

By Jnae Bryant Quinn, Chicago Tribune, Sunday, June 1, 1997

On review, HMOs a stacked deck

WASHINGTON POST WRITERS GROUP

One thing everyone knows about health maintenance organizations is that treatment is denied far more often than in traditional plans.

Sometimes the HMO doesn't cover the treatment your doctor advises. Sometimes it could be covered but the HMO takes another view.

Not to worry, says the HMO. Turndowns can be appealed to a review board. You also assume that, in extremis, you can sue.

But the deck is stacked against you when your HMO is part of an employer plan. The appeal you innocently present may keep you from winning a court case, even if your position is right.

Here are two examples of what you're up against when you appeal the HMO's decision not to pay for treatment:

1. You're rarely given anything more than general information about how to make your case. You don't have the plan's formal standards or definitions. You also don't have the information the HMO relied on when it turned you down.

Yet at the appeal, you won't succeed unless you rebut these mystery standards and definitions point by point, with witnesses and medical research. Furthermore, the standards are so broad that the HMO has a lot of discretion.

That's the experience of Carroll Duncan, 63, of San Marino, Calif. He's wheelchair bound, with cerebral palsy, and newly diagnosed with prostate cancer. Because of his health, his doctor advised proton beam radiation rather than X-ray radiation.

HMOs don't cover experimental treatments. Duncan's insurer, Prudential Health Care Plan of California, said that particular therapy was experimental and it wouldn't pay (although Duncan's doctor testified that PruCare had paid in other cases).

Duncan mounted his appeal without a detailed definition of "experimental" and no information about PruCare's case against that treatment. He showed that the therapy was offered at 13 medical centers and is covered by Medicare, but that wasn't enough.

Duncan had the treatment, shouldering the \$45,450 cost. He sued PruCare for payment, was denied and has appealed to a higher court.

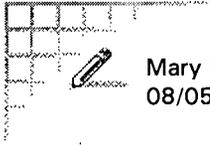
Why did he lose? Because PruCare, like most health plans offered by employers, has the right to interpret what its contracts mean. If there's doubt about whether "experimental" describes a particular case, federal law resolves it on the insurer's side, says Duncan's cocounsel, Sharon Arkin, of Shernoff, Bidart, Darras & Arkin in Claremont, Calif.

PruCare spokesman Kevin Heine says that Duncan had other options and that the definition of "experimental" would have been available if he'd asked.

But how many patients know to ask or how to use it while developing their appeal?

2. Joseph Chambers, 69, of Lindsborg, Kan., was diagnosed with a rare and usually fatal lung disease. The only treatment other than a transplant was ruled experimental by his HMO, the Family Health Plan Corp. (now called Healthcare America Plans, in Wichita, Kan.).





Mary L. Smith
08/05/98 12:14:46 PM

Record Type: Record

To: Julie A. Fernandes/OPD/EOP, Sarah A. Bianchi/OPD/EOP, Jeanne Lambrew/OPD/EOP
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June Shih

**PRESIDENT WILLIAM J. CLINTON
REMARKS TO THE WHITE HOUSE CONFERENCE
BUILDING ECONOMIC SELF-DETERMINATION IN INDIAN COMMUNITIES
WASHINGTON, D.C.
AUGUST 6, 1998**

Acknowledgments: Mickey Ibarra, Lynn Cutler, the 15 federal agencies co-sponsoring this event with the White House.

In a little more than 500 days, America will celebrate the arrival of a new millennium. I have called upon all Americans to do their part to strengthen our nation for the 21st Century. I believe our Native American communities -- whose ancient cultures have shaped the history of our still very young nation -- have important roles to play in the America of the next millennium.

For most Americans, our understanding of Native Americans is frozen in time -- in sepia-toned photographs of legendary chieftains; in the ancient names of rivers, lakes and mountain ranges; in the chapters of old history books. But as we have seen at this conference,

the more than two million members of our Tribal Nations -- from energetic young entrepreneurs such as Dominic, to innovative leaders like the ones sitting behind me -- are a vital part of America today and have the potential to become an even more vital part of America's future.

We are living in a time of great hope and possibility. Our economy is the strongest in a generation. We will soon have the first balanced budget and surplus in thirty years. Our social problems are finally bending to our efforts -- crime and welfare are the lowest in a generation. We are taking great steps toward the America I envisioned when I first ran for president six years ago -- an America that provides opportunity for all, that demands responsibility from all, that lives as a community of all. It is a time of unprecedented prosperity for some of our tribal nations as well. Gaming and a variety of innovative enterprises have enabled tribes to free their people from lives of poverty and dependence. The new wealth is sparking a cultural renaissance across Indian Country as tribes build new community centers and museums, language schools and elder care centers.

But we also know that on far too many reservations across America, such glowing news means very little. While some tribes have found new success in our new economy, too many more remain caught in a cycle of poverty, unemployment and disease. The facts are all-too-familiar: More than a third of all Native Americans live in poverty. While unemployment is at a 28-year low all across America, on some reservations, 80 percent of all adults still do not have regular work. Diabetes in Indian Country has reached epidemic proportions; other preventable diseases, and alcoholism continue to diminish the quality of life for hundreds of thousands.

This is unacceptable in a time of great prosperity for America. That is why we are here today -- to find new ways to empower our people -- especially our children -- with the tools and the opportunity to build brighter futures for themselves and their families. The federal government alone cannot solve the problems of Indian Country. Nor can the tribal governments be left to fend for themselves. Instead, we must follow a third way. Tribal and Federal government must work together to empower people with the tools to improve their own lives. But progress can only take root if the people themselves take the lead. Individual must stop making excuses and begin taking responsibility for themselves their futures.

As president, I have worked hard to honor tribal sovereignty and strengthen our government-to-government relationships. Long ago, your ancestors gave up land, water and mineral rights in exchange for peace, security, health care and education from the federal government. It is a solemn pact. And while the United States government did not live up to its side of the bargain in the past, we can and must honor it today and into the next millennium.

Four years ago, when I became the first president since James Monroe to invite the leaders of every tribe to the White House, I issued a memorandum directing all federal agencies to consult with the Indian Tribes before making decisions on matters that affect their people. This spring, I strengthened this directive so that the decisions made by the federal

government regarding Indian country are always made in cooperation with the tribes. And in the last six months, Jackie Johnson has joined the staff at HUD, Carrie Billy at Education, and Rhonda Whiting at the Small Business Administration to help coordinate and promote Native American initiatives at these agencies. Finally, Raynell Morris will join the White House Office of Intergovernmental Affairs to help Mickey Ibarra and Lynn Cutler with Native American initiatives and outreach. I welcome all of them to my administration.

Today, I'd like to talk about three tools of opportunity that every American must have to thrive in the 21st Century -- and how we can work together to bring these tools to every person in every corner of Indian Country -- from Pine Ridge, South Dakota to Window Rock, New Mexico to Pembroke, North Carolina.

The first and most important tool of opportunity is education. Throughout our history, education has been the key to a better life for generations of Americans. This will be even more true in a global economy that will reward only those children with the skills to take advantage of the growing number of high-paying, high-tech jobs. Today, fewer than two-thirds of Native Americans over the age of 25 hold high school degrees; fewer than 10 percent go on to college. If this trend continues, then the future for Native American children will become even bleaker; the opportunity gap between them and their peers will widen into a dangerous chasm in the Information Age. That is why, in a few moments, I will sign an executive order directing my administration to work together with tribal and state governments to improve Native American achievement in reading and math; raise high school and post-secondary graduation rates; reduce the influence of poverty and substance abuse on student performance; create safe, drug-free schools; and expand the use of science and technology.

The second tool is high-quality health care. Native American communities will never reach their full potential if their people continue to be hobbled by disease -- diseases that are often preventable and easily treatable. Last summer, I signed legislation that strengthens research, prevention and treatment of diabetes in our Native American communities. Earlier this year, I launched an initiative to eliminate health disparities in infant mortality, immunizations, diabetes, cardiovascular disease, cancer screening and management, and HIV/AIDS between racial and ethnic minority groups by the year 2010. Today, I am proud to announce an adjustment in our new Children's Health Insurance Program to ensure that eligible Native American children can get the health coverage and care they need.

And I am proud to announce my support for Secretary Shalala's proposal to promote of the Director of the Indian Health Service, Dr. Ernest Trujillo, to the rank of Assistant Secretary. By elevating the head of the Indian Health Service, we can ensure that the health needs of our Native Americans get the full consideration they deserve when it comes to setting the health policy of this country.

The third tool is economic opportunity in the form of jobs, credit, and small businesses. Too few grocery stores, gas stations, restaurants, banks are doing business on reservations. As a result, money that could be used to build tribal economies and create jobs is spent off-reservation. I have issued a new directive to boost economic development on our

reservations. The directive will do three things: It will ask the Department of Commerce to work with Interior and the tribal governments to study and develop a plan to meet the technology infrastructure needs of Indian Country. No tribe will be able to attract new businesses if it doesn't have the phone, fax, Internet and other technology capabilities essential to commerce in the 21st Century. The directive also calls on several agencies to coordinate and strengthen all of our existing Native American economic development initiatives. It will direct the Departments Treasury and HUD to create one-stop mortgage shopping centers on reservations that will help more Native Americans obtain loans more easily. A pilot program will soon go up in the Navajo Nation.

Finally, I am proud to announce a plan by the USDA to help seven tribes get a foothold in our high-tech economy. The department will help these tribes establish small technology companies to obtain government contracts for software development and other services.

The next millennium can and must be a time of great progress for our Native American communities. Today's American Indian population is still very young. In the last Census, thirty-nine percent of all Native Americans were under the age of 20. It is a statistic that should bring us great hope -- even as it poses our greatest challenge. We have a new, large generation of young people, who, if given the tools, the encouragement and the opportunity, can work together to lead their people out of the stifling poverty and despair of the past.

An ancient Indian proverb says that "We do not inherit this earth from our ancestors, we borrow it from our children." Let us work to bring the newest descendants of our oldest Americans a world of abundant hope and opportunity where all tribes will have vanquished poverty and disease, and all people will have the tools to achieve their greatest potential.



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Doctor Gag Rules Defended

October 30, 1996

By: *Andy Kravetz*

State Capital Bureau

JEFFERSON CITY - Representatives of Missouri's managed health care industry urged lawmakers to drop the idea of giving doctors legal rights for full discussions with their patients.

Several health industry representatives told the Joint Interim Committee on Managed Care Wednesday that they did not think problems such as "gag rules" on doctors were as prevalent as the committee was led to believe.

But later in the afternoon, Dr. Robert Mecker, representing the Missouri chapter of the American College of Emergency Physicians, said gag rules are alive and well for several of his colleagues.

"They are the ones who have to provide the continuity of care and yes, they do have problems with the HMOs on a regular basis," he said.

In hearings this fall, committee members heard several health horror stories from physicians and patients about gag rules and their effect on health care. Of the three HMOs represented; Kaiser, Principal Health Care of Kansas City and St. Louis-based Cigna, none of them have gag rules written into their health plans, claimed their representatives.

However, they said they did have anti-disparaging clauses to prevent doctors from discussing the financial aspects of the HMOs. These clauses prevent a doctor from advising a patient on whether to join a specific managed care plan.

The managed-care representatives said complaints that had been voiced to the committee represented a small minority of an otherwise happy and content population.

And they warned that several of the committee's proposed recommendations might worsen health-care options for Missourians.

"In the big picture, any legislative actions by the General Assembly would not affect 60 percent of Missouri's insurance population," said Gerard Grimaldi, of the Kaiser-Permanente HMO.

The committee is in the final stages of a nearly six-month look at managed care in Missouri. Committee co-chairs Sen. Joe Maxwell, D-Mexico, and Rep. Tim Harlan, D-Columbia, said they hope to finalize a list of recommendations by the end of November.

A major point before the committee is coverage for emergency care.

For months, Maxwell and Harlan have held up letters from HMOs saying that broken bones were not considered medical emergencies for which the HMOs would provide emergency-room coverage.

When the HMO representatives told the committee that anyone in their plans could go to emergency

rooms for such ailments, Rep. James Foley, D-St. Louis was incredulous. "I am amazed," he said. "What are you, the three angels of managed care?"

Mike Winters, a lobbyist for Missouri Managed Healthcare Association, told the committee that legally defining the term "emergency" or "medical necessity" like some members wanted could limit rather than help a patients options.

Previously, both Harlan and Maxwell said any recommendation would have a provision that include a "prudent layman's" definition of an emergency. That means if an average person would reasonably believe an emergency-room visit was warranted, then the HMO would be bound to cover the expenses.

None of the HMO representatives said they favored such a definition, saying they preferred to stick with judgments their company medical directors.



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Two Missourian's Tell Their HMO Stories

October 4, 1996

By: David Freitas

State Capital Bureau

Behind the issue of managed care are the people who it affects.

With HMO's becoming increasingly popular, the curiosity about whether people are satisfied with their health care is growing.

Each account that we hear from people about their HMO's is unique.

David Freitas talked with two Missourian's who have had very different experiences with their HMO's.

Story:

RunTime:

OutCue: SOC

Actuality:

RunTime: 09

OutCue:

Contents: *Jefferson says that when we buy an appliance we know what we're going to get, why can't we do the same thing with health care?"*

Jeanette Jefferson is a registered nurse who was so sick three years ago her doctor told her she would never walk again.

Then Jeanette did the unexpected.

Actuality:

RunTime: 20

OutCue:

Contents: *Jefferson says her doctor was pleasantly surprised when she could walk after having a stroke. He wanted to get her more physical therapy, but the HMO just kept saying no."*

After being a life-long member of an HMO and a health care professional, Jeanette thought she was taken care of when she retired.

But when her HMO told her she could not have any more physical therapy after her stroke, she says she got scared.

Actuality:

RunTime: 10

OutCue:

Contents: *Jefferson says when doctors and nurses are in charge she get scared.*

The irony is that Jeanette worked for an HMO her entire career as a nurse.

And now Jeanette says she cannot depend on her HMO anymore and has to look elsewhere for support.

Actuality:

RunTime: 15

OutCue:

Contents: *Jefferson says she has her faith and family and friends.*

Like most of us, Jeanette says she got her insurance through her employer and wasn't aware of the plans restrictions.

Actuality:

RunTime: 10

OutCue:

Contents: *Jefferson says she did not know her doctor would not be in charge when she became ill.*

HMO critics say Jeanette's situation is not unique and that many people do not know exactly what is and is not covered even if they have a copy of the contract.

Even though Jeanette had such a bad experience with her HMO, she still says managed care is not all bad.

Actuality:

RunTime: 20

OutCue:

Contents: *Jefferson says there are good sides, but if the bottom line is going to be money than HMO's are bad.*

Actuality:

RunTime: 06

OutCue:

Contents: *Napton says that the big problem is m-o-n-e-y.*

But even the biggest supporter of HMO's thinks money can be a problem.

Mexico resident Jack Napton has been in one of the nations largest HMO's, Kaiser Permanente, for over forty years.

Every three months Jack makes the two and a half hour trip Kansas City to get his health care.

But he says it's worth it.

He had a triple-by-pass about fifteen years ago, at a time when procedures like that weren't very common.

He's also had a lot of other major operations, but through all of them he says Kaiser has been wonderful.

Actuality:

RunTime: 15

OutCue:

Contents: *Napton says he had wonderful treatment and never saw a bill.*

Even in a day when the kind of care people saw on Marcus Welby is considered over by most, Jack still has a great relationship with his doctor.

Actuality:

RunTime: 19

OutCue:

Contents: Napton says he has a lot of rapport with his doctor and even knows that her new daughter is red-headed.

But rapport isn't something that most critics say is possible between a doctor and a patient-- when an HMO is involved.

For KBIA's Capitol Edition, I'm David Freitas.

mail address: sambrola@ix.netcom.com

Age: 48 years old

Residence: Miami

State: FL

Samuel Brola

Monika D. Brola

P6/b(6)

December 25, 1996

RE: Our history with AvMed HMO, Miami Plan

Patient: David Lee Bissonette, born March 5, 1976

David is unable to walk, stand, or sit alone. He has little or no functional use of his extremities. He is totally dependent on others in all areas. He cannot feed, clothe or bathe himself and cannot speak to ask for assistance or to describe his pain.

Diagnoses: Cerebral palsy, spastic quadriplegia, anoxic encephalopathy, microcephaly, scoliosis (partially corrected by CD rods on spine), esophageal reflux (partially corrected by fundoplication surgery), seizure disorder, chronic pulmonary disease (right lung tested 5% function - no blood circulation).

None of these is curable, nor will they improve substantially. While David is severely physically handicapped, he is not a vegetable. He is very aware of his surroundings and communicates by eye-pointing and answering questions by yes and no head movements. His facial expressions communicate more than most people's words.

HISTORY WITH AVMED:

We are covered by AvMed through my employer, Florida Power & Light, Inc. which is self-insured. Our enrollment in AvMed was effective on January 1, 1991. The contract covers all pre-existing conditions immediately and has no financial cap limiting costs. We thought we had found a tremendous blessing. We did not know that a seemingly unending nightmare was just beginning.

These letters were all delivered to us at Miami Children's Hospital on Friday

evenings AFTER normal business hours, stating that David's hospital benefits would terminate either at midnight or the next day. The intent was to coerce us into discharging David without being able to contact anyone at AvMed, or in some cases, David's physicians.

1. July 5, 1991 - Letter delivered to us at Miami Children's Hospital on Friday evening stating that David's hospital benefits would terminate the next day.
2. Aug. 30, 1991- Letter delivered to us at Miami Children's Hospital on Friday evening terminating David's benefits that night at midnight. This was a 3-day holiday weekend.
3. Sept. 27, 1991 - Letter delivered to us at the hospital on Friday night terminating David's hospital benefits that night at midnight.
4. Jan. 18, 1992 - Letter delivered to us at the hospital on Friday night terminating David's hospital stay the next day at midnight.

ALL OF THE ABOVE LETTERS WERE SENT BY AVMED WITHOUT CONTACTING DAVID'S PHYSICIAN, HIS FLOOR NURSES, OR THE HOSPITAL'S RESIDENT PHYSICIANS TO INQUIRE ABOUT HIS CONDITION!!

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5. After one of his many hospital admissions, David was discharged to Greenbriar Nursing Home in Kendall. We were forced to accept this arrangement. After only 12 days at Greenbriar, the situation was:
 - A. There was no air conditioning in David's room (approx. 86 degrees), David had a 104.2 degree fever, and he was on oxygen. He was on a heated air bed dressed only in a diaper. He had a huge fan blowing on him. The nursing home's personnel had not even called to inform us that he was sick.
 - B. Even after four phone calls, Dr. Grijalva, the Nursing Home physician, refused to come. He told my wife that David's blood test (CBC) showed a white cell count in the normal range (approx. 7,000 to 9,000) and that it was "normal" for "these kids" to "sometimes spike a temperature". My wife informed him that, having raised David at home for 15 years, she knew it was not normal for David. The doctor still did not come. He said he would stop by "later this evening".
 - C. When I arrived, I called David's pulmonologist, Morton Schwartzman, M.D. He told me to get David to Miami Children's Hospital emergency room right away. I instructed the nursing home's nurse supervisor to call an ambulance to transport David. She REFUSED. I called 911 for an ambulance for transport. When David arrived at Miami Children's Hospital, he was evaluated and then admitted to the Intensive Care Unit. His white cell count was now over 20,000, quite contrary to Dr. Grijalva's earlier "diagnosis".
6. In October 1991, after David's hospital admission caused by the nursing home's neglect, AvMed tried to have David discharged to the same nursing home. We refused and David was finally discharged with 12 hours per day of nursing care in our home. We were able to keep him out of the hospital for all of two months.
7. On December 4, 1991, David was again admitted to Miami Children's Hospital with a serious pulmonary infection and pleural effusion, including abscesses and fluid in and around the right lung. David failed to respond to many different treatments and, by mid-January, 1992, we thought he would die any day.
8. January 18, 1992 - Letter delivered to us at the hospital stating that David no longer required treatment in an acute care facility and could be discharged to Greenbriar Nursing Center. His doctor said that he was nowhere near ready for discharge AND we would not return him to Greenbriar, since they had nearly killed him once already.
9. Jan. 30, 1992 - Letter delivered to us at Miami Children's Hospital threatening not to pay for David's care unless we agreed to transfer him back to Greenbriar. They had obtained a "second opinion" about David's suitability for Greenbriar. The so-called "second opinion" was from Dr. Grijalva, the physician from Greenbriar who had refused to come when David was there. We again refused to transfer David to Greenbriar AND refused to discharge him from the hospital.

After several weeks, AND after obtaining the services of an attorney, AvMed provided David with nursing, respiratory therapy, etc., at home as a substitute for hospital care. David has a RIGHT to high quality care provided by licensed medical professionals. AvMed has continually attempted to curtail care without changes in medical orders and to do so without our prior knowledge. To date, we have kept them from reducing his

care to dangerous levels.

10. June 1992 - AvMed attempted to cease providing licensed respiratory therapists by calling the home care agency telling them to stop sending therapists, but not to tell us in advance. We notified the company that there had been no change in the medical orders and that they would be liable along with AvMed, if care was stopped.
11. Aug. 23, 1992 - David admitted to hospital with pulmonary infection.
12. AUGUST 24, 1992 - HURRICANE ANDREW - My wife, Monika, stayed at the hospital with David while I endured the northern eye wall of the storm in our master bathroom with my daughter, father-in-law, sister-in-law, and my nephew. We all huddled there while most of the rest of our house came apart. We experienced the eye wall of Andrew for hours without injury, but our home, was destroyed.
13. Aug. 31 - Sept. 10, 1992 - When we were finally able to retrieve telephone messages from the Southern Bell message service, we heard AvMed threatening to disenroll us if we did not immediately discharge David from the hospital. I called to remind them that there had been a hurricane and we no longer had a home to take him to. They said the hurricane was not their problem, that we should seek public assistance if we had no home, and that they would immediately stop payment for David's care if we did not discharge him. They also stated that Greenbriar was no longer an option. I told them Greenbriar would NEVER be an option and that we would discharge David WHEN we had a home to take him to AND when AvMed had arranged for resumption of his nursing and respiratory care.
14. Sept. 10, 1992 - After days of phoning, found a rental house in North Miami Beach and discharged David with home nursing care and respiratory therapists.
15. Jan./Feb. 1993 - AvMed attempted to curtail respiratory treatments and prescription drug deliveries by phone calls. We demanded a Member Appeals Committee.
16. March 1993 - Result of Member Appeals Committee was that AvMed would NOT attempt to cease providing care without prior written notification to us with sufficient time for us to appeal. We were accompanied by Attorney Arthur Garcia.

It was about this time that Roger H. Strube, M.D., became the Medical Director of AvMed HMO in Miami. He is licensed in Wisconsin and Indiana but has never been licensed in Florida. His license record in Wisconsin reflects that he accepted a disciplinary entry on his license record that he had improperly prescribed amphetamines over a seven year period. This is on his record with his acquiescence and that of his attorney. It was also placed in his record without the cooperation of the patients involved. The average person would have to question his ethics and judgement. AvMed may or may not have known about his lack of license or the discipline in Wisconsin.

If AvMed did not know about his past, it means that a huge medical corporation hired a top executive at a large salary and gave him responsibility for the medical care of 110,000 AvMed members in Dade County WITHOUT the most cursory background check. I believe that constitutes: reckless endangerment of the members by IMPROPERLY HIRING an executive with questionable (at best) background. I believe that AvMed did do a background check and decided that Roger H. Strube had EXACTLY the ethical behavior pattern they desired. I stated this belief clearly at our hearing before the Statewide Providers & Subscribers Assistance Panel in early 1995. The Panel was made up of representatives from the Florida Department of Insurance and the Florida Agency for Health Care Administration.

17. July 1993 - AvMed tried to terminate respiratory services without a change in medical orders or prior notice to us. Mr. Garcia, our attorney prevented AvMed's action.
18. Oct. 1993 - Unknown to us at the time, a patient filed a complaint against Roger H. Strube with the Department of Business and Professional Regulation, Case No. 93-18811. Roger Strube was notified of the complaint and was requested to sign a Cease and Desist Agreement. The Investigative Report shows Stephen J. deMontmollin to be Strube's attorney. Stephen J. deMontmollin is Vice President and General Counsel of AvMed.
19. Jan. 9, 1994.- The medical home care provider, Infusion Therapies, fired their subcontracted respiratory therapists, Greg Lane and Associates. Mr. Lane received the letter on Saturday which told him to cease providing care to all of his patients on Monday. This incident coincided with the visit to Miami AvMed of Infusion Therapies' Chief Operating Officer from Atlanta.
20. Jan. 12, 1994 - A Mr. Thomas P. Jarrett from Infusion Therapies came to bring a new pulse oximeter. He informed our nurse that he would be taking over David's respiratory treatments the next day.
21. Jan. 13, 1994 - Mr. Jarrett did not show up for David's 8:00 a.m. and 12:00 noon treatments. When he finally arrived for David's 4:00 p.m. treatment, I asked to see his respiratory license. He showed me a folded up copy of a copy of a copy of a respiratory license. His drivers license picture did not look like him and the license had been peeled open. We wrote down his drivers license number and his respiratory license number. The year of birth in his drivers license number did not match his respiratory license information. We later filed Complaint # 9402474 with the Dept of Business and Professional Regulation in Tallahassee. They refused to investigate even though the local BPR Miami office had expressed an interest, since multiple users of a single license are apparently a large problem.
22. Jan. 1994 - Mr. Jarrett came from Davie to our home in South Dade 3 times a day for the next week, accompanied by a Mr. Hopper of Infusion Therapies, to insist that Mr. Jarrett did not have to show me an original of his license. I agreed but had to remind these people that this is MY home and my son. I will NOT be forced to let just anyone into my house, especially someone whom I consider to be unqualified.
23. Jan. 1994 - We received a visit from an HRS Child Protective Services investigator because of an anonymous report that we were purposely denying David needed respiratory treatments. I am sure that it was Roger H. Strube of AvMed who filed the false and malicious complaint because he threatened in writing to do the same thing to Mr. Dennis Peterson, another AvMed member whose son is chronically ill.
24. March 1994 - At another AvMed Member Appeals Committee, I presented eight pages of facts to the attending AvMed managers and executives. I have their names in their own writing. The result of this meeting was an agreement that NO CHANGES to David's care would be attempted until AFTER a meeting was held among us, David's primary care physician and AvMed's Complex Case Manager.
25. April 1994 - AvMed attempted to cease providing David's feeding formula, feeding bags, and other medically necessary "disposable and consumable" medical supplies. They attempted this in spite of a Member Appeals Committee agreement to make no changes prior to the meeting with David's Primary Care Physician.
26. June 1994- The meeting took place between us, Dr. Jarrett, and Sue Shepper, RN, of AvMed in the doctor's office. The doctor did not examine

David. He merely stated that since the current care plan was keeping David as healthy as possible, he did not intend to change it. He also agreed that it was not up to him to decide WHO provided the care, since Florida law specifies the qualifications required to perform various levels of medical care.

27. Sept. 12, 1994 - Roger H. Strube of AvMed sent us a letter claiming to have "recently received updated orders from both Dr. Jarrett and Dr. Gustman," and that the case would be transferred to Roche Professional Service Centers, a home care agency whom we had previously fired for incompetence. What happened is clearly described in a response I received from Karen Nagle, an attorney for Roche Professional Service Centers, Inc. in New Jersey. "RPSC was following the directions of Dr. Strube to create a plan of care for your son and get physician orders in order to be able to follow through on this plan. It is necessary to obtain physician orders before rendering service, so that only care ordered by a physician is rendered."

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2. [Physicians Who Care](#)
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Sam Brola's 6 year Nightmare in AvMed HMO Managed Care Summary

Email address: sambrola@ix.netcom.com

Residence: Miami

State: FL

Part 2 of SUMMARY:

19. Jan. 9, 1994.- The medical home care provider, Infusion Therapies, fired their subcontracted respiratory therapists, Greg Lane and Associates. Mr. Lane received the letter on Saturday which told him to cease providing care to all of his patients on Monday. This incident coincided with the visit to Miami AvMed of Infusion Therapies' Chief Operating Officer from Atlanta.
20. Jan. 12, 1994 - A Mr. Thomas P. Jarrett from Infusion Therapies came to bring a new pulse oximeter. He informed our nurse that he would be taking over David's respiratory treatments the next day.
21. Jan. 13, 1994 - Mr. Jarrett did not show up for David's 8:00 a.m. and 12:00 noon treatments. When he finally arrived for David's 4:00 p.m. treatment, I asked to see his respiratory license. He showed me a folded up copy of a copy of a copy of a respiratory license. His drivers license picture did not look like him and the license had been peeled open. We wrote down his drivers license number and his respiratory license number. The year of birth in his drivers license number did not match his respiratory license information. We later filed Complaint # 9402474 with the Dept of Business and Professional Regulation in Tallahassee. They refused to investigate even though the local BPR Miami office had expressed an interest, since multiple users of a single license are apparently a large problem.
22. Jan. 1994 - Mr. Jarrett came from Davie to our home in South Dade 3 times a day for the next week, accompanied by a Mr. Hopper of Infusion Therapies, to insist that Mr. Jarrett did not have to show me an original of his license. I agreed but had to remind these people that this is MY home and my son. I will NOT be forced to let just anyone into my house, especially someone whom I consider to be unqualified.
23. Jan. 1994 - We received a visit from an HRS Child Protective Services investigator because of an anonymous report that we were purposely denying David needed respiratory treatments. I am sure that it was Roger H. Strube of AvMed who filed the false and malicious complaint because he threatened in writing to do the same thing to Mr. Dennis Peterson, another AvMed member whose son is chronically ill.
24. March 1994 - At another AvMed Member Appeals Committee, I presented eight pages of facts to the attending AvMed managers and executives. I have their names in their own writing. The result of this meeting was an agreement that NO CHANGES to David's care would be attempted until AFTER a meeting was held among us, David's primary care physician and AvMed's Complex Case Manager.
25. April 1994 - AvMed attempted to cease providing David's feeding formula, feeding bags, and other medically necessary "disposable and consumable" medical supplies. They attempted this in spite of a Member Appeals Committee agreement to make no changes prior to the meeting with David's Primary Care Physician.
26. June 1994- The meeting took place between us, Dr. Jarrett, and Sue Shepper, RN, of AvMed in the doctor's office. The doctor did not examine David. He merely stated that since the current care plan was keeping David as healthy as possible, he did not intend to change it. He also

agreed that it was not up to him to decide WHO provided the care, since Florida law specifies the qualifications required to perform various levels of medical care.

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At approximately this time, AvMed either fired Roger H. Strube or allowed him to resign. This despicable individual was then selected by CareFlorida as their Vice President and Chief Medical Officer for their operations throughout the entire State of Florida. I then convinced the Fort Lauderdale Sun Sentinel to publish an article regarding the Probable Cause findings on Strube. CareFlorida terminated him.

Finally, after dozens of letters to the State Attorney's Office and dozens of phone calls to Katherine Rundle, a single count of practicing medicine without a license has been filed against Roger Strube. It is Police Case # 951592, Court Case # F95032394 and was assigned to Herb Andrews at the SAO. His trial has been delayed several times.

Since this case began, our provider, Nations Health Care, and Roche Professional Services have merged. The pharmacist from Roche who always gave our nurses a hard time about everything the doctor ordered, is now the pharmacist at our provider. Karen Martel, R.N., the nurse from Roche who illegally obtained medical orders, is now a supervisor at this company. FPL, my employer, is undergoing "Strategic Review" (layoffs). Being self-insured, FPL could save lots of money by laying me off.

In the Spring of 1995 we had a hearing before the Statewide Providers & Subscribers Assistance Panel. AvMed's attorney, Mr. Cholodofsky, stated that the care being provided for David was not medically necessary. The doctor on the Panel asked Mr. Cholodofsky, WHO at AvMed was qualified to make that decision. The doctor asked FOUR times. He did not get an answer. The nurse on the panel asked Dr. Edelstein of AvMed., WHY anyone would ever consider reducing care to a patient whose conditions will not improve and can only get worse and who has a DO NOT RESUSCITATE order in place. She asked FIVE times and the main response was to complain about how complicated David's case was and that my letter writing made the case even more complicated.

Part of the BPR Case File on Strube is a letter obtained by the investigator simply to show how he signed his letters. Apparently, no one there had read it until I pointed out its contents. In it, Roger Strube clearly described how AvMed controls physicians financially. He states: "Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased, or did not change..." the physician's bonus. To me, that states very clearly, "Do what we tell you or you will not receive a bonus.

AvMed has used financial leverage in other ways. With the cooperation of Nations Health Care, Nursefinders' (nursing agency subcontracted by Nations) payments were delayed by up to six months. At one time the past due amount exceeded \$200,000.00. This was a successful attempt to force the nurses to accept several dollars an hour less pay.

The January 22, 1996 TIME Magazine reports on a case in California where an arbitration panel found that telephone calls made to "influence or intimidate" the doctors was interference in the doctor-patient relationship. They decided this constituted "intentional infliction of emotional distress". They also determined that the California HMO's actions fit the legal definition of "extreme and outrageous behavior exceeding all bounds usually tolerated in a

civilized society." I believe the actions of all the individuals/entities in our case exceed those described in the magazine and these people should be held legally and financially accountable.

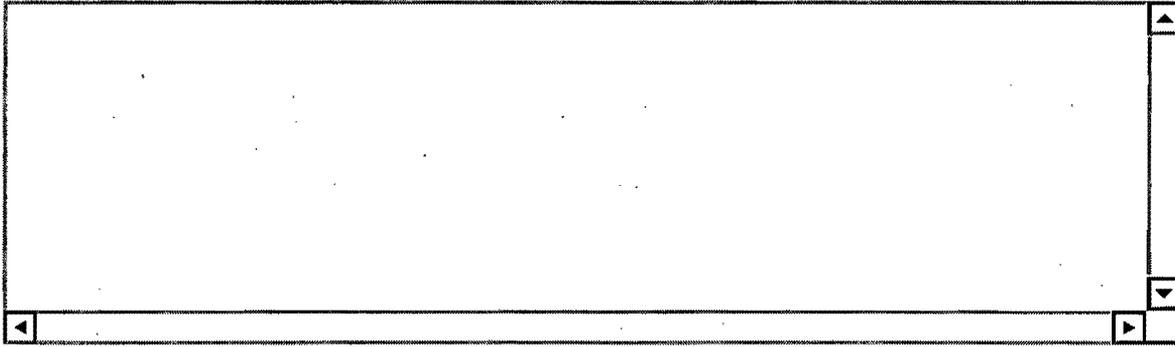
As of April 25, 1996, we learned that AvMed, their Miami Attorney Steven Ziegler and Venturi Investigations have improperly, unethically and probably illegally, been attempting to gather information about me and my family. They have contacted our son's health care providers and used false statements in their efforts to induce cooperation. They have threatened to use subpoenas. AvMed is not charged with anything and therefore cannot subpoena anyone. We believe this is one more attempt to frighten or intimidate us into dropping every available avenue to pursue our rights under the law, and to see that justice is done, finally.

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Sam Brola's 6 year Nightmare in AvMed HMO Managed Care Summary

Email address: sambrola@ix.netcom.com

Residence: Miami

State: FL

Part 3 of SUMMARY:

August 1, 1996

We have been told by Assistant State Attorney Paul Silverman that the charge against Roger H. Strube will be dismissed because he is only consulting and because the Florida Agency for Health Care Administration now claims there is no one at that agency to testify that Roger H. Strube's actions constituted practicing medicine. Trial date is still set for August 19, 1996.

August 2, 1996

Sent fax letter to Paul Silverman and a copy to Dade State Attorney Katherine Rundle, citing the Florida Supreme Court decision in Reams v. State, which states: "In prosecuting for practicing medicine without a license, State is required to prove only that defendant is not a licensed physician and that he practices within the statutory definition and exceptions to the act must be raised and proved by the Defense."

August 4, 1996

Sent fax letter to State Attorney Katherine Rundle with a copy to Paul Silverman, citing the Florida Supreme Court decision, Florida Statutes, Black's Law Dictionary, and the Notice of Dismissal/Closing Order for BPR Case 95-00489. I stated clear concise methods to convict Roger H. Strube without expert witnesses. It is IMPOSSIBLE for Roger H. Strube to prove that he meets the exception requirements for consultants.

August 6, 1996

Sent fax letter to Katherine Rundle with copy to Paul Silverman, citing the Florida Constitutional Amendment, Article 1, Sec. 16(b) about crime victims having the right to be informed, to be present, and to be heard when relevant, at all crucial stages of criminal proceedings. I demanded to be heard at the motion hearing scheduled for August 19.

August 7, 1996

I called Paul Silverman to ensure the faxes had been received. He confirmed that he had received them and informed me that I would be heard at the hearing. He also informed me that it would probably be rescheduled for Friday, August 16 due to a conflict.

August 8, 1996

I called Paul Silverman to request more information about the Motion Hearing. He informed me that now there would be NO hearing at all. He plans to present a Nolle Prosequi to the judge and that will end the case. I asked if I would still be heard. He said probably not, since once he submits the Nolle Prosequi, the case ceases to exist. I informed him that there sure must be a lot of people who don't want me to be heard. Nobody in the State Government wants me "On the Record".

August 16, 1996

A grave miscarriage of justice was perpetrated on the people of Dade County which will have a horrible effect on all Americans. Assistant State Attorney Paul Silverman submitted a "nolle prosequi" to Judge Rudolfo Sorondo. I was only allowed to voice my objection to this and state that the reasons given to me by Mr. Silverman were not valid. A criminal who had direct control of the medical care of 110,000 families in Dade County was allowed to go free.

The Statewide Providers & Subscribers Assistance Panel did NOT get a transcript of our hearing. I had to order and pay for it myself. I have offered to meet with AvMed's attorneys. They refused. Roger H. Strube's

attorneys have chosen to not depose me because I would then be "On the Record." Now the Dade State Attorney plans to further deprive me of my rights. Not only has Katherine Rundle REFUSED to file all charges against all persons/entities I have accused (and provided documentation for), she now plans to completely drop the only charge filed without my having a chance to be heard. Paul Silverman informed me that not only didn't he have to tell me why they were dropping the case, he didn't have to tell the Court and did not plan to.

Nobody wants my case to go to court because that will require a court ruling that the HMO medical director IS practicing medicine when he tells physicians what care to order or not to order. Most state laws are similar in defining "practice of medicine" and this decision would have national consequences. If the HMO medical directors, case managers, etc. are practicing medicine, then they must be properly licensed under the laws of the state where they are located. But the big thing the HMO's are afraid of is this. Those persons who would now have to be licensed physicians would also now be personally liable for malpractice civil suits. When a person is personally responsible for his actions, they are less likely to be as vicious in denying care as the HMO's want.

It sure seems like the criminals have all the rights while the victims have none. This is especially true if the criminals are huge corporations, managed care lobbyists, and high government officials.

That is why the "powers that be" are determined to shut me up.

Is this still the United States of America?

THIS IS NOT THE SORT OF FREEDOM & JUSTICE I THOUGHT I WAS DEFENDING DURING MY 20 YEARS IN THE U. S. MILITARY!!!!

*****ADDENDUM*****November 5, 1996*****

Katherine F. Rundle, Dade State Attorney, is re-elected without even running. Her office was not even on the ballot because she was un-opposed. She was probably notified of this in mid-July. Hence, she knew that I would not be able to provide information about her mishandling of the Roger H. Strube criminal case to her political opponent who would make it public. That is why she ordered Assistant State Attorney Paul Silverman to file a nolle prosequi with the court. Then I would have no recourse.

Well, she was wrong. I have been reading the rules & regulations of the Florida Bar Association as enforced by the Florida Supreme Court. I intend to file a complaint with the Bar with copies to the Governor, U. S. Attorney, and the media. I don't know if anyone has the courage to print the truth, but I am not afraid to tell it.

Katherine Rundle acted to benefit her own re-election, the HMO's, the huge corporate employers, and the governor's goal of forcing all Medicaid patients into HMO's. She did great damage to my family, to the 110,000 AvMed members whose care Strube controlled, and to all HMO members in this country. She also did great damage to the criminal justice system by refusing to fully investigate and prosecute this case. Any ONE of these results of her actions constitutes cause for disbarment. I intend to ask the Florida Supreme Court to do just that.

Comments to the Fort Lauderdale Sun-Sentinel by Asst. State Attorney Paul Silverman stating that this situation should be handled in other venues are false and absurd. Practicing medicine without a license is a CRIMINAL offense and a FELONY. It MUST be decided in Criminal Court, and nowhere else.

Medical fraud, unlicensed doctors, unlicensed nurses, and malpractice are rampant in Dade County. Katherine Rundle REFUSED to prosecute a case that would have set precedent for the whole country and would have protected the

people of Dade County from the illegal actions of HMO's.

*****ADDENDUM DECEMBER 25, 1996 *****
 It has just come to my attention, that MEDICAL ECONOMICS magazine/journal ran an article in their June 24, 1996 issue and a follow-up about the case having been dismissed, in their October 14, 1996 issue. These articles should be taught in Journalism schools because they are great examples of either A) Very poor writing, no valid research, no facts, only opinions, opinions from only one side, and poor concentration on the issue OR B) Complete Journalistic Prostitution. Mark Crane, Senior Editor of "Medical Economics" has played the role of defense attorney by deliberately leaving out facts, quoting misleading statements, not contacting patients involved, and knowingly validating the false position of Roger Strube, M.D. and AvMed. He has also condoned the inaction of the Dade State Attorney in this. This is a Criminal case and must be decided by a judge and jury. It is Florida LAW, not the AHCA, that defines the practice of medicine. Most states have the same definition.

COST & QUALITY quarterly has contacted me for information and I have provided them with this Summary and four the twenty letters I wrote to the Dade State Attorney. I have also faxed him a copy of Strube's "bonus letter" and the Probable Cause Finding of the Florida AHCA. The article should appear in the next issue and be titled "The Corporate Practice of Medicine" or similar. Watch for it.

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[UPDATE since case dropped by Dade State Attorney Katherine Rundle](#)

[Miami Herald story & picture, March 1, 1997](#)

[Fort Lauderdale Sun Sentinel story about AvMed HMO](#)

[Miami Herald front page story about Federal lawsuit against State of Florida](#)

[Miami Herald editorial about Federal lawsuit against State of Florida](#)

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(AS SECRETARY OF CONFERENCE)

August 5, 1998

Mr. Chris Jennings
Deputy Assistant to the President for Health Policy
Old Executive Office Building
Room 216
The White House
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Dear Mr. Jennings:

As Co-Chairman of the Democratic Policy Committee, it is my pleasure to confirm your participation as the featured speaker at the Democratic Policy luncheon on Thursday, September 3, 1998. You will be joined by HFCA Administrator Nancy-Ann Min DeParle.

The meeting will be held in S-211 in the Capitol. Lunch will be served at 12:30 p.m. The roundtable discussion will begin at 1:00 p.m. and will last for approximately one hour. The discussion will be informal and off the record. Your remarks on Medicare plus need not exceed 5-10 minutes to allow sufficient time for a question and answer period.

If you have any further questions, please call me at (202) 224-3542 or have your staff contact Lenna Aoki at (202) 224-3232.

With all best wishes,



Harry Reid
Co-Chairman
Democratic Policy Committee

LEVEL 1 - 46 OF 222 STORIES

Copyright 1998 Multimedia Publishing of North Carolina, Inc.
Asheville Citizen-Times (Asheville, NC)

April 6, 1998, Monday

SECTION: Local; Pg. A1

LENGTH: 2029 words

HEADLINE: MANAGED NIGHTMARE HMOs DON'T ALWAYS DELIVER WHAT THEY PROMISE

BYLINE: By Clarke Morrison STAFF WRITER

BODY:

Betty Milton was scared out of her wits.

During a family vacation to Disney World in June, her daughter, 17-year-old Emily, became very sick. She had a high fever, dizziness and vomiting.

Milton called a nurse at an Orlando hospital and described the symptoms. After consulting with a doctor, the nurse relayed the frightening news: Emily might well have spinal meningitis, a sometimes deadly illness of which there had been an outbreak in Florida.

"The nurse said, I recommend you put her in an ambulance and get her to us at once," Milton said. "I freaked out at this point."

Fortunately, it turned out that Emily didn't have anything as serious as meningitis. But the incident sparked a confrontation with the family's HMO that dragged on for months.

Even though Milton had telephoned her Asheville doctor just before the emergency room visit with instructions to "do whatever is necessary for the insurance," she was later notified the HMO didn't plan on paying. The virus that Emily had contracted wasn't serious enough to warrant a trip to the hospital, a company representative said.

"They said that these charges would not be allowed," Milton said. "They said it wasn't life or death."

After many phone calls and much haggling, the insurance company finally relented and paid. But Milton believes that HMOs take an attitude of: "If there's a way to shaft this person, then let's do it."

"When something is due me, I will raise hell and half of Georgia to get it," she said. "I will not cave in. But I can certainly see why people do cave in. (Managed care companies) don't give a flip about what you're going through. It boils down to greed."

PERSISTENCE PAYS AGAIN: An ultrasound this past October showed Carolyn Weeke of Asheville had three gall stones and lesions on her gall bladder. The 46-year-old freelance computer researcher needed surgery.



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She selected a surgeon not on the list of her HMO's preferred providers, knowing that her insurance policy stated that the company would still pay for a portion of the procedure, albeit a lesser amount than had she chosen a surgeon in the HMO's network.

The surgery was a success, but what came next was a surprise.

"When the bills were submitted from the hospital and the surgeon, the HMO denied them all and said they were paying zero," Weeke said. "They said because the surgeon was not a participating surgeon, they were entitled to pay zero, which is not what's in their policy and not what they said on the telephone.

"I pointed this out. I wrote letter after letter and called them several times."

But it didn't do any good. So Weeke delved into the Internet, doing research on how to get the problem with her HMO resolved. That ultimately led her to file a complaint with the state Insurance Commission, which took the matter up with the administrators of her policy.

"They then told the Insurance Commission it was all a big mistake and that they would pay," she said. "They didn't want to pay and were going to drag this out and see if I would give up. It's so much of a hassle to write all these letters and make all these phone calls, that I'm sure lots of people do give up. I'm sure that's what the HMOs count on so they don't have to pay."

CAUGHT IN THE MIDDLE: Melisa Quinlan's daughter was born at Mission two years ago on April 30, and the Marion teacher said she didn't have any problems with her health care coverage during the pregnancy or the delivery.

But at three months, she thought her daughter might be deaf because she seemed to not be responding like a normal baby.

At nine months, she pursued testing more aggressively because her child was still not doing the "usual baby stuff."

Meanwhile her daughter was classified as developmentally delayed and thus not qualified for some types of care. But an MRI scan turned up a birth defect in the child's brain stem, and Quinlan said her daughter needs special therapy to help her develop normally.

The managed care company won't pay, so she's stuck because she can't afford the therapy in addition to the \$ 160 a month insurance premium, she said.

"I'm caught," she said. "I'm not poor enough to get Medicaid but not rich enough to pay for it myself."

She now goes everywhere with a referral and reads the fine print of her insurance coverage.

"The insurance company has fought me tooth and nail," Quinlan said. "They can just kind of shove me off and get rid of me."



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THREE-MONTH WAIT FOR SURGERY: Harold Fletcher, 55, of Hendersonville, ran into trouble with his managed care plan when he went to the doctor for a second back surgery in December.

He went through pre-op and on the Monday before Wednesday surgery, Fletcher found out that his managed care plan had denied his claim. Since the first back surgery didn't work, the company wouldn't pay for the second, he said.

"I was furious," he said. "It was something I needed to have."

One vertebrae had deteriorated and was causing Fletcher pain. He couldn't sit for an extended period and had to remain inactive.

He fought the denied claim and asked for help from state Rep. Larry Justus, who referred him to the Department of Insurance. The claim was approved soon after and Fletcher had his surgery in early March. He's still in pain but recovering and progressing. A plate runs up his spine from his tailbone and stabilizes the deteriorated vertebrae.

Fletcher said his doctor had to take up his fight with the insurance company, and though he was successful, he feels that his interests are threatened by that arrangement.

"He's not paying the premiums, I am," Fletcher said.

UNCERTAIN FUTURE: Milton, Weeke and Fletcher may have won their skirmishes, but the future of health care in America is clouded with uncertainties driven by market forces that are profoundly changing the face of medicine.

These accounts of patients denied care by hard-nosed HMOs illustrate the battle under way between the old-fashioned type of personalized health care that doctors have practiced for decades and the new style of managed care in which patients and physicians are taking a back seat to bureaucrats.

Despite the **horror stories** about HMOs, many agree that managed care still has a broad mandate to squeeze billions of dollars in inefficiency and excessive care out of the health care system. HMO enrollment increased 13 percent last year on top of a 16 percent jump in 1996, and the growth is expected to continue.

The number of HMO enrollees has tripled from 22 million in 1985 to 67 million today, and revenues have reached \$ 110 billion a year.

Many employers credit HMOs with reining in their health insurance costs. Rates for health coverage grew at an annual inflation rate of 10 to 15 percent in the late 1980s and early 1990s, but have been below 5 percent for the past three years.

Ray Linder, human resources director at Baxter Health Care Corp. in Marion, said managed care has saved his company "countless millions" over the past several years. Of the plant's 2,500 workers, about 85 percent choose a managed care plan and 15 percent go with traditional fee for service.



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A standard visit to the doctor's office can cost a patient just \$ 10 under an HMO, while a patient with conventional insurance often pays \$ 50 or more. However, managed also means less choice of doctors. Those in HMOs usually must choose from a list of physicians who have contracts with the company.

"Managed care is the only way we as a country have been able to control our spiraling medical costs," Linder said. "Our employees are pleased with the cost containment from the standpoint of their premiums and copayments.

"It's very popular here. I know the horror stories, and certainly there are those cases. My opinion is you have a balanced system in place."

Over the past year physicians have been under increased pressure from managed care companies to cut their fees, said Sandy van der Vaart, director of managed care for the N.C. Medical Society.

But from the doctors' perspective, the companies are barking up the wrong tree, she said. Fees for physician services represent just 15 percent of the dollars spent on health care.

"We're seeing pretty significant fee reductions across the board and not a willingness to negotiate," van der Vaart said. "It makes it hard for physicians to succeed financially, but it really doesn't solve the ultimate problem, which is health care costs."

ADMINISTRATIVE BURDEN: Dr. Paul Martin, an Asheville family physician specializing in addiction medicine, said that of the managed care companies he's dealt with, not one has increased its reimbursements over the past five years. At the same time, he has to pay more for employee salaries, malpractice insurance and other operating expenses.

"The only way I can cover my overhead costs and maintain my salary is to see more patients," said Martin, past president of the Buncombe County Medical Society. "Lots of doctors see this.

"But it's not the reimbursement issue that most physicians complain about. It's the increased administrative burden they have to deal with. It's very disruptive to the time we spend with our patients. We waste huge amounts of time just trying to jump through the managed care hoops."

Martin also complained about the restrictions managed care often places on what drugs it is willing to pay for. Even if a drug is clearly the most effective for a particular malady, the company sometimes won't pay, "so the patient either settles for the second-choice drug or pays for it himself."

But despite its faults, managed care has served a useful purpose, Martin says. The mental health care field became heavily managed in part because so much money was wasted on ineffective inpatient treatment before, he said.

"It used up huge amounts of health care dollars. Managed care, to its credit, cut down on those abuses."

As for managed care and how it affects quality, it depends on how you measure quality, Martin said. If you measure it in terms of death rates for enrollees,



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managed care is on a par with traditional fee-for-service insurance. Managed care also does well in some measures of patient satisfaction, but not in others.

"It's absolutely affected care in many ways," he said. "In some areas it's caused tremendous inconvenience for patients and physicians, so it's a mixed bag. I think the public has to be prepared for a different health care system if we are going to contain the costs."

MANAGING MONEY: Glenn Wilson, professor of social medicine at the University of North Carolina School of Medicine, dislikes the term managed care.

"We're talking about managing benefits and managing money, not managing care," he said. "If you were managing care you would figure out what's best for the patient and organize it so the patient could receive it, not figuring out how to limit the benefits and cut the payments to the doctors and the hospitals. I think those are very different things."

And Wilson believes that reports of HMOs cutting the cost of care are greatly exaggerated. Studies show that 3 percent of Americans use 20 percent of the health services, while 25 percent use no care at all. And the managed care companies have been very clever in enrolling people who are healthy, he said.

"Despite all the public relations, the evidence that managed care is saving the public money is very doubtful," he said. "Health care for 20 years has been about double the rate of inflation. It's still about double the rate of inflation, and I don't think managed care had anything to do with the general inflation rate in this society."

And although insurance payments by employers may have been reined in to some extent, part of the reason for that is they've increasingly passed the cost on to the employees, Wilson said.

"And there's no question that many of these managed money companies set very low rates to increase their enrollment with the idea of purchasing market share and raising rates later," he said. "Now, rates are going through the roof and the companies are having trouble."

Staff writer Mark Blaine contributed to this report.

GRAPHIC: Photos of Harold Fletcher

LANGUAGE: ENGLISH

LOAD-DATE: April 9, 1998



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LEVEL 1 - 178 OF 354 STORIES

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November 6, 1997 Thursday ALL EDITIONS

SECTION: FINANCE; Pg. 040

LENGTH: 439 words

HEADLINE: No 'charitable immunity' for HMO in malpractice suit

BYLINE: By Eric Convey

BODY:

As the malpractice suit of cancer patient Elaine Nascimento drew to its \$ 1.4 million conclusion late last month, a behind-the-scenes legal agreement averted another courtroom battle that could have had broad implications for the state's health care industry.

Harvard Pilgrim Health Care, the state's biggest health maintenance organization, quietly agreed it would not invoke the state's "charitable immunity" law that caps the liability of non-profits at \$ 20,000.

Instead, the HMO will pay \$ 1.4 million to Nascimento. She is a Harvard Business School secretary who developed widespread cancer after a Harvard Pilgrim doctor failed to diagnose Nascimento's breast cancer.

"There are no plans for an appeal. As far as Harvard Pilgrim is concerned, the case is over," said Harvard Pilgrim spokeswoman Patti Embry-Tautenhan.

She refused to discuss the HMO's legal strategy or elaborate on why the 1.1 million-member health plan is not invoking charitable immunity or appealing the jury's verdict.

"The issues of our charitable status are no longer being pursued," she said. "There are no further proceedings in the Nascimento case."

Nascimento's lawyer, Stephen J. Lyons, raised the immunity issue in May 1994 when he first sued the HMO.

"We made that an issue at the very beginning. And we made it clear we were not going to permit them to hide behind the charitable shield they had raised from the very beginning. We spent two years doing discovery, looking into the facts," he said.

After two years of depositions and other legal maneuvering, the charitable immunity issue went before Judge James McHugh, who ruled that a jury should decide whether Harvard Pilgrim is truly a non-profit.

Even with the Nascimento case apparently concluded, Lyons said he is not done pushing the issue.



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Lyons said he has "numerous" cases against Harvard Pilgrim, and sooner or later he will get the issue of charitable immunity before a jury.

Harvard Pilgrim could have several reasons for wanting to retain its non-profit status, said Stephen Davidson, a professor in the Health Care Management program at Boston University. For one, it would have to pay taxes as a for-profit enterprise.

Another reason is "cultural commitments," Davidson said. "I can't imagine, for example, (Harvard Pilgrim) ever becoming for-profit trying to make a financial profit off of people who are sick," he said.

Employers are unwilling to let premiums rise quickly and doctors and other health care providers are getting better at charging HMOs more for their services, Davidson said. "(HMOs) are going to be squeezed in both directions."

LOAD-DATE: November 06, 1997



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THE DALLAS MORNING NEWS

December 23, 1997, Tuesday, ARLINGTON MORNING NEWS EDITION

SECTION: BUSINESS; Pg. 1C

LENGTH: 710 words

HEADLINE: Kaiser case could spur more suits;
\$ 5.35 million settlement a bargain by test jury's standard

BYLINE: Charles Ornstein, Staff Writer of The Dallas Morning News

DATELINE: DALLAS

BODY:

DALLAS - A multimillion-dollar settlement involving Kaiser Permanente's North Texas HMO could trigger more medical malpractice lawsuits against other managed health care companies, lawyers and insurance officials said.

"People need to know that they are not helpless at the hands of their HMOs," said Paula Sweeney, a Dallas medical malpractice lawyer and president-elect of the Texas Trial Lawyers Association.

"One case can take a system to task and educate the public that they have recourse."

Although consistently denying any wrongdoing, Kaiser agreed to pay \$ 5.35 million last week to the family of a 56-year-old Irving man who collapsed and died in a company clinic in 1995. Hours earlier, a Dallas County test jury said it would have ordered Kaiser to pay \$ 62 million had it been acting in a real trial.

The case, which has drawn national attention, was settled three months after a new Texas law gave patients the right to sue health maintenance organizations and other managed care companies on grounds of medical malpractice. The suit against Kaiser was filed last year under old laws because of the company's unique corporate structure and close relationship with its physicians.

Local managed care officials said they might see a temporary increase in lawsuits because of the Kaiser case and the new law. To prevent that, health plans must provide quality care and maintain physicians' authority to care for their patients, said Pat Feyen, president and chief executive officer of Pacificare of Texas.

"The proof is in the pudding," he said. "Even if there is more activity from a litigious standpoint, it won't be directed at HMOs that provide quality care."

Kaiser spokesman David O'Grady said the company settled the malpractice suit because it wanted to avoid a protracted courtroom fight. But lawsuits, he said, are not the way to address perceived industry shortcomings.



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"Are they sending the message that suing is really the answer to getting better health care?" he asked. "I think that's a horrific vision of the future."

Some members of the test jury that heard the case last week said they believed Kaiser put cost-cutting ahead of patient care.

Plaintiffs' lawyers had introduced a Kaiser business plan to cut hospital expenses by 45 percent and an official's speech emphasizing the importance of "the bottom line."

"We felt the only thing they really paid attention to was the bottom line," said Vernon Selvidge, the test jury's foreman. "So we had to get the attention of the bottom line."

"If there was an ability for a jury to set a precedent, we wanted to do it. Any medical care executive thinking about whether shortcuts were going to get them anywhere, we wanted to make them think twice," said Mr. Selvidge, who is enrolled in a preferred provider organization.

During a unique minitrial Dec. 15 and 16, the test jurors listened to 90-minute summaries of each side's case and then deliberated without knowing that their verdict was only intended to produce a settlement.

Kaiser lawyers portrayed the Irving man as an overweight smoker who refused to obey doctors' orders. Plaintiffs' lawyers said Kaiser doctors and nurses misdiagnosed his heart disease in the five weeks before his death.

"We can only hope that all health systems are not like this," said juror Bill Gullic, who has traditional fee-for-service insurance. "If they are, we're in big trouble."

Still, the nonbinding verdict did not surprise many managed care representatives. The Texas HMO Association plans to send out information on the case to all of its members, as it does with other high-profile lawsuits.

"Due to years of seeing anti-managed care stories in the media, juries are more than willing to hold health plans liable and award significant damages, even under a lower burden of proof than they had historically for just physicians," said Geoff Wurzel, executive director of the HMO association.

Lisa McGiffert, a senior policy analyst with Consumers Union in Austin, said a series of malpractice lawsuits could raise awareness of the risks inherent in managed care.

"If you have enough of these cases and they are high-profile enough, the industry is going to have to change the way it behaves," she said.

LANGUAGE: ENGLISH

LOAD-DATE: December 24, 1997



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LEVEL 1 - 113 OF 626 STORIES

Copyright 1998 The Buffalo News
The Buffalo News

May 8, 1998, Friday, CITY EDITION

SECTION: LOCAL, Pg. 5B

LENGTH: 648 words

HEADLINE: **HMOs FAILING MANY PATIENTS, HEARING IS TOLD**

BYLINE: HENRY L. DAVIS; News Medical Reporter

BODY:

Managed health care may have reduced costs but has failed to improve care to patients with special needs, including the mentally ill and children with disabilities.

That was the message echoed by patients, physicians and others at a hearing Thursday to lobby state and federal legislators to help reform the health system.

Again and again those who testified at the session organized by the Ad Hoc Committee to Defend Health Care took aim at the health insurance industry.

Tony Cimino, a former physician who turned in his medical license seven years ago to be treated for alcohol abuse, told how he learned a hard lesson about the cost of health care after he was denied insurance because his alcoholism was considered a pre-existing condition.

"In 60 days, I spent \$ 23,000 on treatment, money that I had set aside for my children," he said.

Bonnie Meyer described how her mother's Medicare **health maintenance organization** refused to pay for acute rehabilitation after she suffered a stroke even though her physician saw the need for it. The **HMO** wanted the patient moved to a less-costly setting where the supervision is less intense.

"At a time of medical crisis, we were forced to confront additional pain," Ms. Meyer said.

Ted Wienczek, coordinator at BryLin Hospitals, criticized the Medicaid managed-care program, recalling how a patient's health plan denied payment for admission because prior approval was lacking and questions were raised about whether admission was necessary.

"The thing is at the time we admitted her, we didn't know she was in managed care," he said.

Wienczek cited reasons for admitting the patient, including statements from clinicians at her sentencing for petit larceny that she was dependent on alcohol and heroin.



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The Buffalo News, May 8, 1998

Thursday's session was the third organized by the group of Buffalo-area doctors, nurses and advocates who fear HMOs have become concerned with cutting costs at the expense of patients.

The group argues that a growing number of business practices are displacing values once held sacred by doctors and patients, and eroding the trust that once defined their relationships. Meanwhile, members say, the ranks of the uninsured have grown, the safety net of public hospitals has eroded, and those with insurance have seen payments denied or coverage limited for expensive illnesses.

"Subjecting medicine to the forces of the marketplace is like mixing oil and water," said Dr. Deborah Richter, a Buffalo physician involved with the committee.

Others who testified called for a wider selection of HMO physicians, particularly for the mentally ill and drug and alcohol addicted, so that access to care is not limited by a small choice of clinicians.

They also called for insurance coverage of mental illnesses that is equivalent to coverage of physical ailments.

Still others lobbied for more government controls on HMOs.

"We've got to be realistic. HMOs are here to stay. But we need safeguards," said Dr. Franklin Zepfowitz, president of the Erie County Medical Society.

He and others support legislation that would make HMOs liable for their members' injuries if the HMO improperly denies or delays care or payment for the care.

They also want legislation to provide independent appeals of denials of treatment, which are now handled within the HMO, and to create a managed care ombudsman's post in New York State to help consumers navigate the increasingly complex world of managed care.

Independent Health, the region's largest HMO, posted a letter to members on its Internet website that criticized the committee for not inviting its representatives to rebut the testimony.

The letter defended the company and said the committee had chosen to focus on anecdotal stories of "frustrated health care practitioners and angry patients" rather than what the HMO had done to improve health care.

LANGUAGE: ENGLISH

LOAD-DATE: May 10, 1998



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LEVEL 1 - 94 OF 626 STORIES

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May 27, 1998, Wednesday, FINAL EDITION

SECTION: TELEGRAPH (NEWS), Pg. 1A

LENGTH: 812 words

HEADLINE: HMO paying \$ 249,000 for sick boy, after all; NYLCare had denied out-of-network tab at Kennedy Krieger

BYLINE: Shanon D. Murray, SUN STAFF

BODY:

One of the region's largest health maintenance organizations has agreed to pay nearly \$ 250,000 in medical expenses for an Ellicott City boy who was treated outside the HMO's network and whose bills the HMO initially refused to pay.

The Maryland Insurance Administration said yesterday that the reversal is one of the largest it has obtained.

Last week, NYLCare Health Plans of the Mid-Atlantic Inc. waived its right to contest the charges at a hearing and agreed to pay \$ 244,512.50 for the boy's inpatient treatment at the Kennedy Krieger Institute in Baltimore for a rare digestive disorder, an additional \$ 5,085 for his outpatient services, and a fine of \$ 1,000.

The patient, Justin Helwig, 13, has multiple disabilities and medical conditions, including mental retardation. NYLCare said it made a mistake in denying care to the boy, but the incident could have been avoided if his parents, Stephen and Peggy Helwig, had formally appealed the decision.

"This is not a finding against us," said Jeff D. Emerson, NYLCare's president and chief executive. "We agreed to pay it."

"We didn't quarrel. We didn't go to hearing. We didn't ask for weeks to study it. We didn't litigate it. We paid it."

Emerson said a "subcontractor" with the managed care company originally denied the payment for care that Justin received in 1996 and 1997 because Kennedy Krieger is not in the HMO's network of providers. When NYLCare was alerted by the insurance administration in March that it was being ordered to pay, a company official "concluded it was something we should cover," Emerson said.

NYLCare has about 500,000 subscribers in Maryland, and 77 hospitals and 14,120 physicians in its mid-Atlantic network. Blue Cross Blue Shield insures about 1.4 million Marylanders.

One of the most contentious issues in the case is whether the Helwigs and



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Kennedy Krieger appealed the initial decision by the company to not pay the medical costs.

Emerson said the parents and the hospital did not appeal. According to the judgment order by the insurance administration, the hospital appealed NYLCare's decision in November 1996, when Justin began treatment there.

And the Helwigs appealed in their own way, they said.

"We begged NYLCare," said Peggy Helwig, who filed the complaint with the insurance administration in December 1997. "In letters and phone calls from us and doctors, we asked them to please let our child go to Kennedy Krieger. We let them know this was our only ray of hope.

"They made a very poor judgment call," said Helwig, who also has an adult daughter with her husband Stephen.

The case is a look at what can happen when a managed care company exercises its right to not pay bills incurred by clients -- or authorize treatment -- at facilities not in its network of hospitals and doctors.

"This is clearly an issue society is trying to deal with in terms of access to health care," said Nancy Fiedler, senior vice president of the Maryland Hospital Association, a coalition of the hospitals in the state that often deals with HMO payment issues.

"The insurer is primarily concerned with managing costs effectively. And the patient is more concerned with getting access to health care," she said. "And then we have the insurance administration trying to be the arbiter."

The issue began in October 1996, when a team of doctors determined that the only facility in Maryland that had the capability to treat Justin's complex digestive disorder was Kennedy Krieger Institute, said Steven B. Larsen, the insurance commissioner.

He began treatment at the hospital in November of the same year.

At that time, Justin had no digestive capability and weighed 47 pounds. He received seven months of inpatient care at Kennedy Krieger, and then had a nine-month interruption in his care because NYLCare also refused to pay for outpatient services, the Helwigs said.

Justin began his outpatient care in March after the Helwigs left the NYLCare plan and enrolled with another health care provider. Currently, the boy can eat only if he's placed in a specially designed chair and hand-fed his food after it's chopped or pureed, the Helwigs said.

In March, the insurance administration found that NYLCare had violated the terms of its contract with the Helwigs and provisions of Maryland law. Because the state's medical assistance program compensated Kennedy Krieger, under the settlement, NYLCare will reimburse the program.

The insurance administration has not kept track of what health care providers in the state have had multiple complaints against them, said Larsen. A computer system that was installed last month will begin tracking such trends.



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Thousands of complaints are forwarded to the administration a year, he said. In about half of the cases, companies are ordered to pay or they pay voluntarily.

Pub Date: 5/27/98

GRAPHIC: COLOR PHOTO, NANINE HARTZENBUSCH : SUN STAFF, Family: The family of Stephen and Peggy Helwig and their son, Justin, 13, are greatly relieved to learn that NYLCare Health Plans of the Mid-Atlantic Inc. will now be paying for Justin's treatment at the Kennedy Krieger Institute in Baltimore.; PHOTO, NANINE HARTZENBUSCH : SUN STAFF, Dinner: Justin, who has multiple difficulties in addition to his digestive disorder, must be hand-fed food that has been chopped or pureed. Here, his father, Stephen Helwig, assists with the evening meal.

LOAD-DATE: May 28, 1998



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**PRESIDENT UNVEILS TEN LEGISLATIVE PROPOSALS AS PART OF HIS
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January 23, 1998**

- (1) **Eliminating Wasteful Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare paid more than double the actual average wholesale prices, and in one case pays as high as ten times the amount. This proposal would ensure that Medicare payments be reduced to the actual amount that the drugs cost.
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Draft 1/23/98 4:00pm

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON MEDICARE FRAUD
January 24, 1998

Good morning. Today I want to talk about our continuing efforts to fight fraud and abuse in the Medicare system.

For more than 30 years, Medicare has helped us to honor our oldest obligations to our parents and grandparents. And since I took office, our administration has made strengthening Medicare one of our top priorities. The balanced budget I signed into law last summer will extend the life of the Medicare Trust Fund for at least a decade. But to ensure that Medicare is as strong in the 21st Century as it has been in the 20th, we must do more to root out fraud and abuse.

Medicare fraud cheats beneficiaries and tax payers out of billions of dollars every year -- and it undermines the strength of this vitally important program. Since 1993, we have assigned more federal prosecutors and investigators to fight Medicare fraud than ever before, increasing fraud convictions by a record 240 percent. All told, we have saved tax payers over \$20 Billion. And the Kennedy Kassebaum legislation I signed into law in 1996 has given us new resources and tools to investigate, prosecute, and convict dishonest providers and medical suppliers.

On Monday, I will send to Congress a report that shows just how effective those new tools have been. I am proud to say that in the last year alone, we have collected nearly \$1 Billion in fines and settlements for health care fraud. Money that would have lined the pockets of scam artists is going instead to preserve the Medicare Trust Fund -- and to improve health care for millions of Americans. We have increased prosecutions for health care fraud by more than 60%. And we have stopped health care fraud before it starts by keeping nearly twice as many bad providers out of the system.

Make no mistake: Medicare fraud is a real crime, committed by real criminals intent on stealing from the system and cheating our most vulnerable citizens. Let me give you just one example. In New York City, a Russian immigrant believed by federal investigators to be part of an organized crime ring defrauded Medicare of \$1.5 Million dollars by selling substandard medical supplies to elderly people and billing Medicare for premium goods. We shut him down, and put him in jail -- but he never should have been there in the first place. Last week, I put in place new regulations that require medical suppliers to post surety bonds to prove that they are legitimate, solvent businesses.

And to further ensure that medical suppliers are not defrauding Medicare, the Department of Health and Human Services will expand its site inspections of medical supply companies all over the country.

But we must do more to crack down on fraud and abuse in the Medicare system. The balanced budget I will submit to Congress next month will include anti-fraud and waste provisions

that will save Medicare more than \$2 Billion dollars. First, it will eliminate overpayment for certain drugs by making sure doctors receive no more and no less than the price they pay for the medicines they give Medicare patients. Second, it will ensure that when fly-by-night providers go bankrupt, Medicare is at the top of the list of debts to be repaid. And finally, it will bring down costs by allowing Medicare to purchase goods and services at a competitive price.

We will only win the fight against fraud and abuse in the Medicare system with the help of the American people. We know that patients and honest providers want to help crack down on fraud and abuse. Starting next month, we will make it easier for them to do so, with a toll-free hotline that will now appear on every statement Medicare sends out to every beneficiary it serves.

With these steps, we are making sure that the Medicare system which has served our parents and grandparents so well, will serve our children and grandchildren, well into the 21st Century. Thanks for listening.

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① Secretary Shalala

7 Inspector General of Health

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MEDICARE FRAUD AND ABUSE**

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January 20, 1998

Dear Ms. Glover:

Thank you for participating in the Genetics event at the White House on July 14, 1997. I am glad that you were able to take part in this occasion and I enjoyed meeting you. Also, I congratulate you on your lobbying successes for the Genetic Nondiscrimination in Health Care Act. Your determination is truly admirable.

~~On October 25, 1997~~ ^{As you know}, in a White House Radio Address on Breast Cancer Awareness and the Mammography Initiative in support of Breast Cancer Awareness Month, Hillary and I announced new steps to ensure that more women receive regular, high quality mammograms. Our goal is to improve the quality standards of mammography facilities nationwide. New clarifications requiring facilities to hire capable technologists, to use equipment that produces clear and accurate images, and to ensure that physicians have the skills to interpret the rules are among these improvements. In addition, the National Cancer Institute has initiated a new national education campaign that provides women and their families, and health professionals clear, up-to-date information about the steps they should take to detect mammography and breast cancer.

During this Address, the First Lady's National Annual Medicare Mammography Campaign initiatives for this year were also announced. These initiatives include Public Service Announcements encouraging older women to get mammograms, as well as HORIZON Project Grants launched by HCFA focusing on increasing mammography rates among Hispanic and African-American Medicare beneficiaries.

The initiatives taken in October, combined with previous endeavors, all aid in increasing the number of annual mammogram screenings by educating women throughout America on the importance of yearly mammograms for women age forty and older, as well as making this service more accessible and affordable.

Thank you again for your participation in the Genetics event in July, 1997, and for your continued support of the Genetic Nondiscrimination in Health Care Act.

Sincerely,

President William J. Clinton

L. Dickey

SEP 26 1997

From 74151.2045@compuserve.com Fri Sep 5 12:10:32 1997
Date: Fri, 05 Sep 1997 12:07:26 -0400
From: Margarete Williams <74151.2045@compuserve.com>
Subject: Thank You
To: President Clinton <president@WhiteHouse.GOV>
Message-id: <199709051209_MC2-1F48-E66@compuserve.com>

*Not Breast Cancer
Awareness Month Proc.*

September 5, 1997

Dear President Clinton:

Thank you for allowing me to meet you and participate in your Genetics event at the White House on July 14, 1997. Your personal invitation to such a momentous occasion was more than I have ever hoped for. I hope and pray that we can continue our association.

Your bold support for Breast Cancer Research and your stand against Genetic Discrimination encouraged me to lobby for the Nondiscrimination in Health Care Act to over a dozen Senators and Congressmen thus far. Five of the Senators and Congressman I visited attributed their decision to sign on the Genetic Nondiscrimination in Health Care Act to my lobbying. Many people have told me that I make a great activist because I can influence individuals. With your backing and support, we can become a formidable team for Breast Cancer and Genetic Issues.

I would appreciate if you would consider having an event at the White House in October supporting National Breast Cancer Awareness month. If not please keep me in mind when you have other events. I hope to be invited back to the White House to visit with you longer and possibly see the Oval Office.

On behalf of the 2.6 million women living with Breast Cancer, I would like to give you a heart filled thank you for your support. I look forward to the day you sign the Genetic Nondiscrimination in Health Care Act into Law. Lately, I am glad to hear you enjoyed the McClards Bar-B-Q Sauce. If there is anything I can ever do for you, feel free to contact me.

Respectfully yours,

Dana Ann Glover
Breast Cancer Survivor

P6/b(6)

(E-Mail) DA Glover@aol.com

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