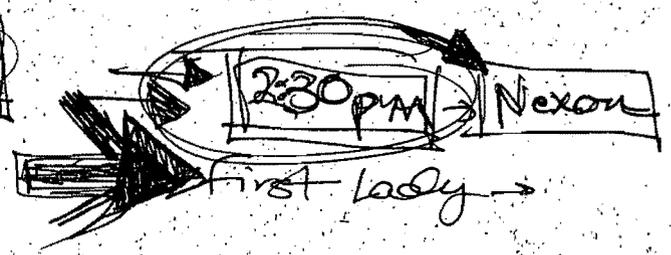


Manjand



Carol breast cancer - oncology group →
 90% → have to be aggressive life & death
 situations, 90% → go back - testified to
 local person →

* Boy w/ amputee Daschle →

→ Christine / Reston → abdominal access to specialist
 who said she could not go to ob-gyn
 settlement - ?? } doctor verification
 appeals process } couple not get physician
 here's what I need

* Cathi breast cancer → denied chemotherapy
 appeals process →
 → health plan →
 doctor → collection agency
 after her. → basic experimental
 ↳ inpatient chemotherapy.

Tumor pancreas.

* Alex → wife pregnant - doctor out-of-network
 → health appeals to pay for

→ **Ching** → refused^{access} specialist → ~~ref~~
financial incentives

→ METLife

→ got the referral →
HMO → contract/

emergency room service → lose money
→ lack of referral
80%

→ Dave ← good specialists

verdict → doctors →

→ **HMOs** → banded up swing doctors.

\$100,000

→ **Scott case** → under litigation
hosp/doctor/managed care plan

Nelene = **case**

→ **School Teacher**

HMOs → ^{coverage} booklet
pay for bone move

centers through → experimental

coerce local doctors →

disease made denial.

Demands →

called coerce medical

network



ERISA Casualty Of The Day

July 16, 1998

Consumers for Quality Care

phone: (310) 392-0522

web: www.consumerwatchdog.org

email: cqc@consumerwatchdog.org

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.

DOMESTIC POLICY COUNCIL (DPC)

ADDRESS

Chris Jennings
Deputy Assistant to the President for Health Policy
Domestic Policy Council
1700 Pennsylvania Ave
OEOB Room 216
Washington, D.C. 20502

Phone -- 202-456-2216
Cell -- 202-487-6223

HELPFUL NUMBERS

Comment Line - 6-1111
Public Liaison - 6-2930
Library - 6-7000
Law Library - 6-3397
Page - 7-5000
Red Dot Pickup - 5-7005
Intern Hotline - 6-5122
Reserve Car - 7-1467
Press Office - 6-2580
Computer Help - 5-7370
White House Main - 6-1414
Intern Desk - Room 468 - 6-5338

FAX NUMBERS

Room 216 - 6-5557
Room 212 - 6-7431
Room 224 - 6-7028

NAME

PHONE

FAX

AGENCY

NAME	PHONE	FAX	AGENCY
Abernathy, David	393-0660 800-381-3830 (pager)		
Altman, Stuart (Ann Cummings)	781-736-3803 800-405-3522 (pager)		
Amberson, Michelle (Laurie Boeder's Asst)	690-4597		
Apfel, Ken	358-6006		
Beier, David (Satish)	6-6222		
Bentivoglio, John	514-2707	616-1239	
Berenson, Bob (Carol/Sharon)	410-786-4164	410-786-0192	
Berg, Olena (Valerie)	219-6620	219-5526	Labor
Boeder, Laurie	690-7850	690-5673	
Brain, Chuck (Janet Murguia)	6-6620		
Brand, Marcia	301-443-4619		
Bromberg, Emily (Sky)	6-2896		
Burton, LaVarne	690-5627		
Callahan, John (Louise)	690-6396		
Chang, Debbie (Barbara) Jennifer Ryan (Special Asst.)	690-5960	690-8168	
Chang, Gregg	6-6406		
Chow, Barbara (Sandra Yamin)	5-4844	5-5730	
Clarkin, Sharon (Tenisha)	690-7450		HHS
Claxton, Gary (Roxanne, Michelle)	690-6870 490-4023 (pager)	401-7321	ASPE
Cooper, Barbara (carolyn/Stephanie)	690-7063		
Corr, Bill (Eileen)	690-7431	401-5783	
Dailard, Cynthia Room 217L	6-7871		
Damus, Bob	5-5044		
Deparle, Nancy-Ann (Joanne) (Joanne-Private 690-6332) Deputy - Mike Hash (Linda)	690-6726/786-3151 690-5727	202-690-6262 410-786-8060 841-4684 (cell)	HHS Administrator
Donahue, Mary Beth (Delano)	690-7431	401-5783	HHS-- COS
Donenfeld, Toby	6-6265		VP's
Duvall, Fred	6-2896		IGA
Easley, Chuck (Waves Problems)	5-6206		
Eisenberg, John (Geri)	301-594-6662		AHCPR
Ellis, Philip	622-2342		
Emmanuel, Rahm (Michelle Crisci) (Franklin)	6-2531	6-2530	

NAME

PHONE

FAX

AGENCY

NAME	PHONE	FAX	AGENCY
Fontenot, Keith (Denise Bray)			
Foster, Rick (Donna Holt)	410-786-6374		HHS - Actuary
Geisbert, Donna	410-604-1666 (home) 410-456-9452 (cell)		
Gips, Don(Dan)	6-6222		
Gotbalm, Josh (Vikki Wachino)	5-9188 (5-9149)	5-4995	254/253
Green, Melissa	5-4742		
Gruber, Jon (Chris) McClellan, Mark	622-0090	622-2633	Treasury
Harahan, Mary	690-6613	401-7733	DHHS, Office Disability, LTC
Hash, Mike (Linda Cooper)	690-5727	690-6262	
Haynes, Audrey (Tania) Women's Office	6-7300 (6-7395)		
HCFA	800-448-4232		
Horvath, Jane (Stephanie)	690-7450	690-8425	
Jennings, Tom	301-654-8538		
Justice, Diane	401-4634		
Kagan, Elena (Laura)	6-5584 (6-5565)	6-2878	
Kakani, Anil NEOB 8222	5-4686	6-0851	
Katzen, Sally (Phyliss)	5-4852		
King, Kathy (Lynette)	690-5974		HHS
Lambrew, Jeanne	6-5377		
Lew, Jack (Sandy Via) Melissa Green	5-4742		OMB-Rm 252
Lewis, Ann(Ruby Shamir)	6-2640 (6-5696)		
Lowensen, Jane	224-3460		Sen. Daschle
Mays, Cathy	6-6515	6-5542	
McClellan, Mark (Chris)	622-0090		
McCullough, Ned	224-4042		
McGuire, Anne	6-2572		Cabinet Affairs
Mendelson, Danny (Gina Mooers)	5-5178	5-5631	Rm. 238
Miller, Mark (Farooq) NEOB 7001	5-7810/5-4930	5-7840	
Miller, Meredith (Avis, Tiffany)	219-8233	219-5526	Labor
Monahan, John (Margaret)	401-5180		HHS
Murguia, Janet (Mindy Myers)	6-6620		Leg Affairs
--Brain, Chuck			
--Jacoby, Peter			
--Thornton, Tracy			

NAME

PHONE

FAX

AGENCY

NAME	PHONE	FAX	AGENCY
Nexon, David	224-5406	224-3533	
Ogle, Becky	219-6001x147		
O'Hara Jim (Betty)	690-7694		
Orszag, Jonathan	6-5367	6-2223	Rm. 235
Parker, Emil	6-2809	6-2223	Rm. 235
Perrelli, Tom	514-2267	616-5117	
Popp, Karen	6-7594		WH Counsel Office
Porter, Margaret (Jean)	301-827-1137	301-827-3051	FDA
Rabb, Harriet	690-7741	690-7998	
Raines, Frank (Janet Graves)	5-4840		Dir-OMB
Ricchetti, Jeff	628-4650	626-4833	
Ricci, Linda	5-3814		OMB-Rm 253
Rice, Cynthia	6-2846	6-7431	
Richardson, Sally (Lavinia)	410-786-3870	410-786-0025	
Rovin, Lisa	690-7800	401-7321	
Rudolph, BA	371-5963		
Ryan, Jennifer	690-6321		
Scholz, Karl (Louise)	622-0120		
Schwartz, John	305-8060		Justice
Shalala, Donna (Ken Choe)	690-7699		HHS
Shireman, Bob (Sonyia Matthews--Asst.)	6-2803		
Simmens, Lance (Anita)	690-6060		HHS
Skolfield, Melissa (Margo, Phyllis)	690-7850	690-5673	HHS
So, Anthony	690-7230	690-6154	
Sperling, Gene (Pete)	6-5804	6-2878	
Stein, Larry (Jessica)	6-2230		
Takamura, Jeannette	401-4634		
Tarplin, Rich (Rose, Stephanie)	690-7627 800-800-7759 (pager)	690-7380	HHS
Tarica, Alan	5-6490		
Thurm, Kevin (ALEY)	690-6133		
Toiv, Barry	6-6796/6-2580		
Tramantano, Karen (Erica)	6-1906 (6-1987)		
Uhalde, Raymond (Joanne)	219-6050		DOL
Verveer, Melanne (Katy Button)	6-6266		
Wagner, Alex	818/ 346-8269		
Washington, Bonnie	690-5960		

NAME

PHONE

FAX

AGENCY

NAME	PHONE	FAX	AGENCY
Watson, Tony (Carolyn/Carleen)	212-630-5110		
Webb, Shirley C5-16-03	786-3151		
White, Bill	6-2896	6-2889	106
Woolley, Barbara (May Zhou)	6-2155		Public Liaison
Yamin, Sandra (B. Chow)	5-4844		
Chris Transfer #	6-6241		
DPC Main #	6-2216		
WH Main #	6-1414		
Phone Extensions	395/456		
Aids Office - Todd Summers	6-2437	6-2438	
Clear Senators/Guests	Elisa Milsap		
Computer Help	5-7370		
Color Copier - Ben Kirby (Across NEOB)	5-6705		
Customer Service -- Signal	7-1234/1236		
Facilities Management	5-2335		
FAX	6-5557 -- 216 6-7431 -- 212 6-7028 -- 224		
GSA -- Recycle/Burn Bags	5-3675		
Interns Desk - Room 468	6-5338		
Intern Office Room 84 - Alison Kolwaite	6-2742		
Medicare Commission (Request)	205-3333		
OEOB Library	5-7000		
Phones/Trouble Desk	6-9611		
Press Office	6-2580		
Print Shop	5-2294		Room 82
Records Management	6-2240		
Request Car	7-1467		West Basement
Request Messenger/Red Dot	5-7005		
RSVP Office -- Social Office	6-7787		
Secret Service (Keys)	5-4497		
Security 17th & G	7-1742		
Security SW Gate	7-1724		
Signal Conference Line 757-2104	Signal Operator Customer Service		
Social Office	6-7787/6-7136		

Michael Darling and Associates

Los Angeles, CA Washington, DC Santa Fe, NM
1400 20th Street, N.W., Suite 504; Washington, DC 20036 202.232.4039 FAX:202.232.4089

July 31, 1998

Mr. Christopher C. Jennings
Deputy Assistant
to the President
The Old Executive Office Building
Washington, DC 20502

By Facsimile: (202) 456-5557

Dear Mr. Jennings:

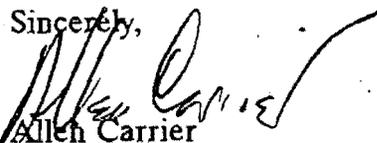
I am writing to you at the suggestion of Ira Magaziner to invite you to be the keynote speaker at an event celebrating the 35th Anniversary of the Association of Reproductive Health Professionals (ARHP). The event will take place Saturday, October 24 at the Westin Hotel in Washington. Depending on your interest and availability, we would welcome your participation in the evening's gala dinner.

The topic should relate to "a look forward", or where reproductive sciences and our nation's health care system is likely to go in the 21st Century. The audience will include physicians, researchers, educators, counselors and pharmaceutical executives. More details can be provided later.

Please let me know at your earliest convenience if you will participate. If you are unable to accept our invitation, perhaps you could suggest another Clinton Administration official who might be an appropriate speaker.

Until then, should you have any questions or need any additional information, I can be reached at my office with Michael Darling & Associates at 202-232-4039. Thank you.

Sincerely,


Allen Carrier

Patient Advocate Foundation

780 Pilot House Drive Suite 100 C
Newport News, Virginia 23606
Phone: (757) 873-6668
Fax: (757) 873-8999

TO: BRANDON HOFMEISTER

Date 7-20-98

FAX # 202-456-5557

COMPANY: WHITE HOUSE (DOMESTIC POLICY COUNCIL)

FROM: Nancy Davenport-Ennis, Executive Director

Number of Pages (INCLUDING COVER SHEET): 19

COMMENTS:

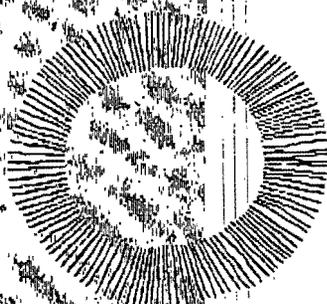
PLEASE SEE ATTACHED SUMMARY OF PATIENT
CASES IN SUPPORT OF PATIENT BILL OF RIGHTS.

PATIENT ADVOCATE FOUNDATION

A National Network for Healthcare Reform

780 Pilot House Drive, Suite 100-C Newport News, Virginia 23606

TEL: 757.873.6668 FAX: 757.873.8999 E-MAIL: patient.pinn.net INTERNET: http://www.patientadvocate.org



Nancy Davenport-Ennis
Founding Executive Director

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To: The White House
Domestic Policy Council
Brandon Hofmeister

Re: Patient Cases Illustrative of Problems Identified in Patient Bill of Rights

From: Nancy Davenport-Ennis
Founding Executive Director
Patient Advocate Foundation

Date: July 20, 1998

As requested by you Friday, July 17th, please find below narratives of patient cases we have resolved recently that illustrate the problems being addressed in the Patient Bill of Rights. If additional information is needed, please call us.

Preface:

As we examine the eight primary rights and responsibilities of the Consumer Bill of Rights and Responsibilities; it is very apparent from our experience in resolving patient conflicts with insurers, that seldom do these cases involve violations of only one or two of the matters addressed in the Bill of Rights. Typically, the case involves multiple violations of several of the areas being addressed in the Bill of Rights. Further, it is noted, that those plans that are ERISA plans offer enhanced resistance to settlement either negotiated through our case managers or developed legally through our ERISA attorneys; however, we have been successful to date in achieving negotiated settlements in all of our cases. Unfortunately, patients in this process have died before the therapy in question, once approved, could be rendered; thus from our perspective, the case was lost, though administratively the appeals process was a success.

Our summary conclusions would be that consumers, as reflected by our cases, have sought to "play by the insurer rules" only to be confronted with new game plans that "kopt the case rolling in a tight ball from one hoop to another" as defined to us by our patients. Our health care attorneys, among our nation's finest, and our case managers, thoroughly versed in filing effective insurance appeals, experience delays, multiple requests for the same exhibits, slow responses to phone calls throughout thier appeals and settlement negotiations.

Case Summaries:

National Case Manager Cases resolved by Patient Advocate Foundation Case Managers

Patient: Joyce Lessely Age: 54 years
1234 Riverwood Drive
Algonquin, Illinois 60102
(847) 854-8392

Diagnosis: Squamousal Carcinoma of Perianal Area (Rare Skin Cancer)

Disabled due to disease, therefore not employed.

Insurer: Medicare managed by United Health Care of Illinois

Continuity of care

Patient contacted PAF in February 6, 1998 when denied treatment of surgery for her skin cancer. Patient expressed that she was originally denied care in 1994 when the disease was originally diagnosed and when the disease was visible to the naked eye. Surgery was initiated twice. After the second surgery patient was told all is well. The pathology report from the second surgery was never checked. She requested a copy of the path report repeatedly and was denied. She finally received a copy in October of 1997, three years after the surgery. The report was noted "moderate to severe multiple dysplasia". In November of 1997 a new physician did biopsy and referred her back to the doctor of 1995 who had failed to provide a copy of the path report and had told her for three years "everything is fine". He refused treatment until she had further muscular neurological problems. Her 1995 doctor dropped her and refused to treat her based on "breakdown in communications and trust." He did not refer her to another physician. The Medical Director of the HMO stepped in and referred her to another physician. April 1998 she had ostomy with extensive split thickness skin graft. Currently the patient states she felt that the HMO tried to Psyche her out and that we as a nation have "population control by HMO." HMO physician would not assist with her application for disability, so she hired an attorney.

Patient: Betty Havens

Age 47 years

P6/b(6)

Diagnosis: Breast Cancer

Employer: Self

Insurer: Kaiser Permanente / Portland, Oregon

NO women's spec. acc't

Patient contacted PAF 5/6/98 when insurer refused payment for her diagnosis and treatment of Breast Cancer while visiting for several months with family members in New York. Ms. Havens residence is in Vancouver, Washington. Her insurer refused payment based on the fact that the treatment was not an emergency and that she was out of network. The patient protested that she lives for several months each year in New York with family members, and that while living in New York she detected the breast lump and sought medical care. She is currently in the process of completing a first appeal with the aggressive support of her New York physician. She has requested that PAF refer her case to an attorney if the appeal is denied. Her physician in New York noted that she had 5 of 19 nodes positive and that her care was of an energy nature. Appeal results are pending.

Patient: Edward Basham

41 years

P6/b(6)

Diagnosis: Brain Tumor

Employer: John Deere
South Wilmington, Illinois

Insurer: ERISA Plan
National Heritage, Inc.

no access to specialist

Mr. Basham has confronted repeated challenges in accessing specialists who have positive reputations for treating his type of brain tumors. His oncologist originally referred him to Evanston, Illinois to consult with a brain tumor specialist. The visit was denied by the insurer. Mr. Basham paid for the consult personally; however, he had to return to in-network providers where he has been receiving both radiation and chemotherapy. He was told by a local radiologist involved in his radiology therapy that his "tumor had shrunk 50%". Subsequent additional test reflected that the tumor had shrunk only 20%. He is disabled and has not worked since December, as his tumor causes considerable dizziness. His wife contacted PAF to seek support in getting him referred to the best of the in-network providers for chemotherapy, which was completed in April 1998. Mr. Bashma's concern is that as a "young man", he wants the very best treatment available to try to save his life. He feels that treatment is in Evanston, Illinois. He is concerned to confront the employer, as his disability and health insurance are both provided by the insurer.

Patient: Jose Manuel Marin, Jr. Age: 6 years

P6/b(6)

Diagnosis: Mylo-dysplastic (pre-Leukemia)

Father's Employer: Jones Blair Point Co.

P6/b(6)

Father: Jose Manuel Marin

**Insurer: Cigna
Sherman, Texas**

Child received Bone Marrow Transplant in 1995. Father applied for family coverage and was denied because his son had BMT in 1995. Family called PAF 3/30/98. Case Manager contacted the insurer and negotiated full coverage for family for \$213.42 per month. Family funds are extremely tight due to husband's injury at work and enrollment in Workman's Comp. PAF suggested they appeal to their church, community fund raising to procure insurance funds. He has been told that when he is released to return to work, they would hold his job for him; however, he has just received a letter (7/16/98) from his employer stating that he could continue to work but would have to work out of another office one to 1 1/2 hrs. away from his home. Family is currently uninsured; although, Mr. Marin has pay stubs reflecting that funds were taken out of his weckly payroll check for family insurance. Family remains uninsured due to lack of funds at present time.

Patient: Diane Burman Age: 40 years

P6/b(6)

Diagnosis: Replacement of torn, defective breast implant implanted after breast cancer surgery in 1996.

**Employer: Sandy Hill
Greenwood Lake, New York**

**Insurer: Physicians Health Systems (PHS)
1-800- 848-4747**

Ms. Buurman contacted PAF 3/3/98 requesting our intervention in her efforts to appeal the denial of replacement of a defective implant which she had sought to reverse through her own appeals for months before contacting us. She "played by their rules" supplying all information they requested, only to be given another set of assignments. We encouraged her to contact both the State Attorney General to file a complaint and the State Insurance Commissioner to request help in resolving the matter. We further provided counsel in how to specifically submit and write her final appeal letters. Her reversal of the denial was completed within two weeks of her call to PAF; corrective surgery has been completed and her bills have been paid by the insurer. Her evaluation of her case is that her persistence paid off and that her complaints to the her state agencies moved the insurer to reconsider. Her final observation is thought provoking as she stated "they send you to their doctors who prescribe your care and then they deny the care that their doctors have prescribed."

Patient: Annice Laroche Age: 45 years

P6/b(6)

Employer: INS of Swanton, VT
Insurer: MVP of VT
Schenectady, New York

Annice Laroche, mother of three children, ages 11, 22 and 26 years diagnosed with Breast Cancer 1994. Referred by her oncologist for a Bone Marrow Transplant. She was denied by the insurer. Patient was enrolled in standard protocols. Patient's sister-in-law related that for months the patient was moved from one protocol to another by the in-network oncologist. Patient called PAF 3/18/98. PAF filed an appeal that resulted in approval for BMT within one week of our appeal. Patient traveled to University of Connecticut for transplant where she was advised that her disease had progressed too far to have the BMT. Annice Laroche died April 15, 1998.

Patient: Devon Bush Age : 42 years

P6/b(6)

Diagnosis: Brain Tumor

Employer: Self-employed with ABC, Inc. Changed to Disney, effective 4/1/98.

Insurer: Health Insurance Plan

P6/b(6)

Patient sought second opinion out of network. Denied. Patient contact PAF. After consulting with our case manager, he negotiated insurance coverage with Disney which allowed second opinion from preferred physician, since the physician was in their network. Very fortunate resolution.

Patient: Saylor Creswell Age: 58 years

P6/b(6)

(212) 674-8554

Diagnosis: Prostate Cancer 4/97

Employer: Costume Designer with United Scenic Artists
New York, New York

Insurer: Aetna (Mr. Creswell's primary insurer through 7/31/98 which is his wife's insurer.)
Actors' Equity League Health Plan managed by Empire Blue Cross Blue Shield
is his plan that will become his primary plan 8/1/98.

Mr. Creswell contacted us when he was seeking treatment with an out-of-network provider that was denied by his insurer. He was successful in gaining this approval "because my primary care physician is a friend of a member of the appeals board of my insurer." Mr. Creswell has been treated out of network with payment made to the physician by his insurer using the "usual and customary" standard for payment.

Patient: Jimi Allen Age: 21 years

P6/b(6)

Diagnosis: Liver Transplant

Insurer: Medicaid

Upon son's 21st birthday 9/14/97, Medicaid dropped Mr. Allen from their insured rolls. The parent, Alinda Allen, stated that she received no notice that this would happen and learned that it had happened when she received bills not reimbursed during the time that her son was uninsured. PAF consulted with the mother to enroll the son in Nylcare HMO; however, reimbursement for his anti-rejection medication is still a problem. PAF recommended application to the pharmaceutical company for charity care or reduced billing. The insurer had a \$1,000.00 limit on Prograft which was met the first time the son needed the transplant. Patient is currently employed by Americorps, paid a stipend instead of salary and receiving educational money. He had to drop out of college due to illness and finances.

Patient: Jeffrey W. Farrar Age: 38 years

P6/b(6)

Diagnosis: Myelodysplasia (pre-Leukemia)

Employer: Duck River Utility Commission
Tullahoma, TN

Insurer: Fortis Benefits Insurance Co. PPO
Milwaukee, WI

Patient denied bone marrow transplant because he was not in blast crisis. Insurance also did not pay for BMT evaluation in St. Luke's Hospital in Kansas City, Missouri. PAF became involved in filing appeal with insurer. Case was resolved May 15, 1998 with insurer reversing denial and Mr. Farrar receiving transplant. Appeal time from date of initial call to PAF to resolution was 30 days.

National Legal Resource Network Patient Cases

All cases have been handled by attorneys within the PAF National Legal Network.

Patient: Susan Eubanks**Age: 46 years**

P6/b(6)

Diagnosis: Breast Cancer Stage 2**Employer: National Board of Certified Counselors
Greensboro, NC****Insurer: Trustmark
Youngstown, Ohio**

Patient was referred by her local oncologist for Peripheral Stem Cell transplant with High Dose Chemotherapy for CalGB9282-Randomized NCI trial. Patient refused to be randomized and requested transfer to Duke University Medical Center. Trustmark denied based on experimental nature of the therapy. Also stated that HCFA guidelines noted the treatment as experimental and therefore denied by HCFA. Patient needed transplant March 3, 1997. Patient and Duke University Medical Center (DUMC) contacted PAF 2/14//97. After preliminary discussions with Trustmark representative, PAF referred case to Edward Connette, Esquire, ERISA attorney of Charlotte, N. C. He secured a court injunction. Trustmark staled their negotiations with Mr. Connette. An agreement was reached March 13rd requiring a signed "gag order" of Ms. Eubanks. She began stem cell harvest at Duke March 16th. The delay from March 3rd to March 16th exposed patient to additional rounds of chemotherapy, not to mention mental anguish. Ms. Eubanks is fully recovered and enjoying the resumption of her life activities.

Patient: Joyce Trainer**Age: 51 years**

P6/b(6)

Diagnosis: Duodonal Cancer January 17, 1998**Employer: Texas Retirement System/ School System
Teacher: Houston, TX****Insurer: Prucare
Houston, TX**

Patient initially complained of pain and illness September of 1997. When she visited her primary care physician, she requested transfer to specialist. Request was denied. She requested lab work be done to determine why she was losing weight and suffering from extreme fatigue. She was told by primary care physician to fill a prescription for Zantac to relax her and alleviate stomach pain. She was also told to relax, that the problem was stress. In October, she returned to the primary care physician with same complaints, increasing her description of pain and weight loss. She was given anti-acid and Prevacet for ulcers without any additional tests. She requested tests. They were denied. She requested referral to specialists. It was denied.

In November, she visited another doctor in the network. They provided Elavil and an anti-depressant. Ms. Trainer requested immediate transfer to a surgeon for second

P6/b(6)

Diagnosis: Brain Tumor

Employer: Rabco Enterprises
Insurer: Kaiser Permanente
California

Patient contacted us when insurer was denied access to University of San Francisco to be treated by Dr. Burger, a specialist in brain tumors. Patient appealed. Appeal was denied. PAF contacted attorney to assist with appeal preparation. Second appeal was filed with support of attorney, Gary Tysch, Sherman Oaks, California. Request was for transfer to Cedars Sinai for treatment. Second appeal was approved. Care was initiated with PAF December 8, 1997 and resolved January 13, 1998.

Patient: **Regina Kegley** Age: 34 years

P6/b(6)

Diagnosis: Breast Cancer

Employer: Russell County Medical Center
Lebanon, Virginia

Insurer: Community Health Systems (ERISA plan)
TPA: ASO North America/ Houston TX
UR: Intracorp
Case Management: Select Health Care
Re-insurer: Trustmark (New York Underwriters)

Patient was denied bone marrow transplant with high dose chemotherapy while seated in the pre-admission office at Duke University Medical Center with the admissions case manager 8/22/97. Case manager called and urged an immediate reversal, as patient had received initial indication that treatment would be approved, as had the Duke case manager. Case was denied. Patient and case manager contacted PAF. PAF attorney traveled to Durham while patient and her family checked into local hotel from Friday evening through Tuesday morning while attorney and insurance representatives met to negotiate denial. If Mrs. Kegley did not begin her treatment on Wednesday, her "window of opportunity" was gone. A sealed agreement was reached Tuesday evening 8/26/98. Mrs. Kegley was immediately admitted and the transplant was initiated Wednesday.

Patient Advocate cases reflect the need for equity in the managed care marketplace in defining in understandable terms the benefits of the plan, providing assistance with proper application for preauthorization to assure timely response, negotiating coverage requests for out-of-network providers that enhance patient confidence in their provider and assure access to the most beneficial care available in our marketplace and the urgent need to reform ERISA regulation and enforcement so that plans are accountable for decisions made. *Sheldon Weinhaus, Esquire of Weinhaus and Dobson, St. Louis, Mo. is Pro-bono Director of the National Legal Resource Network for the Patient Advocate Foundation. Mr. Weinhaus served on the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry.*

DONALD T. NETTER

P6/b(6)

Via Facsimile

P6/b(6)

July 16, 1998

The Honorable Joseph I. Lieberman
United States Senate
One State Street, 14th Floor
Hartford, CT 06103

Dear Senator Lieberman:

Enclosed please find a copy of a 1997 letter outlining the extraordinary and unfair requirements to obtain health coverage for a life-saving procedure in connection with my wife's (Kim) metastatic breast cancer. If coverage had ultimately been denied, fortunately I would have been able to afford the requisite prompt care. However, there are those less fortunate that would have been unable to afford the care if the insurer had not provided coverage and/or died or further injured as a result of the insurer stalling.

Our government and the nation has encouraged the growth of managed care. In this great nation, although we often do not have unanimous agreement with enacted legislation, we generally abide by the laws as we have faith in our system of government because elections are held openly and honestly. We cannot have faith in our healthcare system if policyholder benefits are unfairly denied with little redress and cases are not promptly reviewed.

In Kim's case, the medical review board was not truly independent, which fostered a series of unintelligible denials. The failure to provide a truly independent medical review board (free from any conflicts of interest) leaves a burning hole in this nation's healthcare system and causes countless unnecessary tragedies.

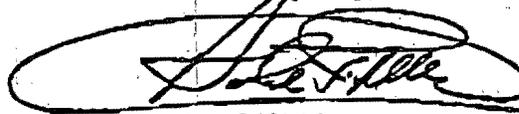
As a result of the specialized treatment Kim received, she is presently disease free and more vibrant than ever. While my wife was receiving treatment in Detroit, Michigan, I encountered another metastatic breast cancer patient that had been denied coverage for similarly frivolous reasons. She was also the subject case for litigation against the Blues in Detroit which lead to a change in the law in the state. While the trial was pending, only through a court order, was she able to receive treatment. The delay in treatment did cause her further harm, though. Today she is doing quite nicely.

As a businessman and a director of a publicly traded life and health insurance entity, I recognize legitimate issues of companies that have, in particular, public shareholders to represent. However, the responsibility must first be to policyholders, and then second to shareholders. There is an inherent economic conflict of interest between policyholders and shareholders, and the ERISA Pre-exemption further tips the scale in favor of the insurer. History strongly suggests that we have too many insurers that have proven to be irresponsible in setting their priorities. We must have legislation that removes this conflict of interest for them and modifies the ERISA Pre-exemption. With these adjustments, it is quite probable that all of our health insurance premiums will rise modestly, but then we will have the assurance that when a medical catastrophe strikes any one of us, we will be afforded the coverage prescribed by our policy, and it will be administered in good faith. Consequently, when we unfairly deny policyholder benefits, we underestimate the true cost of healthcare.

Therefore, I urge you to support the Patient's Bill of Rights Act of 1998 (S1890/HR3605), that will insure that policyholders are dealt with fairly with no possibility of conflict of interest and provide for severe penalties for irresponsible insurers.

I would be happy to visit with you on this matter, either in person or by telephone. I can be reached at P6/b(6)

Yours very truly,



Donald T. Netter

DTN:pg
Encl.

Donald T. Netter

P6/b(6)

August 4, 1997

VIA FEDERAL EXPRESS

Dr. Frank N. Medici, M.D.
Vice President, Medical Affairs
Oxford Health Plans
800 Connecticut Avenue
Norwalk, CT 06854

Re: **Oxford Denial of Coverage for Transplant in Stage IV Breast Cancer
Kimberly Lawrence Netter - ID No. F 569035*02**

Dear Dr. Medici:

On June 10, 1997, I sent a letter (attached) to Ms. Corene Raynor explicitly requesting that all communications regarding pre-certification for my wife's (Kim) pending transplant be sent to my office so as not to unnecessarily upset her.

We are in receipt of Oxford's second denial of coverage letter (attached) dated July 14, 1997 from Heather Burdin which was sent to Kim, greatly upsetting her. Oxford continues to deal with this matter in an insensitive and one-sided manner. Patients, such as Kim, who are undergoing this treatment protocol, including induction chemotherapy, don't need the additional stress of adding greater financial requirements on their family at a time when their family is already under considerable strain. I trust that this unfortunate episode won't be repeated.

On June 17, 1997, we received a letter (attached) from Robin Zander denying coverage for a transplant for Kim, who has Stage IV Metastatic Breast Cancer (advanced) in which disease was found in her right ischium bone. Upon receipt of this initial denial of coverage letter, I discussed at length with Maggie Taylor, also of Oxford, the fact that the denial letter was extremely unclear to me as well as to Dr. Roy Baynes (Kim's transplant doctor), Karmanos Cancer Institute, as to precisely what Oxford's problem(s) is(are). I stated that we intended to appeal this initial decision, but needed specific information to make an effective appeal. Oxford's initial denial suggested the following:

- (i) "It has not been demonstrated that the treatment with the above-mentioned protocol is associated with superior clinical benefits";
- (ii) "The patient is not a candidate because of the total dose of Adriamycin she has received as adjuvant therapy", and;
- (iii) "The protocol is not the most appropriate level of service which can safely be provided and, therefore, not medically necessary."

I'm sure your medical staff is fully aware that there is abundant documentation demonstrating that transplants with this protocol and modified protocols have been widely performed for the past 7-8 years with considerable success and is widely medically accepted. Enclosed again is extensive documentation in clear support of transplantation which was previously forwarded to Oxford. Oxford's second assertion exhibits a complete lack of diligence, as Kim's protocol was modified to take account of the prior dosage of Adriamycin. Oxford's third assertion is incoherent. After inquiry, Oxford hasn't suggested "a more appropriate level of service", and as the protocol was modified to account for the prior dosage of Adriamycin, the protocol is the most appropriate level of service that can be provided safely. Making Oxford's assertions more ridiculous still is the fact that it's outside medical consultant's report (attached) states throughout that this "is the only treatment modality that has the potential to offer this patient long-term disease-free survival (DFS)". It appears Oxford has ignored the provided and available information that is relevant to a truly independent evaluation in order to deny this medically necessary treatment.

Nevertheless, Dr. Roy Baynes, in his appeal letter of July 1, 1997 (attached), clearly makes the following points:

- (i) "Our [Karmanos Cancer Institute] position and that of your outside reviewer's are essentially the same. Although your [Oxford's] reviewer equivocates on the scientific basis of high-dose therapy and stem cell rescue, he/she ultimately concludes that High Dose Chemotherapy (HDC) and Peripheral Stem Cell Rescue (PSCR) offers this patient her only chance of long-term DFS."
- (ii) The three FDA approved drugs to be employed in Kim's treatment plan "have been studied extensively as chemotherapy agents active in this disease and there is extensive literature support documenting the efficacy of these drugs, individually and in combination..."
- (iii) Recognized oncology organizations accept HDC with the regimen described above "... There are no recognized oncology groups in the U.S. which have failed or refused to accept the treatment proposed for Ms. Lawrence Netter."
- (iv) "Given, however, that the data in favor transplantation are so compelling, it would be unconscionable to exclude a patient simply because she had received a significant amount of Adriamycin in the adjuvant setting. Consequently, for patients in this position, a specific exclusion is made whereby they are able to receive another defined induction regimen in the form of Navelbine and Taxotere."
- (v) "It is important that you [Oxford] realize that a large body of scientific data has established that HDC and PSCR is the only modality that gives patients, such as Ms. Netter, with metastatic breast cancer, a chance of long-term DFS."

Although at an embarrassingly slow pace and after many heated phone conversations, importantly, Oxford has finally reimbursed us for undisputed induction chemotherapy of Navelbine and Taxotere. Not surprisingly, co-employees have also had tremendous difficulty obtaining timely coverage and reimbursement for serious medical conditions. One employee had to pay out of his pocket for an angiogram test which ultimately showed a serious heart condition. Only after the results did Oxford reimburse him.

Oxford's second denial of coverage letter of July 14, 1997 asserts the following:

- (i) "There is no well-designed and well-accepted peer reviewed clinical trials to support the recommended treatment as superior to standard therapy," and
- (ii) "Ms. Netter has not demonstrated chemotherapy responsiveness."

Trying to have a constructive dialogue with Oxford is like trying to play the shell game, where we have to guess which administrator is handling the case, or what Oxford's current excuse is. In Oxford's first

denial letter of June 17, 1997, there was no mention of chemotherapy responsiveness, and in your second denial letter of July 14, 1997, you make the assertion that "there is no well-designed and well-accepted peer-reviewed clinical trials to support the recommended treatment as superior to standard therapy." It seems disingenuous to suggest, on one hand, that the treatment is not superior to standard therapy and, on the other hand, be asking for a demonstration of chemotherapy responsiveness. Kim has not been shown to be unresponsive to chemotherapy and I'm sure your medical staff is aware that it may be very difficult to track chemotherapy responsiveness at the induction phase when the lesion is in the bone. Furthermore, it appears that Oxford intentionally switches contact people, making it almost impossible to have a consistent constructive dialogue. Kim's file has been passed from Corene Raynor to Robin Zander to Heather Burdin to Maggie Taylor, and on July 18, I was informed that Maggie Taylor is no longer involved.

In connection with Oxford's first denial letter, on June 23, 1997, I suggested to Ms. Taylor and Ms. Burdin that a conference call between Dr. Lenaz, Dr. Baynes and myself be arranged to define Oxford's concerns. This was not pursued. Shockingly, the same day, Laurie De Rosa informed me that Dr. Lenaz "does not get involved in the appeal process and does not take calls". Considering that it is her judgment that formed the basis for denial, it's extremely defensive that she doesn't get involved in the appeal process. Further, I had inquired of Ms. Taylor as to which protocol Oxford believes would be "associated with superior clinical benefit" and the name of the outside consultant to determine what he/she thinks would be a more beneficial procedure. To date, there has been no response to these questions. As I also mentioned, Kim and I have had in person or over the phone consultations with nine renowned physicians, in the fields of Breast Cancer, metastatic disease and related Oncology, all of whom are listed here:

In Person Examinations and Consultations

3/12/97	Dr. Holland - Mt. Sinai, NY
3/15/97	Dr. C. Hesdorffer - Columbia Presbyterian, NY, NY
3/17/97	Dr. Ross - Denver University Hospital, Denver, CO
3/19/97	Dr. Hudis - Memorial Sloan Kettering, NY, NY
4/10/97	Dr. Bill Peters/Dr. Roy Baynes - Karmanos Cancer Institute, Detroit, MI
Multiple	Dr. Bernard Kruger, NY, NY

By Phone Consultation

Dr. Fredrich Becker, M.D. Anderson, Texas
 Dr. Peter Pressman - New York (Kim's Breast Surgeon)
 Dr. Edward Beattie - Beth Israel, NY, NY

In conflict with Oxford and Dr. Lenaz, it was the overwhelming conclusion of these experts that Kim, being only 40 years of age, healthy in all other respects, presenting a modest level of disease and with a vibrant optimistic attitude, is the ideal candidate for this treatment plan.

If physicians associated with Oxford have a different medical opinions, then I would be pleased to hear them; but your outside medical consultant had the following repetitive comments:

"Patients with metastatic breast cancer are currently incurable with conventional chemotherapy... As stated above, this theory, HDC followed by PSCR, is the only treatment modality that has the potential to offer this patient long-term DFS.... HDC and PSCR offers this patient her only chance of long-term DFS... Conventional chemotherapy would be associated with an extremely low risk of mortality, however the chance of long-term DFS is extremely unlikely. As mentioned, HDC with PSCR is the only modality associated with prolonged DFS...."

Within Oxford, Kim's file has been passed from department to department, and from person to person. Oxford's denial letters are either unintelligible, or inconsistent, and contradict its independent medical consultant. Oxford has caused my wife and me considerable anguish and has so unnecessarily drained an enormous amount of our time. Collectively, these acts on the part of Oxford suggest a lack of good faith and a violation of trust. Given the fact that Oxford is not only the insurer, but also the arbitrator of the policy, there exists a serious conflict of interest. We believe Oxford has misrepresented its policy when it says that it pays for "medically necessary" services when it fails to pay for a transplant in patients with Stage IV Breast Cancer. There is no specific exclusion in Oxford's policy for this treatment, and it appears that Oxford has ignored the very information supplied and available that was relevant to the evaluation. Therefore, it should be concluded that Oxford's decision is arbitrary, capricious, and an abuse of discretion.

Please advise me in writing, executed by an Oxford officer and delivered to my office at the above address by August 18, 1997, definitively if Oxford intends to cover Kim's transplant scheduled for this Fall. If I don't receive such a letter by this date, I will assume that Oxford will not cover Kim's transplant, a medically necessary, widely employed, state-of-the-art and life saving procedure for Stage IV Breast Cancer patients.

Insurance works because all of our houses don't burn down at once. However, when your house goes up in flames, and there's no specific policy exclusion for the loss, you expect coverage to be provided without a dramatic run-around and the insurer seeking any reason not to provide coverage.

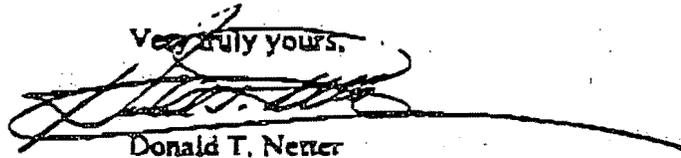
Oxford's 1997 Annual Report to Shareholders boasts the following:

- Annual Revenue growth of 74% to \$3.1 Billion
- Being one of the 500 largest corporations, a feat accomplished in 12 years without acquisitions
- Net earnings advancing 90% to \$99.6 million.
- The common share price growing 59% for the year.

With these enormously profitable results and share price appreciation, it's not necessary to damage policyholders by delaying reimbursement for undisputed claims and denying coverage for "medically necessary" procedures when there is no specific policy exclusion.

When Geneve Corporation, Stamford, CT, (which draws its employees from New York, Connecticut and New Jersey) engaged Oxford on February 1, 1995, it expected that Oxford would be there for its employees in trying times and not create more difficulty for families faced with serious medical illnesses. Thus far, this has not been the case. I sincerely hope Oxford will act responsibly in this matter and truly be the "Health and Healing Company".

Very truly yours,



Donald T. Netter

cc: William M. Sullivan, President, Oxford
Heather Burdin, Oxford
Dr. Maria Lenz, Oxford
Corene Raynor, Oxford
Maggie Taylor, Oxford
Robin Zander, Oxford
Angelo DiMatteo, Oxford Health Plans
Oxford Health Plans Grievance Review Board
New York Department of Insurance
New Jersey Department of Insurance
Connecticut Department of Insurance
Stuart D. Freedman, Esq. - Schulte Roth & Zabel
Elizabeth Gleicher, Esq. - Gleicher & Reynolds, PC
Susan Scelzo Slavin, Esq. - Slavin & Steinberg, PC
Richard Netter, Esq. - Singer, Netter & Dowd

P6/b(6)

June 26, 1998

Ms. Marsha Kimball
The Patient Advocate Foundation
780 Pilot House Dr., Suite 100C
Newport News, VA 23606

Dear Mrs. Kimball:

The authority Prudential HealthCare HMO has over their patients is of serious concern to me. I, a forty-three year old female, have personally experienced a deadly disease and received no help whatsoever from my HMO in securing a specialist to treat my condition. I am thoroughly convinced that major changes are needed soon in this area of the health care industry.

On September 8, 1997, I was diagnosed with breast cancer. Dr. Janice Wood, a Prudential HealthCare HMO general surgeon, informed me that a mastectomy was needed immediately. Not revealing any other options, Dr. Wood set a date for surgery. Although confused, depressed, and frightened, I felt that there were other alternatives and began my search for any and all information about breast cancer and its treatment.

In September 1997, I requested a referral from my primary care physician, Dr. Michelle Scullock, to an oncologist. I visited Dr. Robert Johnson, an oncologist, on September 22, 1997 and on October 2, 1997 I began intense chemotherapy treatments. After three chemotherapy cycles, I inquired about another surgical opinion, Dr. Johnson recommended Dr. Christine Mroz a local breast care specialist.

On November 19, 1997, I requested a referral from my primary care physician, Dr. Scullock, to visit Dr. Mroz. Dr. Scullock authorized a referral for three visits, which included evaluation and treatment to Dr. Mroz; however, the medical director for my HMO denied authorization.

On December 3, 1997, I visited Dr. Mroz paying the bill myself. She believed that breast conservation was probable if there were a significant reduction in the size of the tumor after chemotherapy. On December 18, 1997, I appealed Prudential's decision to deny coverage for medical services to be performed by Dr. Mroz. At that particular time, I was extremely ill and fatigued from Adriamycin and Cytosan, my chemotherapy drugs. Still, I endured the appeals process attempting to secure the breast care specialist I needed.

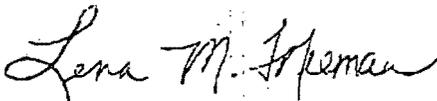
The first appeal for treatment by Dr. Mroz was denied on January 7, 1998; however, the request for a second surgical opinion was approved.

A second appeal for treatment was made on January 23, 1998. I received a letter on February 14, 1998 again denying approval for the professional services of Dr. Mroz. At that point, I was tolerating Taxol and Carboplatin extremely intense and painful chemotherapeutic drugs. Nearing the end of my chemotherapy, I knew that a decision had to be made soon pertaining to surgery. I contacted The Patient Advocate Foundation and was referred to an attorney with whom I spoke. I also contacted a local attorney. Based on my conversations with these attorneys, I decided that Dr. Mroz would perform the surgery and that the issue of reimbursement from Prudential would be pursued at a later date.

On April 3, 1998, I visited Dr. Mroz office. She stated that my breast could be conserved and agreed to speak with the HMO medical director. After their conversation, I received a letter from Prudential agreeing to allow coverage for in-network facility charges incurred by Dr. Mroz; however, professional services provided by her would not be covered. Dr. Christine Mroz performed surgery on April 16, 1998. She removed the remaining cancerous tissue and conserved the appearance of the entire breast.

It is apparent that Prudential Healthcare HMO makes the decisions about the health care of patients. This health maintenance organization does not have the necessary in-network specialists available and refuses to provide coverage for such if needed. The power that Prudential HMO holds is tremendous and major changes need to occur soon.

Sincerely,



Lena M. Freeman

I LENA M. FREEMAN GIVE CONSENT TO USE THIS LETTER REGARDING HEALTH CARE LEGISLATION

P6/b(6)

July 17, 1998

Ms. Marsha Kimball
The Patient Advocate Foundation
780 Pilot House Dr., Suite 100C
Newport News, VA 23606

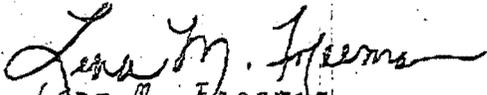
Dear Ms. Kimball:

Thank you for your assistance in my effort to secure authorization from my HMO for medical services to be provided by Dr. Christine Prosz, a local breast care specialist.

The information I received from The Patient Advocate Foundation and Rich Carter, the attorney I was referred to by the Foundation, was invaluable. Individuals like myself, the middle person, need organizations such as yours to advocate changes in laws to insure quality health care.

Again, my sincere thanks to you and the Foundation.

Sincerely,


Lara M. Freeman

LEVEL 1 - 57 OF 626 STORIES

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June 24, 1998, Wednesday, Final Edition

SECTION: A SECTION; Pg. A01

LENGTH: 1738 words

HEADLINE: The Battle For Patient Rights; Final Say: One Patient's Ordeal

BYLINE: David S. Hilzenrath, Washington Post Staff Writer

BODY:

What kind of rights should Americans be guaranteed in a health care system where managed-care plans have gained broad powers to decide how much and what kind of treatment patients receive? That question is becoming a major public concern and a volatile issue in Congress.

One story below examines what has happened in Miami since Florida began to regulate the managed-care industry in ways being considered by Congress. The other story shows the sense of powerlessness some patients feel in fighting the decisions of their health plans -- and why some lawmakers want to intervene.

Diagnosed with liver cancer, Abdul Hakim Al-Warith of McLean wrote a polite but worried letter to his HMO in February 1997 asking it to reverse its position and approve the potentially life-saving liver transplant recommended by specialists at Johns Hopkins University.

"Please contact me and apprise me of the status of matters, as any further delay in my treatment will have critical consequences," wrote the 52-year-old banking consultant and father of five.

One month later, Al-Warith again wrote to Kaiser Permanente, his tone more urgent. The HMO's unresponsiveness "is causing considerable mental and emotional stress," he said.

In April, Al-Warith poured his exasperation into a third letter. "[M]y feeling is that Kaiser is stalling on a decision."

Finally, in May, Al-Warith appealed to the agency that oversees health benefits for the families of federal and some District employees. The agency took five days to review his case and told the HMO to pay for a transplant. But by the time an organ became available, Al-Warith was too sick for the operation. He died the next day.

For people who are already in a vulnerable position, challenging a health plan's decisions on medical treatment can be a frustrating and lengthy ordeal, especially because the plan typically has the final say. Congress is considering ways to tighten controls on HMOs, and one of the most contentious proposals is to guarantee patients the ability to appeal an HMO's decision to an independent authority.



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Unlike Al-Warith, people with private insurance generally lack that option. The federal government is working to provide external appeals for people in Medicare and Medicaid, the government insurance programs for the elderly, poor and disabled, and 18 states have required insurers to provide external appeals that vary in their scope and degree of independence.

President Clinton has proposed establishing an independent appeals process for all consumers, as a patient's basic right.

Some elements of the health insurance industry have resisted legislative mandates, and others say health plans generally do a good job of handling consumer grievances.

"An appeals process that works as fast as it needs to is one of the tenets of our own code of conduct," said Susan Pisano, spokeswoman for the American Association of Health Plans, a major industry lobby.

Patient advocates see it differently. Managed-care companies' procedures for handling disputes are, for the most part, "a mean-spirited joke," complained A.G. Newmyer III, chairman of the Fair Care Foundation, a patient advocacy group in Chevy Chase. "They are structurally designed to take forever, to be as inconvenient as possible, and to achieve the precise result that the insurers want -- that is, to get the policyholders to simply give up."

Yet, for patients "willing to go the distance . . . the insurers very often cave," Newmyer said.

Kaiser officials said they recognized the frustration Al-Warith and his wife felt but disagreed with the complaint that Kaiser was unresponsive.

"I think we were pretty consistent in our answer, but it wasn't the answer they wished to have," said Larry Oates, Kaiser's associate medical director.

The internal appeals that health plans offer consumers often reward perseverance.

One patient who triumphed was Rosalie Lynn, who contested her HMO's refusal to pay a \$ 60 podiatric claim.

After being rebuffed twice by the HMO -- first by the member services department, then by the medical benefit review committee -- Lynn took time off from work as an administrative assistant at the University of Maryland in College Park and drove more than an hour to CareFirst headquarters in Owings Mills, Md., to plead her case before an appeals panel of HMO members.

The panel decided unanimously in her favor. "It was an easy decision," Chairwoman Teri Harrison said.

For \$ 60, "most people . . . would have gave up," said Lynn's husband, Charles, who accompanied her to the hearing.

Few consumers take the formal appeals route. CareFirst and FreeState Health Plan, an affiliated Blue Cross and Blue Shield HMO, processed more than half a



million medical claims last year and received only 703 grievances, said Antoinette Hopkins, director of member services for the two HMOs.

Though health plans may explain their grievance procedures in handbooks sent to enrollees, some consumers say they are not aware of their rights or responsibilities when a dispute arises.

Sometimes, what is presented as a fair outside appeals process can be far from impartial. That was the California Supreme Court's comment last year on an arbitration system Kaiser Permanente has used to resolve disputes in that state.

"[T]here is evidence that Kaiser established a self-administered arbitration system in which delay for its own benefit and convenience was an inherent part," the court said in its opinion.

The court said the appointment of the neutral arbitrator in Northern California malpractice disputes took an average of 674 days in the mid-1980s instead of the promised 60 days or less and that it took almost 2 1/2 years on average for a case to reach a hearing.

Kaiser has taken steps to improve the arbitration system, and the HMO wasn't necessarily responsible for the delays, Kaiser Vice President Pauline Fox said.

As a member of Kaiser's HMO in the Washington area, Al-Warith was not subject to the arbitration system. Told he had about a year to live, he challenged his health plan internally -- and then pursued the external appeal available to those covered through the Federal Employees Health Benefits Program.

Oates, who coordinated Kaiser's review of Al-Warith's case, said the HMO was following sound medical judgment throughout the dispute because Al-Warith's cancer was too advanced for him to receive a new organ.

In October 1996, after Al-Warith had been diagnosed with liver disease, the director of the liver transplant program at the University of Alabama at Birmingham studied his test results for Kaiser. Applying the university's criteria, the Alabama expert concluded that Al-Warith did not qualify for a transplant because his liver had four lesions.

Seeking a second opinion, Al-Warith went outside the Kaiser system to Johns Hopkins Hospital in Baltimore, where by late December doctors had concluded that he was indeed a valid transplant candidate.

Presented with the conflicting opinion from Hopkins, Kaiser began reassessing the issue.

On May 1, more than 10 weeks after Al-Warith began his anxious correspondence, Oates sent his first written response.

"Our process at present is to continue to review his [Al-Warith's] care requirements and re-evaluate our decision as necessary. We have not denied his right to pursue care outside of our system," Oates wrote to the patient's lawyer.

In late April and early May, the HMO got the results of an analysis it had sought from an outside "ombudsman" group. One cancer specialist concluded that a



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The Washington Post, June 24, 1998

transplant offered "the best hope" of extending Al-Warith's life, Oates said. Another gave "a qualified yes" to the question of whether a transplant "might be beneficial," Oates said.

Even with the operation, neither consultant gave Al-Warith more than a 20 percent chance of surviving for five years, Oates said.

With his health -- and his odds of recovery from surgery -- deteriorating, Al-Warith appealed to the U.S. Office of Personnel Management. Covered by his wife's government health benefits, he was able to turn to a higher authority in a way that commercially insured patients generally cannot. Even so, this appeal wasn't as independent as some patient advocates consider necessary, because, like other employers, the OPM could face rising costs if it ordered more care.

It took the federal agency less than a week to respond. Kaiser "re-evaluated the claim and determined that a liver transplant is appropriate for your medical condition," the OPM informed Al-Warith on May 14. When doubts arose about Kaiser's intentions, the OPM on May 20 formally ordered the HMO to pay.

By the time Al-Warith was hospitalized at Hopkins on May 25, 1997, his illness was too severe for doctors there to perform a transplant. Kaiser flew Al-Warith to the UCLA Medical Center in Los Angeles, where he died on July 2.

Al-Warith's insurance struggle continued. Even after his death, a collection agency sent him notices this year for unpaid physician bills. In addition, Hopkins was still owed \$ 18,477.98 as of last week for Al-Warith's hospital stay, according to an account statement, and UCLA was owed more than \$ 100,000, according to lawyer Jacqueline Fox, who represented Al-Warith.

Kaiser was waiting for an itemized bill from Hopkins and will pay for all the care, a spokeswoman said.

Whether earlier transplant surgery would have saved Al-Warith's life can't be known. "I think that's a possibility," Oates said.

But Kaiser had to weigh the odds, because there aren't enough organs for everyone who might benefit, Oates said. Transplant eligibility criteria vary from hospital to hospital, he noted.

Al-Warith's widow, D.C. government lawyer Julie E. Rones, said one lesson of this saga is that any external appeals process "needs to have teeth" -- the ability to enforce its decisions.

The Office of Personnel Management has the power to drop health plans from its program, a potentially disruptive step, but OPM officials said it has no lesser means of penalizing health plans.

For his part, Kaiser's Oates supports the concept of an independent review.

"In the majority of cases, it'll support our decision-making processes. And, where it does not . . . it's going to give us an opportunity to learn," Oates said.

Staff researcher Richard Drezen contributed to this report.



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GRAPHIC: Photo, JAMES M. THRESHER; Photo, FAMILY PHOTO, Cancer patient Abdul Hakim Al-Warith with his wife, Julie E. Rones, before his death last July. Rosalie Lynn took time off from her job as an administrative assistant at the University of Maryland to contest her HMO's refusal to pay a \$60 claim.

LANGUAGE: ENGLISH

LOAD-DATE: June 24, 1998



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U.S. 9th Circuit Court of Appeals

BAST v PRUDENTIAL INSURANCE 9735429

ROGER TIMOTHY BAST, individually
 and as Personal Representative for
 the ESTATE OF
 RHONDA RAE FLEMING BAST;
 No. 97-35429
 DOUGLAS GLENN BAST, a minor
 D.C. No.
 child,
 CV-96-00057-Z
 Plaintiffs-Appellants,

OPINION
v.

PRUDENTIAL INSURANCE COMPANY OF
 AMERICA, an insurance corporation,
 Defendant-Appellee.

Appeal from the United States District Court
 for the Western District of Washington
 Thomas S. Zilly, District Judge, Presiding

Argued and Submitted
 May 7, 1998--Seattle, Washington

Filed June 2, 1998

Before: David R. Thompson and A. Wallace Tashima,
 Circuit Judges and Tom Stagg, District Judge.*

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Opinion by Judge Thompson

SUMMARY

COUNSEL

Michael Fleming, Seattle, Washington, for the plaintiffs-appellants.

Jerry Spoonemore, Montgomery, Purdue, Blankinship and Austin, Seattle, Washington, for the defendant-appellee.

Jane Shapira, Northwest Women's Law Center, Seattle, Washington, for the amicus curiae.

OPINION

THOMPSON, Circuit Judge:

Roger Timothy Bast, individually and as the personal representative of the estate of his late wife, Rhonda Rae Fleming Bast, and their minor son, Douglas Glenn Bast ("the Basts") appeal the district court's grant of summary judgment in favor of Prudential Insurance Company ("Prudential"). The Basts argue that Prudential acted in bad faith and breached its fiduciary duty to Rhonda Bast by delaying authorization for a potentially life-saving medical procedure. The district court held that all of the Basts' state law claims were preempted by the Employee Retirement Income Security Act ("ERISA") and that ERISA provides no remedy for Prudential's alleged bad faith denial of benefits.

We have jurisdiction pursuant to 28 U.S.C. S 1291 and we affirm. Although this case presents a tragic set of facts, the district court properly concluded that under existing law the Basts are left without a remedy.

I

BACKGROUND

Rhonda Bast was an employee of Cole National Corporation ("Cole"). Cole provided major medical benefits for its employees under the "Cole National Corporation Group Benefit Plan" (the "Plan"). Prudential acted as the administrator of this health insurance plan. Additionally, Prudential provided excess insurance coverage to Cole to cover benefits in excess of certain specified limits. During the relevant time period all of Rhonda Bast's benefits were paid for by Cole out of its general assets.

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In December 1990, Rhonda Bast was diagnosed with breast cancer and she underwent a left modified radical mastectomy in January 1991. In August 1991, she was diagnosed with a secondary malignancy in her left lung. Her oncologist recommended that she undergo an autologous bone marrow transplant procedure ("ABMT") and high dose chemotherapy at the Fred Hutchinson Cancer Research Center ("the Center").

On September 9, 1991, the Center contacted Prudential to request pre-authorization for the withdrawal, processing and storage of Rhonda Bast's bone marrow. On September 13, Prudential informed the Center that the bone marrow procedure was not covered by the Plan. This was confirmed in a letter dated September 19th. However, on September 12th, Rhonda Bast, at her own expense, had her bone marrow harvested for processing and storage.

On December 31, 1991, Prudential issued a complete denial of coverage for the ABMT procedure. The denial letter stated that the procedure was not covered because it appeared to be "investigational and/or experimental in nature." The Plan excluded coverage for procedures that were educational, experimental, or investigational in nature.

Rhonda Bast contacted an attorney who sent letters to Prudential on February 13 and 14, 1992. The February 13th letter stated that several other insurers had paid for the ABMT procedure and stated that Rhonda Bast "needs her bone marrow transplant in April [1992]. Without it she will most likely die." The February 14th letter provided a list of cases in which insurance companies had been required to pay for the ABMT procedure.

Rhonda Bast's claim was further reviewed by Prudential on February 28, 1992. On that date, Prudential's medical director informed Rhonda Bast's claim consultant that "while the protocol is clearly investigational, since it is a NCI [National Cancer Institute] sponsored trial, and according to the rules established in a recent GCLM [Group Claim Division Memorandum], it is eligible for benefits." On that same day, the claim consultant called the Center and advised it that the ABMT procedure and high dose chemotherapy would be covered under the Plan. Prudential also mailed a letter confirming the coverage, and in early March 1992, Prudential reimbursed the Basts for the costs of the harvesting and storage procedure.

Prudential's authorization of the ABMT came too late. In April 1992, Rhonda Bast underwent an MRI scan of her brain which showed that the cancer had metastasized to her brain. The spread of the cancer disqualified her from participating in the ABMT procedure. Her health declined steadily and she died in January 1993.

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On January 10, 1996, Rhonda Bast's husband and minor son filed the complaint in this case against Prudential. The complaint alleged causes of action for breach of contract, loss of consortium, loss of income, emotional distress, breach of the duty of good faith and fair dealing, violation of the Washington Consumer Protection Act and the Washington Insurance Code, and ERISA.

Prudential filed an unsuccessful motion to dismiss, followed by an unsuccessful first motion for summary judgment. Subsequently, however, the district court granted Prudential's second summary judgment motion, holding that ERISA preempted the Basts' state law claims, and that they had no ERISA remedy. The district court dismissed the Basts' complaint with prejudice, and this appeal followed.

II

DISCUSSION

We review de novo a grant of summary judgment. Forsyth v. Humana, Inc., 114 F.3d 1467, 1474 (9th Cir.), cert. denied, 118 S. Ct. 559 (1997); Bagdadi v. Nazar, 84 F.3d 1194, 1197 (9th Cir. 1996). We must determine, viewing the evidence in the light most favorable to the nonmoving party, whether there are any genuine issues of material fact for trial. Forsyth, 114 F.3d at 1474.

Whether ERISA preempts a plaintiff's state law claims is a question of law we review de novo. Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1276, 1279 (9th Cir. 1998); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993).

A. Government Exemption

[1] The Basts first argue that the district court improperly granted summary judgment because there is an issue of fact as to whether the Plan was managed by an agency of the government. ERISA exempts from preemption any plan that is established or maintained by the U.S. government, a state government or by any agency or instrumentality of the government. 29 U.S.C. S 1002(32); 29 U.S.C. S 1003(b)(1).

The Basts argue that during the relevant time period, the Plan was "maintained" by the Resolution Trust Company ("RTC"), which is arguably an agency of the U.S. government. They ground this argument on the fact that from 1992 to 1995, the RTC was the receiver for a failed savings and loan association which owned shares in Cole. The S&L's shares represented about 28% of Cole's stock. The RTC was allowed to elect three members to the seven member board of directors of Cole. The RTC, however, exercised no control over Cole or the Plan, and no government employee served as a fiduciary under the Plan.

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[2] The RTC's involvement with Cole did not convert Cole's private benefit plan into a government benefit plan. The Plan was established and paid for by Cole, a private entity, for the benefit of its employees. Cf. *Silvera v. The Mutual Life Ins. Co.*, 884 F.2d 423, 427 (9th Cir. 1989) (holding that where a governmental entity purchases a benefit plan on behalf of government employees and delegates the administration to a private insurer, the plan is a government plan exempt from ERISA); and see *McGraw v. Prudential Ins. Co.*, 137 F.3d 1253 (10th Cir. 1998) (holding that a public trust that exercised control over the beneficiary's employment did not change the benefit plan into a government plan because the trust did not establish the Plan or control it).

[3] Cole's employee benefit plan is not a government plan and is not exempt from ERISA on that basis. The issues then become whether ERISA preempts the Bast's state law claims, and if it does, whether it provides a remedy.

B. ERISA Preemption

[4] ERISA regulates employee benefit plans in order to promote the interests of employees and their beneficiaries. *Ward*, 135 F.3d at 1287. Under section 514(a), a state law cause of action is preempted by ERISA if it "relates to" an employee benefit plan. 29 U.S.C. S 1144(a); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). "A law relates to an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990) (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983)). A state law may relate to a benefit plan even if the law "is not specifically designed to affect such plans, or the effect is only indirect." *Id.*

[5] ERISA's preemption clause "is conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). It is deliberately expansive and should be construed broadly. *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124, 1130 (9th Cir. 1992). However, ERISA does not preempt if the state law has only a "tenuous, remote, or peripheral" connection with the plan. *Shaw*, 463 U.S. at 100 n.21.

[6] The Supreme Court has held that ERISA preempts state common law tort and contract causes of action asserting improper processing of a claim for benefits under an insured employee benefit plan. *Pilot Life*, 481 U.S. at 57. The detailed provisions of ERISA S 502(a) set forth a comprehensive civil enforcement scheme that "would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54.

Similarly, we have held that state law tort and contract

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claims as well as violations of a state insurance statute are preempted by ERISA. Tingley, 953 F.2d at 1131 (holding plaintiffs' causes of action for breach of contract, breach of the duty of good faith and fair dealing, intentional infliction of emotional distress, and violations of the Arizona Insurance Code were preempted by ERISA).

[7] In a factually similar case, we held that ERISA preempts a state law wrongful death cause of action based upon an insurance company's negligent administration of a claim. Spain, 11 F.3d at 132. "ERISA preempts Appellants' wrongful death action because the state law in its application directly relates to the administration and disbursement of ERISA plan benefits." Id. See also Kanne v. Connecticut General Life Ins. Co., 867 F.2d 489, 494 (9th Cir. 1988) (holding that the plaintiffs' state common law causes of actions for breach of contract and breach of the duty of good faith and fair dealing, as well as a statutory cause of action for unfair insurance practices under the California Insurance Code were preempted by ERISA).

[8] Washington state courts have also recognized ERISA preemption in circumstances similar to the Basts'. The Washington Supreme Court has held that common law claims for negligence, outrage, breach of contract, negligent misrepresentation and fraud which are based upon an interference with an attainment of benefits are preempted by ERISA. Cutler v. Phillips Petroleum, 124 Wash. 2d 749, 763, 881 P.2d 216 (1994); Hepler v. CBS, Inc., 39 Wash. App. 838, 696 P.2d 596 (1985) (holding that ERISA preempts a plaintiff's claims for violation of the State Insurance Code and Consumer Protection Act).

[9] ERISA, however, has a savings clause. This clause states that ERISA does not exempt any person from "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. S 1144(b)(2)(A). The Basts argue that their state law claims for violations of the Washington Insurance Code and the Washington Consumer Protection Act are not preempted by ERISA. They assert that these two state statutes fall within ERISA's "savings clause."

[10] The Washington Insurance Code establishes a statutory duty for all insurance companies to act in good faith. It provides:

The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters.

Wash. Rev. Code S 48.01.030 (1997).

[11] Washington's Consumer Protection Act prohibits unfair or deceptive business practices. Wash. Rev. Code

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S 19.86 (1997).

[12] The Basts recognize that, notwithstanding ERISA's savings clause, we have held that insurance bad faith claims are preempted by ERISA. They argue, however, that they are not suing the Plan, they are suing Prudential as an insurance company doing business in Washington. They assert that ERISA does not preempt relationships "where a plan operates just like any other commercial entity, for instance the relationship between the plan and its own employees, or the plan and its insurers or creditors" *General Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1522 (9th Cir. 1993). They contend, therefore, that whether Prudential is administering a benefit plan or not, it is still bound by the good faith obligations imposed upon an insurance company by Washington's Insurance Code and Consumer Protection Act.

[13] These arguments fail to persuade us that the Basts' claims are exempted by ERISA's savings clause. The Basts' claims against Prudential arise out of Prudential's actions as the benefit plan administrator, not as an insurance company or insurance provider. "[T]he key issue is whether the parties' relationships are ERISA-governed relationships." *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1358 (9th Cir. 1997) (citing *Castonguay*, 984 F.2d at 1522). Prudential's alleged breach of fiduciary duty while administering the benefit plan is conduct covered by ERISA. The Basts' claims under the Washington Insurance Code and Washington Consumer Protection Act are not exempt under ERISA's savings clause. Accordingly, these claims are covered by ERISA. If the Basts are to recover, they must do so under ERISA.

C. ERISA Claims

[14] ERISA's civil enforcement provision outlines the possible claims by a participant or beneficiary. 29 U.S.C. S 1132, ERISA S 502(a). They include: (1) an action to recover benefits due under the plan, ERISA S 502(a)(1)(B); (2) an action for breach of fiduciary duties, ERISA S 502(a)(2); and (3) a suit to enjoin violations of ERISA or the Plan, or to obtain other equitable relief, ERISA S 502(a)(3).

[15] Extracontractual, compensatory and punitive damages are not available under ERISA. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986) (holding that ERISA S 502(a)(3) does not allow for extracontractual damages, including damages for emotional distress).

[16] The Basts' ERISA claims are for loss of Rhonda Bast's chance of survival, for out of pocket costs, loss of income, loss of consortium, and emotional distress. These claims all seek extracontractual or compensatory damages

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which are not recoverable under ERISA. Thus, for these claims, ERISA provides no remedy.

The Basts argue that if ERISA provides no remedy, ERISA should not preempt their state causes of action which do provide a remedy. They make two related arguments: (1) they should not be left without a remedy for Prudential's allegedly wrongful conduct, and (2) they are entitled to recover under ERISA's equitable relief provision, section 502(a)(3).

We addressed these two arguments in *McLeod v. Oregon Lithoprint Inc.*, 102 F.3d 376 (9th Cir. 1996), cert. denied, 117 S. Ct. 1823 (1997). In that case, Pamela McLeod claimed that her employer's ERISA plan administrator breached its fiduciary duty by failing to notify her that she was eligible for coverage under a cancer insurance policy. *Id.* at 377. McLeod sought a judgment for the amount of benefits she would have been paid if coverage had been provided under the cancer policy, and for compensatory damages for emotional distress. *Id.* We held that the term "equitable relief" in ERISA S 502(a)(3) does not allow for the recovery of compensatory damages. *Id.* at 378. We stated that McLeod did not seek an injunction, mandamus, or restitution, and damages are not "equitable relief." *Id.*

The basis of [McLeod's] complaint is that the fiduciaries failed to notify her in a timely manner of her right to elect cancer coverage. This is in essence a negligence claim, for which she seeks to be made whole through an award of money damages equal in amount to the benefits that she would have been paid and compensation for her emotional distress.

Id. Even though McLeod asserted that "without monetary relief, she [was] left with no adequate remedy," *id.* at 378, we concluded that ERISA's civil enforcement scheme was exclusive, ERISA preempted the state law claims, and damages were unavailable.

[17] In a lawsuit nearly identical to the present lawsuit, the Tenth Circuit held that ERISA preempts state law claims even if the plaintiff is left without a remedy. *Cannon v. Group Health Serv.*, 77 F.3d 1270 (10th Cir.), cert. denied, 117 S. Ct. 66 (1996). In *Cannon*, Phyllis Cannon was diagnosed with leukemia and needed the ABMT procedure. The insurers administering her ERISA plan denied pre-authorization for the procedure because it was experimental. *Id.* at 1271. Cannon requested reconsideration, and the insurers eventually reversed their decision and agreed to authorize the ABMT. However, by the time the procedure was authorized, Cannon's window of opportunity for receiving the ABMT had passed and she died shortly thereafter. *Id.* Cannon's surviving spouse brought an action against the insurers alleging that they negligently or in bad faith had refused to authorize in a timely

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manner the ABMT procedure. The Tenth Circuit held that ERISA preempts state law claims even if there is no alternative remedy under ERISA. *Id.* at 1272. *Id.* Cannon's surviving spouse was left without a remedy.

The Fifth and Sixth Circuits have reached the same conclusion under equally tragic circumstances. "While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, . . . the lack of an ERISA remedy does not affect a pre-emption analysis." *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir. 1992) (ERISA administrator denied a hospital stay for woman during the final weeks of a high-risk pregnancy and the fetus died); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (wrongful death) ("That ERISA does not provide the full range of remedies available under state law in no way undermines ERISA preemption."); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991) ("Nor is it relevant to an analysis of the scope of federal preemption that appellants may be left without a remedy.").

Although forcing the Basts to assert their claims only under ERISA may leave them without a viable remedy, this is an unfortunate consequence of the compromise Congress made in drafting ERISA. See *Tolton*, 48 F.3d at 943. ("One consequence of ERISA preemption, therefore, is that plan beneficiaries or participants bringing certain types of state actions--such as wrongful death--may be left without a meaningful remedy.").

We agree with our sister circuits that ERISA preempts state law claims, even if the result is that a claimant, relegated to asserting a claim only under ERISA, is left without a remedy. The focus is on ERISA. If it does not provide a remedy, none exists. Here, the only possible remedy under ERISA is for equitable relief.¹

D. Equitable Relief

[18] ERISA S 502(a)(3) provides that a participant or beneficiary may bring a civil action "to obtain other appropriate equitable relief" to redress violations of ERISA or to enforce provisions of ERISA or the benefit plan. 29 U.S.C.S 1132(a). The Basts argue they can obtain, under ERISA, the equitable remedy of restitution because that would be "other appropriate equitable relief."

The district court concluded that to grant restitution to the Basts would be equivalent to awarding them money damages, and such an award would not be an equitable remedy. The court stated:

[I]n this case, where the only conceivable remedy

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that I could foresee would be the cost of the procedure which the plaintiff was not given at a time when it would have hopefully provided some relief for her, is the same as really a legal recovery of cost . . . I see no other possible theory of restitution that would be "appropriate" in the sense of it being different than a legal remedy.

We agree.

[19] The Supreme Court has held that the language "appropriate equitable relief" does not authorize suits for money damages for breach of fiduciary duty. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 257-58 (1993). "[E]quitable relief' in the form of the recovery of compensatory damages is not an available remedy under S 502(a)(3). " *McLeod*, 102 F.3d at 378.

The Basts rely heavily upon the Supreme Court's decision in *Varity Corp. v. Howe*, 516 U.S. 489 (1996). There, the Court held that ERISA participants or beneficiaries may bring an action for equitable relief for breach of fiduciary duties. *Id.* at 514-15. The Court concluded that section 502(a)(3) is a catchall provision designed to act as a "safety net" offering appropriate equitable relief for violations of ERISA where there is no other adequate remedy. *Id.* at 512. ERISA's basic purposes favor providing plaintiffs with a remedy. *Id.* "[I]t is hard to imagine why Congress would want to immunize breaches of fiduciary obligation that harm individuals by denying injured beneficiaries a remedy." *Id.* at 513.

The equitable remedy provided by the Court in *Varity*, however, was reinstatement, not money damages. The *Varity* beneficiaries were tricked by an administrator into withdrawing from their benefit plan and forfeiting their benefits. The Court concluded that reinstatement was an appropriate equitable remedy. *Id.* at 515.

The Northwest Women's Law Center ("Amicus") argues that we should impose a constructive trust as an equitable remedy in the amount which Prudential was unjustly enriched by denying coverage for the ABMT procedure. The Amicus contends that if insurance companies are not forced to disgorge the unjust enrichment that they gain by such bad faith denials, they will have no incentive to honor legitimate requests from their ERISA beneficiaries. To the contrary, the Amicus argues, insurance companies would be given an incentive to deny expensive treatments hoping that the beneficiary would not sue, or if she or her estate did, they would be left without a remedy.

[20] Imposition of a constructive trust for breach of a fiduciary duty is an appropriate equitable remedy under ERISA in some cases. See *FMC Medical Plan v. Owens*, 122 F.3d 1258

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(9th Cir. 1997); Waller v. Blue Cross, 32 F.3d 1337 (9th Cir. 1994); Amalgamated Clothing & Textile Workers Union, AFL-CIO v. Murdock, 861 F.2d 1406 (9th Cir. 1988). In both Waller and Murdock, we imposed a constructive trust upon the employers' "ill-gotten profits" from breach of their fiduciary duties. In both cases an identifiable portion of the beneficiaries' pension plans had been improperly taken from them.

[21] In the present case, however, a constructive trust does not fit the mold. Here, a constructive trust is sought to force Prudential to disgorge the amount of money it saved by not paying for the ABMT procedure. This amount of money is not an "ill-gotten profit" in the same sense as the money taken from the pension plans in Waller and Murdock. While Prudential may have been unjustly enriched, it did not take money from the Plan.

[22] Moreover, the Amicus is unclear as to what form a constructive trust would take. The Amicus suggests the trust could benefit the Plan or the Basts. Under McLeod, however, it is clear that the proceeds of such a trust could not be paid to the Basts because this would be the equivalent of money damages. McLeod, 102 F.3d at 378. And, because no funds were taken from the Plan, there are no "ill-gotten" profits to return to the Plan. We conclude that in this case a constructive trust is not an appropriate equitable remedy under ERISA S 502(a)(3). And there is no other remedy available.

III

CONCLUSION

We echo the words of Judge Porfilio of the Tenth Circuit: "Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm." Cannon, 77 F.3d at 1271. The Basts' state law claims are preempted by ERISA, and ERISA provides no remedy. Unfortunately, without action by Congress, there is nothing we can do to help the Basts and others who may find themselves in this same unfortunate situation.

AFFIRMED.2

FOOTNOTES

*Honorable Tom Stagg, Senior United States District Judge for the Western District of Louisiana, sitting by designation.

1 There was a brief time when Rhonda Bast could have sought equitable relief under ERISA. She could have sought an injunction to compel Prudential to authorize the ABMT procedure when Prudential first denied coverage. See 29 U.S.C. S 1132(a)(1)(B).

2 Prudential's motion requesting "terms" against the Basts for Prudential having to move to strike a document the Basts submitted as a

<http://caselaw.findlaw.com/cgi-bin/getcase.pl?court=9th&navby=case&no=97354296/2/98>

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CASE 97-35429

Insurance firm wins ruling on coverage denial

■ Suit dismissed: The decision in a woman's cancer death is consistent with previous verdicts in such cases

The court ruled Tuesday that the insurance company's denial of coverage for a potentially life-saving breast cancer treatment was not negligent. The court said the company's denial was not negligent because the treatment was not standard of care at the time. The court also ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

The case of *Roberta Host of Seattle v. Prudential Insurance Co. of New Jersey* was argued in the 9th U.S. Circuit Court of Appeals.

The court ruled that the 9th Circuit's decision is consistent with previous verdicts in such cases. The court also ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

The law allowed a living patient to sue over the denial of benefits for breast cancer treatment. The court ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

All these federal judges saying that the insurance company's denial was not negligent because the treatment was not covered by the policy. The court ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

Jerry Spohnmeyer, lawyer for the insurance company, declined comment.

Host was 38 and an optician with Cold National Corp. when she was diagnosed with breast cancer in December 1990 and had a breast removed.

The following August, an oncologist recommended an autologous bone marrow transplant, in which a patient's bone marrow is removed, cleaned and returned to the body after high doses of chemotherapy.

Host said the procedure was her only hope of survival.

The suit originally was among a group of major insurers that agreed in 1989 not to classify the transplant as experimental or investigational and was not covered by the policy.

In 1991, nearly three months after being notified, saying it appeared to be experimental or investigational and was not covered by the policy.

Host v. Prudential, citing the 1989 agreement. The company refused coverage and approved coverage in early March 1992, but it was too late. Her cancer had spread to her brain. She died in January 1993 at 40.

The suit by the insurance firm for breach of contract and violation of the 1989 agreement. The court ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

The court ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy. The court also ruled that the insurance company's denial was not negligent because the treatment was not covered by the policy.

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CITATIONS

Man Dies due to Delayed Emergency Care

Health Against Wealth: George Anders, pg. 138

Victim: Mrs. Mae McGirr

Long Island town of Cutchogue

Other Reference: Peter Hackett, director of the Division of EMS for NY State Health Dept.,
Suffolk County branch

On a previous occasion, Mr. and Mrs. McGirr were billed by their HMO for calling an ambulance when Mrs. McGirr broke her arm. On this occasion, Mr. McGirr was experiencing serious symptoms and Mrs. McGirr called the HMO which sent an out-of-town ambulance that became lost. EMS didn't arrive for twenty minutes, at which time Mr. McGirr was DOA due to cardiac arrest.

Man Suffering Heart Attack Told To Take Antacid

Health Against Wealth: George Anders, pg. 140

Victim: Janis O. Cummins

Other Reference: Janis O. Cummins et al. V. Kaiser Foundation Health Plan of Georgia Inc.
Georgia State court, Fulton County April 1995.

35-year old man experiencing chest pain was told by HMO (Kaiser Permanente) to take an antacid and then drive to a hospital 16 miles away. Before they could leave for the hospital, he collapsed and his wife called the paramedics who were unable to revive him.

Woman Suffering Severe Dehydration Told to Drive 40 minutes to Hospital

Health Against Wealth: George Anders

Victim: Todd Buehler of Milford, MA

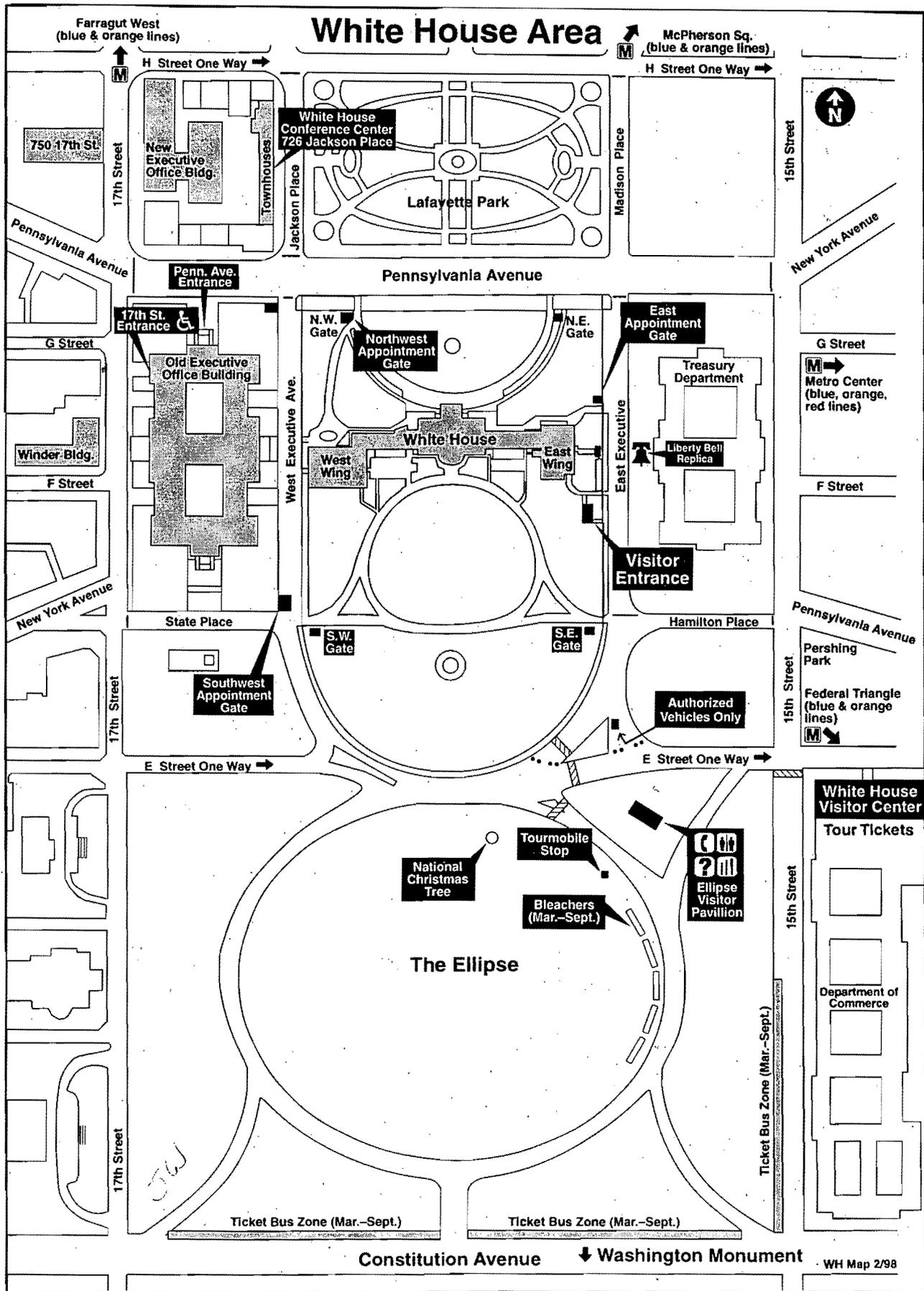
Other Reference: Mary Burke, treating physician

Woman who passed out due to severe dehydration and requiring two intravenous lines at local hospital was told she should have gone to hospital 40 minutes away.

Sources: Interviews with Todd Buehler, from Milford, MA, in Feb. 1996 and Mary Burke, treating physician, in Jan. 1996.

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64-year old man suffering from severe chest pain went to local hospital with a cardiac unit for emergency angioplasty. Aetna refused to pay bills, saying he should have gone to another, smaller hospital under the price-cutting plan. They billed him for \$20,000. The public health program administrator later ordered Aetna to pay all the bills. Sources: Interviews with Edmund Popiden, from McKees Rock, Pennsylvania in Jan and Feb 1996 and with Public Health Admin. Joe Lucia, Jan 1996.



CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES

The "Consumer Bill of Rights" consists of the following rights and responsibilities:

- (1) **Access to Accurate, Easily Understood Information** about consumers' health plans, facilities and professionals to assist them in making informed health care decisions.
- (2) **Choice of Health Care Providers** that is sufficient to assure access to appropriate high quality care. This right includes:
 - Access to specialists:** assuring consumers with complex or serious medical conditions access to to the specialists they need;
 - Access to specialists for women's health needs:** giving women access to qualified providers to cover routine women's health services, and
 - Transitional care:** providing access to continuity of care for consumers who are undergoing a course of treatment for a chronic or disabling condition.
- (3) **Access to Emergency Services** when and where the need arises. This provision requires health plans to cover these services in situations where a "prudent slayperson" could reasonably expect that the absence of care could place their health in serious jeopardy;
- (4) **Participation in Treatment Decisions** including:
 - Requiring disclosure of financial incentives:** requiring providers to disclose any incentives, financial or otherwise -- that might influence their decisions, and
 - Prohibiting "gag clauses":** which restrict health care providers' ability to communicate with and advise patients about medically necessary options;
- (5) **Assurance that Patients are Respected and Not Discriminated Against**, including discrimination in the delivery of health care services consistent with the benefits covered in their policy based on race, gender, ethnicity, mental or physical disability, and sexual orientation;
- (6) **Medical Privacy** which assures that individually identifiable medical information is not disseminated and that also provides consumers the right to review, copy and request amendments to their own medical records;
- (7) **Grievance and Appeals Processes** for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process; and
- (8) **Consumer Responsibilities** which asks consumers to take responsibility by maximizing healthy habits, becoming involved in health care decisions, carrying out agreed-upon treatment plans, reporting fraud, among others.

PRESIDENT ANNOUNCES FEDERAL HEALTH PLANS CONTINUE TO LEAD THE WAY AS REPUBLICANS STALL ON PATIENTS' BILL OF RIGHTS

August 1, 1998

Today, the President joined Congressman Forbes (R-NY) to reiterate his call to Congress to send him a strong enforceable bipartisan patients' bill of rights this year. The President contrasted Congressman Forbes' support for strong enforceable bipartisan legislation with the Republicans Leadership bills which fall far short of assuring patients the protections they need. Moreover, the President noted that the Senate Republicans have allowed Congress to adjourn without The President announced today that DoD is going forward and implementing the patients' bill of rights for the 8 million Americans in military health plans. This action responds to the Executive Memorandum the President released in February directing all Federal health plans, covering 85 million Americans the protections they need.

The Senate adjourned on Friday without even debating or addressing the patients' bill of rights. Yesterday, the Senate adjourned without even debating or voting on a patients' bill of rights. This underscores, yet again, their hollow promise to respond to the real need for a patients bill of rights. While the President has been calling on the Congress to pass a strong bipartisan patients' bill of rights for nine months, the Senate Leadership has tried to stall this issue for months. Last month, they caved to political pressure and introduced inadequate legislation. However, this week they adjourned without having any debate on this critical issue.

Doctors, nurses, and consumers around the nation believe that the Republican House and Senate legislation falls far short of providing patients the protections they need. The American Medical Association, the American Nurses Association, the National Breast Cancer Coalition, the American Small Business Alliance Alliance and the Women's Network??, and the American College of Physicians each sent letters to the President stating that Republican Leadership bills are simply rhetoric not a patients' bill of rights. These bills:

- **Do not cover all health plan, leaving out millions of Americans.** According to the American Small Business Alliance, "the House and Senate GOP bills do little or nothing to improve the quality of care for small businesses and their workers. The House GOP bill shortchanges small businesses by excluding them from the grievances and appeals process, while almost none of the patient protections in the Senate bill apply to people with small business." This is because the House Republican proposal leaves out the millions of Americans in the individual market, the Senate excludes 100 million Americans from the protections they need.
- **Do not guarantee access to specialists.** The National Breast Cancer Coalition writes that the Republican patients' bill of rights "doesn't provide women with what they need or deserve" and cites the lack of access to the right providers. Neither proposals guarantees patients with critical health needs direct access to the specialists they need, such as heart specialists or oncologists.
- **Do not assure access to necessary health care providers.** These bills do not require a plan to have a network with a sufficient number of providers or to cover an out-of-network specialist if they do not have a provider to treat a particular condition.

- **Do not have adequate access to emergency room services.** The American College of Emergency Physicians says that the emergency room provisions in the Republican Leadership bills would “not bring peace of mind to anyone seeking emergency room care.” These proposals do not prohibit plans from requiring enrollees from going to an emergency room that is in the plan’s network.
- **Do not have a sufficient external appeals process.** The American Nurses Association says that the “so-called ‘independent medical review’ of decisions ... is ‘a hoax’” For example, the Senate Republican appeals process is completely inadequate for patients. It only applies to cases over \$1,000 so that patients who are denied breast cancer tests or other critical services could not appeal.
- **Do not compensate patients who are maimed or who die as a result of a wrongful health plan action.** A right without a remedy is simply not a right. Neither Republican proposal has a sufficient recourse for patients who are maimed or injured by their health plans.
- **Do contain “poison pills” designed to kill this legislation.** Finally, these bills includes “poison pill” provisions, such as full blown medical savings accounts and medical malpractice caps that are designed to undermine the chances of passing a bipartisan patients’ bill of rights this year. Even the American Medical Association believes that the medical malpractice caps have nothing to do with patient protections and should not be included in this legislation.

Federal health plans continue to implement the patients’ bill of rights, with the Department of Defense coming into compliance today. While Republicans in Congress delay passing legislation, the Clinton Administration is implementing the patients’ bill of rights for the 85 million Americans in Federal health plans. Today, the Department of Defense is sending a letter to all military bases around the world bringing DoD’s nearly 600 hospitals and clinics and networks into compliance with the patients’ bill of rights. This directive assures military health enrollees access to the specialists they need, forbids anti-gag rules and other efforts to restrict patients communications with their health providers, and assures a strong external appeals process. With this directive, the over 8 million Americans in military health programs will be assured these important patient protections.

The President reiterated his call on Congress to pass a strong enforceable patients’ bill of rights before they adjourn. For nine months the President has been calling on Congress to pass a patients’ bill of rights that includes: guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections to assure patient care will not abruptly change if their provider is dropped; access to a timely internal and independent external appeals process for consumers to resolve their differences with their health plans; a limit on financial incentives to doctors; assuring that doctors and patients can openly discuss treatment options; assuring that women have direct access to an OB-GYN. Any bill of rights should include an enforcement mechanism that ensures recourse for patients who have been maimed or who have died as a result of health plan actions. A right without a meaningful remedy is simply not a right.