, Misac's skyrocketing blood pressure finally forced the HMO to allow him to see one of their cardiovascular surgeons. The HMO surgeon attempted a

by-pass surgery, yet extensive damage had already been done. The surgeon told Misac's family that in fifteen years of surgery, Misac's condition was the worst he had ever seen. A week later they amputated Misac's left leg above the knee.

A few days after the amputation, the HMO decided to send Misac to a convalescent hospital. Still, he had to go to frequent appointments at the HMO, for which the HMO refused to pay all ambulance transport. Four months later, with his condition getting worse, Misac had to have his right leg amputated below the knee.

Misac's medical records show that in 1986 he was diagnosed with the genetic condition homocystinuria, which was discovered in the early 1990's to be linked with arteriovascular disease and renal failure. However, Misac had continually been told that his problems were all due to kidney failure. He had even had surgery in 1991 to have fibrosis removed from his kidneys. If his HMO had properly treated his stroke in 1993, they would have found the linkage between homocystinuria and renal failure, thus treatment could have given them a good chance of saving Misac's legs. Instead, Misac did not receive proper treatment till after 1996, only after the severity of the disease meant his legs had to be amputated.

Misac Negosian has had the ability to walk taken from him. He has even had to pay for his own pair of prosthesis, and was forced to borrow a wheelchair and walker from a family friend. Because Misac receives his healthcare through his wife's employer, his HMO can claim immunity from damages under a loophole in the federal ERISA law.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 15, 1998

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Patient Dies After Insurer Delays Medically Necessary Care



**Steve Spain
California**

According to court papers:

In 1990, Steven Spain's doctors told him he needed a three-stage autologous marrow transplant to treat his testicular cancer. His insurer approved the first two parts of the procedure, but not the last. Since the transplant can be successful only when all three steps are done within a specific period, his insurer's denial was life-threatening. Spain could not afford the procedure himself, and sued the insurer. After a delay, and notification of the suit, the insurer authorized the procedure, but by then

the window of time had closed, and Steven later died.

Steven's wife and daughter brought suit against his insurer for wrongful death. The Ninth Circuit Court of Appeal in California dismissed the case on the grounds that ERISA preempted state remedies for wrongful death. The court wrote, that ERISA "contains one of the broadest preemption clauses ever enacted by Congress.. [which]..supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 14, 1998

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HMO Refuses To Pay For Care Necessary To Prevent Amputation Of Diabetic Woman's Feet



**Rosemary DeJohn
Garland, TX**

As told by husband Al Dejohn

In November, 1995 my wife, Rosemarie, started having trouble with her feet and she immediately went to see her physician. Her doctor diagnosed the problem as stress fractures. The doctor attempted to treat the fractures, but because she is a diabetic and slow to heal, the doctor decided that additional steps were needed to prevent further deterioration of her feet.

On February 22, 1996, the doctor ordered bilateral, diabetic custom-molded shoes, costing approximately \$800, for Rosemarie. Without these medically necessary shoes, the bones in each foot were likely to break through the bottoms of her feet, which would then require amputation. Diabetics must be extremely cautious and aggressively treat any injury to extremities, especially the feet.

Rosemarie and her doctors attempted to do just that. All the while, she was confined to a

wheelchair, unable to walk, while waiting to receive the shoes.

Three weeks after the referral, she had the molds made for her shoes and anticipated being able to walk again soon. However, on March 27, 1996, I received a letter from our HMO stating that the shoes were not covered under the plan even though the language of the policy states that coverage is provided for... "medically necessary services or supplies."

We immediately appealed the denial of coverage. A process that was supposed to take a maximum of 30 days stretched to more than seven months. Our requests for a determination were shuffled from office to office, and from person to person. Invariably the person who had the information was not in when I called.

Finally, in late September, 1996, almost eight months after the initial request, we received a letter from our HMO stating that the claim was denied as not "medically necessary" in spite of several letters my wife's doctors had sent unequivocally stating exactly the opposite. We were finally forced to pay for the shoes ourselves. We are retired, living on a fixed income and pay an extremely high premium of \$780.00 per month for our health insurance. Paying for these custom shoes caused us to suffer a financial strain we should never have had to bear.

We receive our medical coverage through my former employer, which means we are subjected to a loophole in the federal ERISA law. The HMO has relied on this loophole to immunize itself from liability for denials of care.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

July 13, 1998

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HMO Denies Heart Surgery Transplant Patient Dies Waiting

**Bobby Kuhl
Kansas City, MO**

According to court papers:

Mr. Buddy Kuhl suffered a major heart attack. His doctor decided that he required specialized heart surgery. Because the hospitals in his town did not have the necessary equipment for such surgery, the doctor arranged for the surgery to be performed in St. Louis.

When the hospital requested precertification for the surgery, the utilization review coordinator at Mr. Kuhl's HMO refused to precertify the surgery, because the St. Louis hospital was outside the HMO service area. Accordingly, the scheduled surgery was canceled. The HMO instead sent Mr. Kuhl to another Kansas City doctor to determine whether the surgery could be performed at a local hospital. That doctor agreed with the first in that the surgery should be performed in St. Louis. Two weeks later, the HMO agreed to pay for surgery as originally decided. By then, the

surgery could not be scheduled until several months later.

When the doctor in St. Louis examined Mr. Kuhl two months later, Mr. Kuhl's heart had deteriorated so much that surgery was no longer a possibility. Instead, it was discovered that he needed a heart transplant. Although the HMO refused to pay for an evaluation for a heart transplant, Mr. Kuhl managed to be placed on the transplant waiting list in St. Louis.

Mr. Kuhl died several months later, still waiting for a transplant. He was 45 years old. He was survived by Mary, his wife of twenty-five years, and two children.

Because Mr. Kuhl received his healthcare through his employer, the HMO was not liable for any damages. A Federal District Court preempted all of Mr. Kuhl's family's claims. The Court of Appeal for the 8th Circuit concurred reluctantly.

Pending federal legislation would restore the remedies of patients with employer-paid health care who are unable to recover damages against an HMO or insurer that harms them, because state laws providing damages are preempted by the federal Employee Retirement Income Security Act of 1974 or ERISA. Consumers for Quality Care will fax daily the picture and story of another ERISA casualty to legislators and opinion leaders until pending legislation is acted upon.

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

July 13, 1998

CASUALTY OF DAY #9

Dear Colleague:

We will soon be voting on whether to give our constituents in ERISA managed care plans the chance to recover damages from medical malpractice.

Attached are this week's horror stories of how ERISA HMO patients have been hurt by the current lack of remedies. It is time to stop this legislative malpractice.

Sincerely,



Pete Stark
Member of Congress

Consumers for Quality Care

Press Release

www.consumerwatchdog.org

[email: cqc@consumerwatchdog.org](mailto:cqc@consumerwatchdog.org)

For Immediate Release Contact: Jamie Court (310) 392-0522 or (202) 387-8034
July 13, 1998

Rep. Stark & HMO Casualties Call On GOP Leaders To Reform ERISA Or Voluntarily Subject Themselves To ERISA Restrictions

Federal Officials Exempt From ERISA Disparity In Remedies Criticized

Washington D.C. -- Congressman Pete Stark (D-California), injured HMO patients who are "ERISA Casualties of the Day", a physician fired for advocating for his patients and Consumers for Quality Care held a capitol hill press conference today. They asked Congressional representatives to subject themselves to the restrictions on private-sector employees who cannot sue HMOs for damages under ERISA (the federal Employee Retirement Income Security Act of 1974) or to pass legislation reforming the prohibitive federal law.

ERISA prevents patients with private-sector, employer-paid health care from receiving damages against an HMO that denies them treatment. GOP leaders, as government workers, are not subject to ERISA, yet have not supported legislation to guarantee patients the right to sue in state courts for damages.

"If public officials will not restore the average patient's right to sue their HMO for damages, then they should put themselves in the exact same boat and voluntarily accept ERISA's iron-clad prohibitions," said Jamie Court, director of Consumers for Quality Care, the Santa Monica-based watchdog group that mailed a contract entitled "Voluntary Acceptance Of ERISA Restrictions" to federal legislators today. "ERISA is the most draconian restriction on the rights of patients today. Unlike our Congressmen, patients with private-sector, employer-paid health care can never sue their HMO for bad faith or breach of contract."

Disabled Maryland resident Michelle Leasure explained how her private employer-paid HMO forced her to reuse disposable colostomy bags for five days each, like diapers, preventing her from working, yet the HMO is immune from damages. Twenty-one year-old Stephanie Ulrich of Maryland recalled how she had an aneurysm that burst when she was turned away from a hospital because her HMOs would not authorize admission. One HMO, covered by her state of Texas government job, subsequently paid its share of rehabilitation costs for her. But Stephanie is still fighting with the other HMO, provided through her mother's private sector job, to pay its portion of her rehabilitation costs. This HMO is shielded by ERISA from damages.

While federal workers have limits on their remedies, none are as sweeping and draconian as ERISA's. Federal workers have won the right to sue HMOs for bad faith (breach of contract). This month, for instance, the Oklahoma Supreme Court, following the lead of the U.S. Court of Appeal for the Tenth Circuit, ruled that federal workers can sue Blue Cross in state court for damages under a bad faith claim. *Kincade v. Group Health Services of Oklahoma d/b/s Blue Cross* (1997 OK 88; 945 P.2d 485; 1997 Okla. LEXIS 83; 68 O.B.A.J. 2336) Such bad faith claims and any other cause of action for a breach of contract under state common law are completely preempted by ERISA. The US Supreme Court ruled definitively in *Pilot*

Life Insurance v. Dedeaux, 481 U.S. 44 (1987) that "State common law causes of action arising from the improper processing of a claim are preempted." No such total preemption exists for federal officials.

Comparing ERISA to other laws, such as those governing federal workers (the Federal Employee Health Benefits Act or FEHB), the Ninth Circuit Court of Appeal wrote that ERISA "contains one of the broadest preemption clauses ever enacted by Congress...[which]...supersede any and all State laws insofar as they may now or hereafter related to any employee benefit plan." *Spain v. Aetna Insurance Co.* 13 F.3d.310 (9th Cir. 1993)

The United States Court of Appeal For the Tenth Circuit has also allowed federal workers to sue HMOs for bad faith. *Howard v. Group Hospital Service* 739 F.2d 1508; 1984 U.S. App. LEXIS 19823 The Court in *Kincade*, relying on *Howard*, states clearly that for FEHB: "We find nothing in the language of preemption statute, nor its most recent legislative history, that reveals an intent to preempt state-law causes of action that may arise in the performance of a health plan contracted under the FEHB.... The United States Supreme Court has not decided the extent of the preemption of the FEHB. The Supreme Court, however, has repeatedly recognized that state remedies may co-exist with a scheme of federal remedies."

Joining Consumers for Quality Care and patients in their call for ERISA reform was Dr. Thomas Self, a San Diego pediatrician fired for spending too much time with his patients and ordering too many procedures. Self won a landmark verdict this year after being retaliated against just for practicing good medicine. Dr. Self noted that HMOs continue to deny approvals for his patients over the telephone because they have nothing to fear under ERISA's shield of immunity from damages.

Every day since May 1st, Consumers for Quality Care has faxed a different story and picture of an ERISA Casualty Of The Day to every U.S. Congressman, United States Senator and the media (1,000 faxes daily). The group reaffirmed that it would continue its campaign until resolution of the ERISA issue.

Following the press conference, patients personally delivered a contract entitled "Voluntary Acceptance of ERISA Restrictions" to Newt Gingrich for his signature.

New Study Shows No Major Cost Increases Under ERISA

A report released this month by Coopers & Lybrand for the Kaiser Family Foundation examined three big health plans for state and local government employees who already have the right to sue HMOs. The study found that cost of litigation was between three and 13 cents a month per enrollee, or 0.03% to 0.11% of premiums.

The Wall Street Journal describes the report as "the first attempt by an independent group to look closely at costs associated with litigation." (Laurie McGinley, "Lawsuits Have Little Effect On Premiums," July 8, 1998) By contrast, a study by the Barrents Group which shows big cost increases was paid for and contracted for by the HMO industry lobby, the American Association of Health Plans.

###

Hello my name is Stephanie Ulrich. I am a 23-year-old graduate student in history. I am currently a student at Southwest Texas State University in San Marcos, Texas where I plan on graduating with my masters in history in May 2000. I am a teaching assistant and on Jan 26, 1998, I fainted in front of a freshmen survey class. I do not remember walking 15 minutes to class, talking with my professor, or setting up the av. equipment. All I remember is waking up in the hospital scared to death. When I was there, I called my aunt numerous times; I only remember calling her once. At the hospital, the staff did a CAT scan. The test revealed that I had a basilar artery aneurysm. The hospital discharged me because they did not have "the expertise to look at the films." So I went home to my apartment where I lived alone with my dog. That night I called my aunt in Maryland and she told me to fed ex the films to her so a neurosurgeon could read them. By Thurs., 3 days later, I was on a plane to Washington.

At the Washington Hospital Center, my aunt tried to get approval from Prudential. But they denied her plea. They called my primary care physician in Texas for a referral for an angiogram that would confirm an aneurysm. He would not issue the referral because he said he was not informed about my hospitalization. However, my aunt and I called his office the day I fainted and informed a member of his staff. Because I was

outside my network and my primary care doctor would not issue a referral Prudential would not okay my admission to the hospital or the angiogram.

However, I had a second insurance because of my mother's job.

Since I was a full time student and under 23, I was covered under my mother's ^{private sector} policy. NYLCARE approved my angiogram. This test revealed that I needed immediate brain surgery. I had the surgery that following day, Friday Jan. 29. I spent three weeks in intensive care at WHC. Because I was hospitalized and could not work, Southwest Texas was forced to terminate my position as a TA and Prudential dropped me because I was not working.

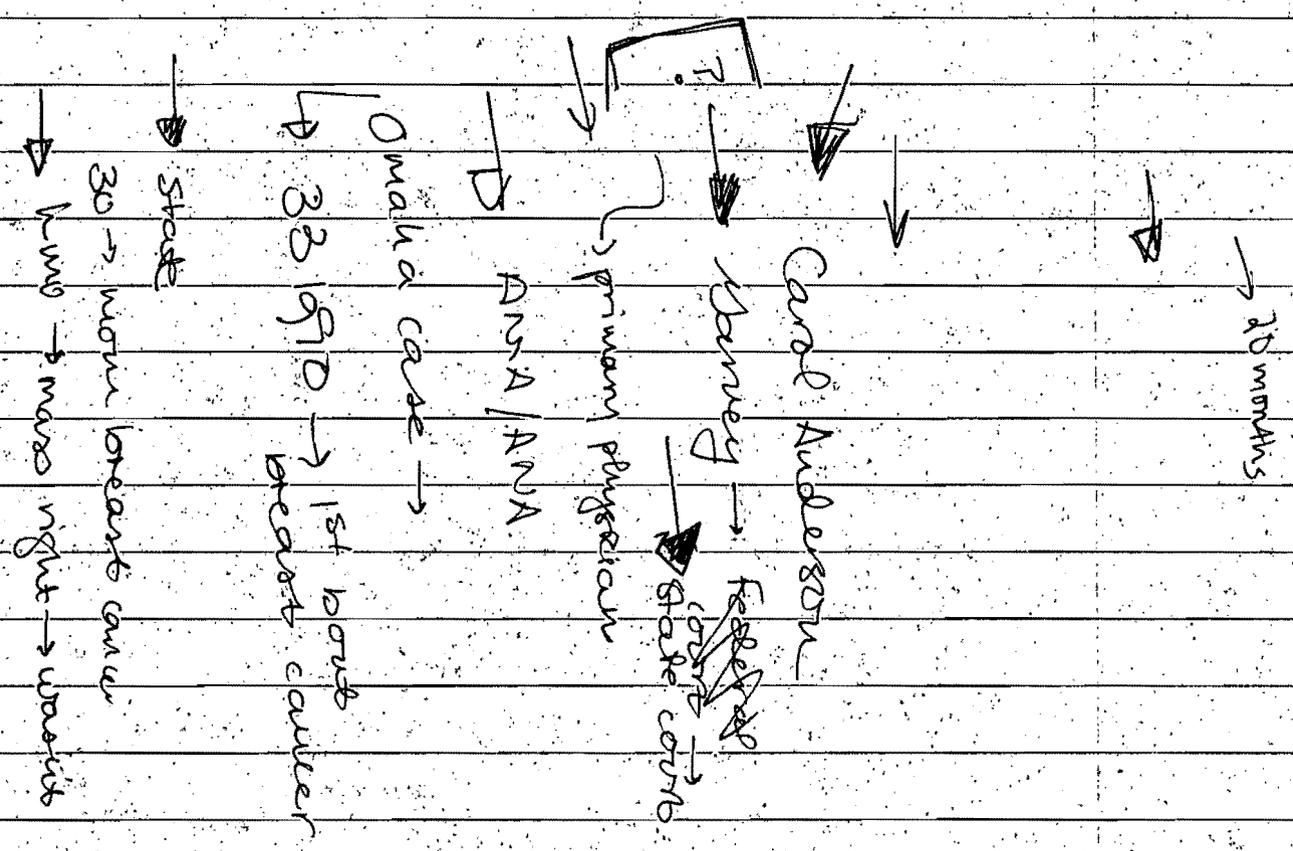
The doctors at WHC wanted me to be transferred to National Rehabilitation Hospital at the end of Feb. The therapists would help me to relearn how to feed myself, tie my shoes, and even walk. NYLCARE refused to pay NRH because they wanted to send me to a nursing home. They wanted to put me, a 22 year old, in a nursing home because they said that I could not be rehabilitated. They said I was not going to get better. Look at me. I am walking and talking now. I could not do that at WHC. Not rehabilitatable? I do not think so.

I was discharged from NRH on April 25. On Monday, April 27, I started a five-day week 7 hours a day rehabilitation program. I was in that

program for 10 weeks and I am currently doing outpatient therapy twice a week. NYLCARE has not paid a dime to NRH because they feel I am not rehabilitatable. Because of ERISA, I cannot sue NYLCARE for damages. They are not accountable for their actions.

Throughout this whole illness, it has been an uphill battle with the insurance companies. I was at the lowest point in my life, and the insurance companies kicked me in the back. They had no right to do what they did to me and I pray this will not happen to anyone else. The last thing anyone should worry about who is going to pay their hospital bills. They should concentrate on getting better and not on fighting the insurance companies. Without the help of my family and friends, I may be dead. I thank them for fighting with the insurance companies and therefore getting me better.

→ medical nec → rare form of cancer / CMN
 standard therapies advanced treatment
 not a medical necessity. Bone marrow
 transplant



McCole-Bennett@dpc.senate.gov

BIOGRAPHICAL SKETCH

BARBARA GARVEY



[Click here to read Senator Durbin's \(D-IL\) floor statement](#)



In May of 1994, Barbara Garvey and two of her girlfriends went to Hawaii on the vacation of a lifetime. Only a few hours after landing on the island she discovered large bruises on her body and immediately went to a local clinic for blood tests. The clinic transferred her to the oncology department of a hospital in Hawaii. She was diagnosed with 'aplastic anemia' and was transferred to the bone marrow unit. The doctor in Hawaii started a medical treatment plan and said a bone marrow transplant would likely be necessary.

After a few days of treatment, the Garvey's HMO decided Barbara would have to return to a hospital in Chicago for continued care and possible transplant. But the doctor in Hawaii said Barbara was not stable and should not be moved in her condition. The Garveys learned later that the first HMO doctor assigned to her case in Chicago spoke to the doctor in Hawaii and agreed that Barbara should not be moved in her condition. That doctor was removed from the case that same day and another doctor in the HMO said Barbara should be returned to Chicago. He never examined her or talked to the attending doctor in Hawaii.

Dr. same deposition devastating - explaining how he didn't want her moved
Despite her Hawaiian doctor's recommendation that she not be moved, the HMO continued to refuse to keep Barbara in Hawaii for the medical treatment and/or bone marrow transplant. Her husband, David, was asked to call the HMO and try to get approval for treatment in Hawaii. He called and spoke with a nurse in the HMO's Utilization Review department who told him, after checking with her Supervisor, that Barbara had to be brought back to Chicago. If not, it would be considered a refusal of services and they would not cover Barbara's medical expenses, which were quickly adding up. Mr. Garvey was also told to put Barbara on a regularly scheduled commercial flight and send her back at personal expense. When asked if at least the HMO would pay for a private air ambulance ("medivac") the answer was "NO."

Barbara's condition left her with a weakened immune system and the inability to clot if she were to bleed. The commercial flight from Hawaii exposed her to all of the impurities of recirculated air, and to pressure changes. These may be harmless to healthy people, but proved to be deadly for Barbara.

Sometime between leaving Hawaii and returning to Chicago, she suffered a stroke (from bleeding in the brain), and a couple of days later she was diagnosed with a fungal infection. She died nine days after returning to Chicago.

Barbara Garvey was 55 years old. Along with her husband of nearly 35 years, she left seven children. She had six grandchildren at the time of her death; three more have been born in the four years since her death.

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*filed as malpractice b/c treating her for rheumatoid arthritis - gold medicine
filed when in Dad court
1 1/2 ago against 2 DRs. - w/ deposition of HMO. review sued HMO. Fed. turned back to state
HMO assigned a physician in Chic. to manage case. Dr. Milonova 'much too ill, danger of bleeding'
he decided she shouldn't be transferred
2 wks. later they transferred her.
Attorney - John Alexander
Dr. Hawaii
312-263-7731
312-616-9770*

GARVEY

Draft

Thank you, Senafors, and Representatives, for this important opportunity to explain why our managed care system must be reformed. I am sharing my story with the hope it will prevent this from happening to anyone else.

In May of 1994, my wife Barbara and two of her girlfriends went to Hawaii on the vacation of a lifetime. Only a few hours after landing on the island she discovered large bruises on her body and immediately went to a local clinic for blood tests. The clinic transferred her to the oncology department of a hospital in Hawaii. She was diagnosed with 'aplastic anemia' and, transferred to their bone marrow unit. The doctor in Hawaii started a medical treatment plan and said a bone marrow transplant would likely be necessary.

After a few days of treatment, our HMO decided Barbara would have to return to our hospital in Chicago for continued care and possible transplant. But the doctor in Hawaii said Barbara was not stable and should not be moved in her condition. We learned later that the first HMO doctor assigned to her case in Chicago, spoke to the doctor in Hawaii and agreed that Barbara should not be moved in her condition. That doctor was removed from the case that same day and another doctor in the HMO said Barbara should be returned to Chicago. He never examined her or talked to the attending doctor in Hawaii.

At this time the doctor in Hawaii was not getting any cooperation from the HMO concerning keeping Barbara in Hawaii for the medical treatment and/or bone marrow transplant. He asked me to call the HMO and try to get approval for treatment in Hawaii. I called and spoke with a nurse in the HMO's Utilization Review department who told me, after checking with her Supervisor, that I had to bring Barbara back to Chicago. If I did not it would be considered a refusal of services and they would not cover Barbara's medical expenses, which were quickly adding up. I was also told to put Barbara on a regularly scheduled, commercial flight and send her back at my expense. When I asked if at least they would pay for a 'medivac' the answer was "NO".

Barbara's condition left her with no 'immune system' and the inability to clot if she were to bleed. The commercial flight from Hawaii exposed her to all of the impurities of recirculated air, and to pressure changes that may be harmless to healthy people, but proved to be deadly for Barbara.

Sometime between leaving Hawaii and returning to Chicago, she had a bleed in the brain - considered a stroke, and a couple of days later she was diagnosed with a fungal infection. She died nine days after returning to Chicago.

Barbara was 55 years old. We have seven children and were married for almost 35 years. We had six grandchildren at the time of her death, and I now have nine. The whole family was devastated. My oldest daughter has been hospitalized for 'depression' several times. Another daughter was to be married three weeks after Barbara died and postponed the wedding. All our plans for the future are gone or changed forever.

I am talking to you today because my wife's HMO was more interested in saving money than in saving her life. I urge you to pass legislation that will prevent a tragedy like mine from occurring again. Thank you.

Scott case

→ sometimes necessary blood for work
→ in the district (coordinate or referral)



- Nancy Dickey → AMA
- Beverly Malone → patients been denied
- Carol Anderson
- Garvey → ~~??~~ ??

→ Ching

- Spina Bifida →
- Sue Costa
- Paige Lancaster

who validates?

baseline → symptomatic → ob-gyn
breast exam wrong

fiber cystic →
Insurance comp. to see if you could do anything go out of state paying for a referral mammogram →
→ Nov. → Jan.

January - office →
wanted to see, mamm, gyn
surgical asser
ob-gyn
false negatives → fiberoptic

→ Scott case

→ ~~Cathy~~ / Cathy ✓

→ Paige

→ Spina Bifida ← out of network

→ Florence Corcoran

→

→ Scott

→ Cathy

→ Paige

→ Spina Bifida

→ Florence Corcoran

→ Other ~~report~~ Robert Pear

→ Kuhl

Burghman