

## PRESIDENT CLINTON ANNOUNCES UNPRECEDENTED PROGRESS IN FIGHTING MEDICARE FRAUD AND ABUSE

Today, President Clinton announced the first annual progress report by the Departments of Justice and Health and Human Services on the nation's successful efforts in cracking down on Medicare fraud and abuse. He also unveiled a series of new legislative and executive actions to build on the Administration's impressive record in this area, specifically, he announced:

- **That Nearly \$1 Billion Has Been Returned to the Medicare Trust Fund in Just One Year**
- **A 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare at Least \$2 Billion**
- **Unprecedented Steps to Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse**
- **Nationwide On-Site Inspections to Target Medical Supplier Rip-Off Artists**
- **A Nationwide Conference, With Law Enforcement Officials and Others, Designed to Identify the Next Steps to Fight Fraud and Waste**

### THE PRESIDENT ANNOUNCED:

**A Justice/HHS Report Which Cites Nearly \$1 Billion in One Year in Savings For the Medicare Trust Fund.** On Monday, the President is sending to Congress the first annual report of the Health Care Fraud and Abuse Control Program -- created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) -- which shows remarkable progress in rooting out health care fraud and abuse. In FY1997 alone, the first full year of anti-fraud and abuse funding under HIPAA, nearly \$1 billion was returned to the Medicare Trust Fund, the largest amount ever. These efforts:

**Returned nearly \$1 billion to the Medicare Trust Fund** from collections of criminal fines, civil judgements and settlements, and administrative actions. This was the largest recovery amount ever collected in one year.

**Excluded more than 2,700 individuals and entities from doing business with Medicare, Medicaid, and other federal and state health care programs** for engaging in fraud or other professional misconduct -- a near doubling (a 93 percent increase) over 1996.

**Increased convictions for health care fraud-related crimes** by nearly 20 percent.

**Pursued 4,010 civil health care fraud cases** -- an increase of 61 percent over 1996.

**A New 10-Step Anti-Fraud and Abuse Legislative Package That Saves Medicare At Least \$2 Billion Over Five Years**, including the following:

**Eliminating overpayments for certain drugs**, for which the Inspector General has reported Medicare currently overpays.

**Ensuring Medicare does not pay for claims that ought to be paid by private insurers**, such as taking steps to ensure that Medicare is aware of liability settlements and of other coverage obligations of private insurers.

**Asking providers to pay for their audits**, which will allow Medicare to double the number of audits.

**Ensuring that providers do not leave Medicare strapped by declaring bankruptcy.**

**Unprecedented Steps to Involve Medicare Beneficiaries in Identifying and Combating Fraud and Abuse.** The President is announcing steps to involve Medicare beneficiaries in rooting out fraud and abuse, such as:

**Providing beneficiaries with new information on how to report fraud.** Starting next month, Medicare beneficiaries across the nation will receive a toll-free number to call to report fraud and abuse in Medicare on every statement, bill, and claim, making it easier to crack down on fraud and abuse; and

**Rewarding beneficiaries for fighting fraud.** Provisions in the Kassebaum-Kennedy legislation will be implemented this spring that give beneficiaries rewards for reporting fraud.

**On-Site Inspections Across the Country to Eliminate Rip-Off Artists and Scam Medical Equipment Suppliers.** To ensure that medical equipment suppliers are providing the medical devices they claim, the Department of Health and Human Services is conducting nationwide on-site inspections of medical suppliers.

**A National Conference to Bring Together Law Enforcement, Providers, Beneficiaries, and Others to Identify the Next Steps to Fight Fraud and Waste.** While the Administration has a long record of fighting fraud and abuse, we must do more. Today, the President is announcing that this spring, the Health Care Financing Administration will hold a conference including consumers and their representatives, law enforcement officials, private insurers, health care providers, and beneficiaries, to build on the successes we have achieved in fighting fraud and abuse in the nation's health care system.

**PRESIDENT UNVEILS TEN LEGISLATIVE PROPOSALS AS PART OF HIS  
ONGOING ANTI-FRAUD, WASTE, AND ABUSE COMMITMENT**

**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.
- (2) **Eliminating Overpayments for Epogen.** In a 1997 report, the HHS Office of Inspector General (OIG) found that reducing the Medicare reimbursement for Epogen (a drug used for kidney dialysis patients) to reflect current market prices would result in more than \$100 million in savings to the Medicare program and beneficiaries.
- (3) **Doubling the Number of Audits to Ensure That Medicare Only Reimburses for Appropriate Provider Costs.** Right now, not all cost-based providers (e.g., hospitals, home health, non-PPS, skilled nursing facilities) are audited. This proposal would assess a fee to cover all audits and cost settlement activities for health care providers. These steps help ensure that Medicare only makes payments for appropriate provider costs.
- (4) **Lowering Medicare's Payments for Equipment Through A Nationwide Competitive Pricing Program.** Competitive Pricing would let Medicare do what most private and other government health care purchasers do to control cost -- lower costs by injecting competition into the pricing for equipment and non-physician services.
- (5) **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit -- in particular that Medicare is sometimes billed for services in inpatient hospitals or homes. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.
- (6) **Creating Civil Monetary Penalties For False Certification of The Need For Care.** Recent HHS Inspector General reports identified providers who inappropriately certified that beneficiaries needed out-patient mental health benefits and hospice services. This proposal would impose penalties on physicians who falsely certify their patients' need for these two benefits.

- (7) **Preventing Providers From Taking Advantage of Medicare By Declaring Bankruptcy.** Providers who have defrauded and abused Medicare often file for bankruptcy in order to avoid paying fines or returning overpayments, leaving Medicare strapped with the bills. This proposal would give Medicare priority over others when a provider files bankruptcy.
- (8) **Taking Action To End Illegal Provider "Kickback" Schemes.** A serious area of fraud is "kickback" schemes, where health care providers unnecessarily send patients for tests or to facilities where the provider is financially rewarded. While we have established criminal penalties for these schemes, additional tools are needed to stamp out this practice: specifically, allowing prosecutors to get a court order put an immediate halt to such schemes, and to allow civil as well as criminal remedies.
- (9) **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. These proposals would take steps to address these problems including: requiring insurers to report any Medicare beneficiaries they cover; allowing Medicare to recoup double the amount owed by insurers who purposely let Medicare pay claims the group plan should have made; and imposing fines for not reporting no-fault or liability settlements for which Medicare should have been reimbursed.
- (10) **Enable Medicare to Capitate Payments for Certain Routine Surgical Procedures Through a Competitive Pricing Process With Providers.** This will expand HCFA's current "Centers of Excellence" demonstration to enable Medicare to receive volume discounts on these surgical procedures and, in return, enable hospitals to increase their market share and gain clinical expertise.

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Copyright 1997 Charleston Newspapers  
The Charleston Gazette

June 13, 1997, Friday

SECTION: News; Pg. P3C

LENGTH: 308 words

HEADLINE: FAMILY SUES HMO FOR TORTURE FOR DENYING CARE

BYLINE: Jay Greene THE ORANGE COUNTY REGISTER

BODY:

A Santa Barbara, Calif., family sued PacifiCare of California, accusing the HMO of torture for denying home health care for their sick infant.

The family's lawyer believes it is the first time an HMO has been sued for torture.

Leonard and Dana Wallock first sought home health care in May 1996, says the Santa Barbara superior court lawsuit. Their infant son Daniel suffered from congenital heart defects that doctors said required home nursing care.

Cypress, Calif.-based PacifiCare and Monarch Medical Alliance in Santa Barbara approved one week of home care. The companies denied requests for additional care.

The family spent \$ 20,000 obtaining the care before filing a complaint with state HMO regulators. PacifiCare then began paying for the home care.

"It's so extreme as to what happened to this family and this baby," said their lawyer, Mark Hiepler. "It just smacks of the idea that this baby is going to die, and it will be cheaper if it does die."

PacifiCare spokesman Ben Singer called the allegations unfounded. The



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HMO said the family should have called its member-services department "before taking matters into their own hands."

"All members - including the Wallock family - have the right and also the responsibility to call and give us an opportunity to meet their special needs," the company said. Monarch executives declined comment.

The Wallocks are using California's criminal torture statute, written to address criminal offenders who torture their victims. The suit alleges PacifiCare's actions were "performed with the intent to cause cruel or extreme pain, and was designed for a sadistic purpose, in this context, to maximize the companies' and doctors' profits while sacrificing the health and well-being of mother and infant child."

LOAD-DATE: June 13, 1997



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The Legal Intelligencer

June 18, 1997 Wednesday

SECTION: REGIONAL NEWS; Medicaid HMO; Pg. 3

LENGTH: 559 words

HEADLINE: Children's Hospital Suit Claims Medicaid HMO Refuses to Reimburse for Kids' Emergency Care

BYLINE: By Claudia N. Ginanni, Special to the Legal

BODY:

Children's Hospital of Philadelphia has joined the legal sparring involving Pennsylvania's "Health Choices" managed care health plan with a lawsuit alleging that a state-funded HMO is illegally refusing to reimburse the hospital for emergency medical services provided to Medicaid recipients.

Attorneys Thomas C. Zeilinski and Mark H. Gallant of Cozen & O'Connor filed the suit in federal court, alleging that Health Partners, an HMO that is "de facto owned by several area hospitals and/or health systems," is reaping financial benefit from denying payment for emergency services rendered by Children's Hospital.

Pennsylvania's "Health Choices" plan required nearly all 450,000 Medicaid recipients in Philadelphia, Bucks, Chester, Delaware and Montgomery Counties to enroll in one of four HMOs approved by the state as of Feb. 1, 1997. Health Partners is one of the designated four.

The Health Choices plan differs from the traditional delivery of federally-funded health care in that recipients of aid under the plan are generally restricted to doctors and hospitals that belong to their HMO's network.

In order to switch to the new plan, Pennsylvania had to obtain a waiver of federal rules which require that Medicaid recipients be free to choose health care providers.

But Medicaid HMOs are still subject to federal regulations, and Health Partners is required by both federal law and its contract with the Pennsylvania Department of Welfare to pay for emergency hospital services to its enrollees even when the hospital providing the service does not belong to its network, the lawsuit says.

According to the suit, Health Partners "frequently denies payment" for its patients who are given emergency treatment at Children's Hospital "on the grounds that [the hospital] has not obtained a prior approval" for the treatment by Health Partners.

The suit alleges that Health Partners has refused to reimburse Children's

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OF EMERGENCY  
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Hospital for emergency services for at least 22 children whose health "could have been compromised by delaying emergency treatment to obtain a prior authorization" from the HMO.

Lawyers for the hospital say that it has no agreement with the HMO compelling it to obtain approval from the insurer for emergency treatment, but that it usually notifies the HMO of an emergency hospital admission of a Health Partners enrollee within 24 hours, a practice it terms "consistent with industry standards."

The suit charges that Health Partners' denial of coverage for emergency treatment at Children's Hospital -- which is neither an owner of nor a participant in the Health Partners network -- helps create a surplus which financially benefits the hospitals and health systems that do own the organization.

The complaint alleges that Health Partners, acting under color of state law, has violated Title XIX of the Social Security Act. It also asserts breach of contract and unjust enrichment claims.

Health Partners spokesperson Barbara Katz-Chobert denies any wrongdoing by the HMO.

"Health Partners is well aware of the regulatory requirements and our care management processes conform with all applicable requirements. ... In an emergency we instruct our members to seek care at the closest emergency facility regardless of whether it is a participating hospital or not," a statement released by the HMO said.

LANGUAGE: ENGLISH

LOAD-DATE: June 18, 1997



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Copyright 1997 Gannett Company, Inc.  
USA TODAY

August 6, 1997, Wednesday, FINAL EDITION

SECTION: NEWS; Pg. 3A

LENGTH: 1096 words

HEADLINE: Holding HMOs accountable

BYLINE: Steven Findlay

BODY:

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

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

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

"We get calls every day from people who are enraged at their HMOs and want to sue. We have to tell most that it may get them nowhere. And they are shocked to learn why," says Mark Hiepler, an Oxnard, Calif., health-care lawyer. The loophole was barely noticed when HMOs were in their infancy in the 1980s. But with the growth of managed care, about half the 160 million Americans enrolled in such health plans are now affected.

#### The consequences

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

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

The law also makes it futile to sue in federal court. It doesn't



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USA TODAY, August 6, 1997

allow plaintiffs to seek punitive or compensatory damages, as they can in state court. They can sue only to pay for the cost of the care resulting from medical negligence. This gives lawyers, who usually take their fee from a slice of the punitive award, little incentive to take on such cases.

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

-- In May, Texas became the first state to challenge the HMOs' shield. The Legislature passed a law giving consumers the right to sue their HMOs for medical malpractice. Similar measures are pending this year in Alabama, Georgia, Maryland, New York and New Jersey. And consumer groups pledge to press the issue before state lawmakers in a dozen more states next year. But the Texas measure already is facing a court challenge because it conflicts with ERISA.

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

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

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

-- The Clinton administration has filed eight "friend of the court" briefs in malpractice cases in the past three years. The administration supports giving consumers the right to sue HMOs in state courts.

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

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

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



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

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

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

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

#### Uphill battle

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

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

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

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

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

GRAPHIC: PHOTO, b/w, Bob Riha, Jr., USA TODAY

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March 21, 1998, Saturday

SECTION: NEWS; Ed. 1,2,3,4,5,6,7; Pg. A-23

LENGTH: 1150 words

HEADLINE: Patients seek rights in painful fights over HMO coverage

BYLINE: Karen Winner; AMERICAN NEWS SERVICE

## BODY:

Mary Halm was in a medical bind. Her doctor had referred her to an out-of-state specialist who treats internal scar tissue. But her health maintenance organization rejected the referral -- twice.

Halm invoked her right to a formal review of the decision under her HMO contract and state law in Ohio, where she lives near Columbus.

But as the process dragged on, the pain from a condition called endometriosis -- a disease of the female reproductive organs that causes internal bleeding and builds up scar tissue -- became so severe that Halm could sleep at night only by curling up into a ball on the couch, she recalled.

Nine months after filing the grievance, she heard the final word -- no.

Halm said she then borrowed \$10,000 to pay for the specialized surgery herself, which she underwent Feb. 12 in Atlanta.

"I feel better now than I have for four years," she said. "I can sleep in bed again. It's incredible."

Cases such as Halm's have caused intense worry over HMO red tape and delays and the dearth of information about the complaint process itself.

President Clinton in February issued an executive order creating a "patient Bill of Rights" for the 85 million people in federal health programs, including federal workers and people in programs such as Medicaid.

The Clinton administration also is pushing Congress to adopt a patient bill of rights for all health care consumers.

Among other things, the order upholds the right of consumers to speedy appeals when managed-care companies deny coverage and, if necessary, to a hearing by an independent review board.

Halm thought she already had that right under Ohio law as well as with her contract with the HMO, Community Health Plan of Ohio. But she learned otherwise.

HMO admits delay Department of Insurance, the HMO admitted to delays in her



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case, citing what it termed "inexperienced staff" and high turnover in the past year.

"While this is not an excuse, it is merely an explanation of some of the difficulty incurred throughout this process," said the Dec. 15 letter that Halm obtained from the department.

But the HMO has stood by its final decision to deny Halm coverage of the surgery in Atlanta. Dr. Robert Kamps, president and chief executive officer of Community Health Plan, said the surgery Halm needed could have been obtained through an HMO provider at Ohio State University Hospital.

"It distresses me when we get complaints," Kamps said. "We get very few of them."

Halm said the doctor recommended by the HMO was not a specialist in endometriosis. She said her primary care physician urged her strongly to seek out the surgeon in Atlanta, who performed a special laser technique called laparoscopic microsurgery (which requires only minute incisions).

Every state requires HMOs to set up grievance procedures of some kind for complaints by consumers, according to research conducted by the Families USA Foundation, a nonprofit group in Washington.

But often the requirements are easy to evade, and several states have taken steps to stiffen the rules.

Texas, Connecticut and Missouri, for example, allow consumers to go outside the HMO to seek speedy reviews from independent boards of physicians and other health-care practitioners that could overturn the HMO's decision. New York and Illinois are proposing similar legislation.

External review unneeded? White, spokesman for the American Association of Health Plans in Washington, agreed with the need for orderly and timely grievance procedures, but said external reviews by independent boards are unnecessary.

"What we're talking about here is a very small percentage of total grievances," said the managed-care industry spokesman, adding that appeals usually get resolved within the internal grievance process "to everyone's satisfaction."

Last year, New York passed an HMO reform bill that set rules for grievance procedures, without calling for external review boards.

Health policy advocates say the provisions have fallen short of protecting consumers, partly because of lax enforcement by the state.

"The problem here in New York is that we don't get a sense that anybody is monitoring the plans to see that they're complying with the law and enforcing the law," said Mark Hannay, director of the Metro New York Health Care for All Campaign, a coalition of advocacy organizations and labor unions.

State regulators deny the charge.



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The San Diego Union-Tribune, March 21, 1998

"We will do undercover stings to ensure that one of the most comprehensive bills in the nation is implemented and complied with," said Robert Hinckley, spokesman for the New York Health Department.

He said the state already conducts routine checks on managed-care companies to ensure compliance.

New York's Managed Care Consumer's Bill of Rights was conceived as a sweeping reform with specific provisions to improve grievance procedures.

Among them: a toll-free number that consumers can call to file a grievance with the HMO, access to information on how long an appeal will take, the right to appeal the decision, the right to pick an advocate to represent the consumer in the appeal process.

Those who claim the provisions are lacking enforcement point to a December 1997 report by a task force of private and professional organizations that concluded: "Unfortunately, in New York, some managed-care organizations provide very little information about grievance processes, while others sometimes provide incorrect information."

The report, "How to Make Managed Care in New York Consumer Friendly," was prepared by agencies including the Legal Aid Society and The National Association of Social Workers.

Private inquiries over grievance procedures has prompted social workers in New York to begin their own private inquiries into HMO practices.

The national association has created "critical incident forms" being distributed to 30,000 social workers who are asking clients to fill them out with details about their tussles with managed-care companies.

After the forms are returned, the information will be analyzed and shared with the public and government officials, according to Penny Schwartz, a spokeswoman for the city's chapter of the national association.

Despite the problems, S



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Copyright 1998 Chattanooga News-Free Press Company  
Chattanooga Free Press

April 13, 1998, Monday

SECTION: NEWS; Pg. A10

LENGTH: 565 words

HEADLINE: N.J. Couple Suing HMO For Malpractice

BYLINE: By The Associated Press

BODY:

TRENTON, N.J. -- Michelina Bauman was born May 16, 1995, was discharged from the hospital the next day and died of an undiagnosed infection the next.

Steve and Michelle Bauman's account of their heartbreak, including testimony before the U.S. Senate and network TV appearances, helped sway government officials nationwide to end "drive-through deliveries" and require insurers to cover a minimum 48-hour hospital stay after birth.

"We don't feel like we did it; we feel like our daughter did," said Steve Bauman, 32.

"She made birth safe," added his wife, 31.

Now the Baumans hope one more retelling -- this time in court, in a groundbreaking malpractice suit against their HMO -- will change managed health care even more.

A recent shift in federal court interpretations has given the Baumans and about a dozen other plaintiffs the chance to sue their health insurers under state malpractice laws, breaking through the immunity from lawsuits which a legal loophole has given employer-sponsored health plans.

"It means that HMOs, managed care providers, will no longer be immune from financial accountability when their policies result in inadequate medical care," says the Baumans' attorney, Joshua Spielberg.

The Baumans, of rural Williamstown, argue that Michelina's infection would have been detected and promptly treated if the HMO's policy didn't require discharge within 24 hours.

Their lawsuit accuses U.S. Healthcare of negligence and recklessness for having that policy and another discouraging readmission when problems developed after hospital discharge.

The lawsuit also names the hospital and pediatrician as defendants.

Jill Griffiths, a spokeswoman for the since-merged insurer Aetna U.S. Healthcare, said the company will prove it was the doctor who decided to



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discharge the infant and not to readmit her when the first-time parents kept calling about her worsening condition.

"We've been very saddened by what happened in this case, but we do not believe we're liable," she said.

Employer-sponsored health plans have not had to prove that, until now.

The 1974 Employee Retirement Income Security Act, meant to guarantee that employees get the benefits promised them, was interpreted as exempting such plans from lawsuits claiming harm from denial of benefits.

For the 60 percent of Americans insured through an employer, this meant they could not sue for compensation if an insurer's denial or delay of treatment led to death or complications.

But now plaintiffs' attorneys are fashioning lawsuits accusing managed care companies of providing poor-quality care, rather than just denying a particular treatment.

Howard Shapiro, a New Orleans lawyer who represents employers' interests in Employee Retirement Income Security Act litigation, said managed-care companies are doing what employers asked: holding down costs by controlling how care is delivered.

Critics counter that that amounts to practicing medicine, and sometimes to putting profits before patients.

Even if the Baumans don't prevail in court, Sen. Alfonse D'Amato, R-N.Y., and Rep. Charlie Norwood, R-Ga., are sponsoring legislation that would give people the right to sue employer-sponsored managed-care plans for malpractice.

Business groups argue that this and similar bills would push up medical costs and force many employers to drop health insurance.

GRAPHIC: Michelle and Steve Bauman Display a photo of their daughter.

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LOAD-DATE: April 17, 1998



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Copyright 1997 The Washington Post  
The Washington Post

December 07, 1997, Sunday, Final Edition

SECTION: FINANCIAL; Pg. H02; JANE BRYANT QUINN

LENGTH: 664 words

HEADLINE: One Woman's HMO Horror Story

BYLINE: Jane Bryant Quinn

BODY:

When you read about problems with managed care, they're always big ones, involving denial of costly treatment. But if my mail is any guide, a million so-called "little things" are troubling you too -- all of which challenge the vaunted efficiency of HMOs.

It's hard to check up on the personal stories readers tell. So when my reporter, Kate O'Brien Ahlers, started grinding her teeth about her own plan, Aetna U.S. Healthcare, I asked her to document what she was going through. Here's her report (concealing individual identities):

June 9. I decide to quit the medical group that I'd picked from U.S. Healthcare's list. Among other things, it lost my appointments, shuffled doctors on me and kept so few telephone lines that I had a hard time getting through. I send a letter, asking that my records be shipped to another office.

Early August. I feel tired and ill and am losing some weight, so I call my new doctor for a checkup. Oops. She has left, and no one told me. In her place, I choose Dr. C.

Aug. 25. I hear from the medical practice I just quit. It welcomes me as a new patient. Grrrrr. I write back, saying I want out, not in.

Early September. After receiving the new paperwork, I leave a voice mail for Dr. C, asking for a checkup. No one calls back.

Oct. 6. I call Dr. C again. Linda the receptionist gives me an appointment. My medical records still haven't arrived. Are they being held for ransom?

Oct. 29. Thorough checkup with Dr. C. She even got my records! I'm sent for a blood test to a lab upstairs. Oops. The lab says it doesn't take U.S. Healthcare patients. I'm sent to the New York University Medical Center blood lab instead. There, the wait is two hours. I'm advised to come back.

Nov. 6. I return to NYU. Now I learn that I'll have to pay for the test because I don't have a referral form. I call Linda. She tells me to call the Quest Diagnostic lab center for a facility near my home. She'll fax my referral there.



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The Washington Post, December 07, 1997

Nov. 10. Quest gives me an office that's miles away. I fax Dr. C asking if that's where I'm supposed to go.

Nov. 11. No reply. I fax again. Calling is useless. The answering machine disconnects me.

Nov. 12. Success! I get the actual Linda on the phone, who advises me to go back to the lab I visited first. Later that evening, I feel lightheaded and pass out.

Nov. 14. The upstairs lab does the test, after telling me that it has had "a lot of trouble with U.S. Healthcare not paying." The test costs about \$ 20.

On my way out, I stop at Dr. C's office. Oops. Dr. C forgot to mention that she was going on pregnancy leave. Linda will call.

Nov. 20. No call yet. When I finally reach Linda, she says my test results are normal. But even in HMO-land, should I accept a diagnosis from the receptionist? I ask for the doctor replacing Dr. C. Linda says Dr. J will call.

Nov. 24. Still no call. I leave Dr. J a message about the blood test and the fainting incident, which worries me.

Nov. 25. Success again! I hear from Dr. J. He found that I'm slightly anemic and says he's sorry for what I've been through.

I'm comforted. But the episode has taken 4 1/2 months. What if the blood test had shown I was really sick? What if I couldn't have taken hours off work to pursue an answer? What if I needed help to get around?

I tell my story to Dr. Arthur Leibowitz, chief medical officer for Aetna U.S. Healthcare. He calls my struggle a failure of the medical system, not of his company's "access to care." He explains how U.S. Healthcare monitors its doctors for quality.

I ask Leibowitz what he thinks I should have done. He says: (1) Call your doctor (was he listening to how hard I tried?); (2) Switch to yet another doctor (and delay my blood test even more?); (3) Call U.S. Healthcare for help.

That same day, in fact, I had called about a billing problem. I was transferred four times, then told the computer system was down. "We want to offer the best possible service," Leibowitz said.

LANGUAGE: ENGLISH

LOAD-DATE: December 07, 1997



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LEVEL 1 - 72 OF 222 STORIES

Copyright 1998 Newsday, Inc.  
Newsday (New York, NY)

February 4, 1998, Wednesday, QUEENS EDITION

SECTION: NEWS; Page A06

LENGTH: 743 words

HEADLINE: A HEALTH PLAN TO MAKE YOU SICK

BYLINE: Ellis Henican

BODY:

In the new Jack Nicholson movie, "As Good as It Gets," the Helen Hunt character has been trying desperately to get medical care for her asthmatic 7-year-old son.

But the stingy insurance company is driving her nuts.

Finally, the mother's luck begins to change. A real doctor shows up at the family's apartment in Brooklyn, ready to treat the boy. One inch this side of a meltdown, the mother finally explodes.

"--- HMO!" she shouts in an angry barrage of vulgarities. "--- pieces of ---!"

She catches her breath and tells the doctor: "I'm sorry. Forgive me."

He shakes his head, understandingly.

"No, actually," he says, "I think that's their technical name."

When I saw the movie a few weeks ago on the Upper West Side, the audience erupted in cheers at that line. It got more response than anything else in the movie. I was clapping, too.

All of us, by now, have learned to hate an HMO.

Yesterday, the doctors of New York added their voices to Helen Hunt's. The villain this time: Oxford Health Plans, which was supposed to be the class act of the so-called managed-care world.

Managed care?

The main thing Oxford has been managing lately is the swift alienation of its patients and its docs.

Claims are being irrationally denied.



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Newsday (New York, NY), February 4, 1998

Patients aren't getting the basic answers they deserve.

And when it comes time to mail out those reimbursement checks - well, the Oxford computers always seem to be down.

Things have gotten so bad that the state Insurance Department has imposed its largest fine in history, \$3 million. The company's stock has tanked. And yesterday, the normally placid New York County Medical Society filed an extraordinary legal action, accusing Oxford of dragging its feet on \$140 million worth of unpaid bills.

And this is supposed to be best HMO around?

It wasn't hard yesterday to find New York doctors with Oxford horror stories.

"Oxford started out as the ultimate managed-care company," Dr. William Rosenblatt was saying at his office on East 79th Street. "They were going to be the best - take care of the clients best, be terrific to their doctors. Let's just say they haven't lived up to expectations."

The simplest bills, he said - bills that are already pre-approved - routinely take three to six months to be paid, when they are paid at all. Rosenblatt is out many thousands of dollars at a time, he said. And the company has been kicking back all but the most standard of claims.

"I have one patient right now," he said, "I excised a skin-cancer from her face. It was cancerous. No doubt about it. That's what the pathologist said. I submitted a bill to Oxford, according to their standards. They denied the claim."

All the HMOs say they're going to decrease costs by "managing care," he said. "Instead, they've decreased cost by not providing service - and by not paying for the service they do provide."

One physician yesterday, East Side internist Margaret Lewin, said she had gotten so disgusted with Oxford she had 'dropped out, sending nearly a thousand patients off in search of other care.

"It got to the point in August that I couldn't handle the losses," she said. "It was really heartbreaking, saying good-bye to so many patients."

Now, hold on a second here, docs.

I usually don't pay much attention when physicians start to complain about their pay. Even in a bad year, most New York doctors do pretty well.

Heck, I know some deli clerks who'd be pleased to trade salaries with them.

But after a couple of hours of talking to the doctors around here, I'm convinced their complaints are legit. And I'm just as convinced that, eventually, the patients are the ones who will really feel the pain.

Let me personalize this for a moment, if I may.



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Newsday (New York, NY), February 4, 1998

I'm on Oxford insurance at work. I'd like to tell you how the company has been treating me. Unfortunately - unfortunately for the column, that is, not for my life - I really haven't gotten sick much since joining.

So I'll have to rely on the things I'm hearing this week. What I'm hearing is that the next time I go to the doctor and pull out my Oxford card, he doesn't expect not to get paid for months and months.

This will not cheer him, I am sure.

But I want my doctor as focused and happy as can be. An unpaid doctor is not the doctor I want.

I want him grateful to be treating me.

As the Helen Hunt character says in that new Nicholson film: "--- HMO! --- pieces of ---!"

GRAPHIC: Photo by Ralph Nelson - Helen Hunt, in As Good as It Gets, had wise words for the rest of us about HMOs.

LANGUAGE: English

LOAD-DATE: February 4, 1998



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Copyright 1998 The Buffalo News  
The Buffalo News

March 6, 1998, Friday, CITY EDITION

SECTION: LOCAL, Pg. 1C

LENGTH: 627 words

HEADLINE: SESSION AIRS PROBLEMS WITH MANAGED CARE

BYLINE: ANTHONY CARDINALE; News Staff Reporter

BODY:

Several physicians and patients shared horror stories Thursday evening about how the "managed care" promised by health-maintenance organizations has degenerated into mere "managed cost."

Two dozen health-care professionals and patients took turns addressing 200 people in St. Thomas Aquinas Church in South Buffalo.

"What's on the horizon is going to be much worse," said Dr. Franklin Zepowitz, president of the Erie County Medical Society.

"The big problem is that the HMOs are unable to meet their expenses, and they're not increasing their premiums," he said. "Instead, they're ratcheting down what doctors get, what health-care professionals get and what hospitals get."

Zepowitz said his 1,700-member organization wants an outside grievance procedure.

"When care is denied, when physicians are deselected, you can't have the managed-care organization itself be the attorneys, the prosecutor, the judge, the jury and making the final decision," he said.

HMOs are here to stay, Zepowitz said, but "we have got to force safeguards that will protect the population and everyone involved in the health-care system.

"We ought to change the nomenclature. It's not managed care -- it's managed cost," he said.

Dr. Deborah Richter, a leader of the Ad Hoc Committee to Defend Health Care, which held the hearing, set the theme with an opening statement:

"Too many people can't get the health care they need. The insurance companies make many of the decisions regarding patient care, and many of them are wrong. Patients are sicker when they're discharged from the hospital than they used to be. Hospitals are merging and laying off essential employees."

Many physicians complained that HMO employees, in effect, are practicing



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medicine by second-guessing the doctors.

"I'm board-certified as a pediatrician," said Dr. Jack Coyle of Mercy Hospital. "My diagnosis shouldn't be turned over to a secretary or to an institution that's there for profit."

Dr. Richter was followed to the microphone by several patients:

Retired autoworker Max Berman said that when he came down with cellulitis, inflammation

of the connective tissue, last fall, his doctor had to struggle to get him into a hospital against his HMO's wishes. He stayed a week.

Patricia DeVinney, executive vice president of Nurses United, read a statement from Roxena Weaver, who said she fell on ice last November and, in addition to injuring her leg, couldn't open her right eye. But she was sent home from the emergency room without treatment for what turned out to be a head injury.

Dr. Peter Purcell, a pediatric dentist, said he sees many poor "kids with a mouthful of rotten teeth" and prefers to work on them under sedation in a hospital. But HMOs have stopped covering treatment outside his office.

"What they're basically saying to these kid is, 'Too bad -- guess you shouldn't have let it happen.' "

Responding to issues raised by patients, William D. Pike, president of the Western New York Healthcare Association, blamed "reduced government and health insurer payments" and medical advances that make possible more outpatient and home care.

"Health systems are developing to allow for shared services and reduced duplication in a constrained reimbursement environment," he said. "Such systems development is the result of outstanding hospital board and executive leadership -- in the interest of preserving access to high-quality, cost-effective health-care services . . . not to generate profits and dividends."

Since deregulation last year, Pike said, Western New York hospital payments are the lowest in the state. Average monthly premiums per HMO member ranged from \$ 94 to \$ 102 here, he said, compared with a state average of \$ 135.

GRAPHIC: Dr. Jack Coyle of Mercy Hospital tells Thursday night's hearing that health insurance organizations are dictating care.

LANGUAGE: ENGLISH

LOAD-DATE: March 8, 1998



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Copyright 1998 Newsday, Inc.  
Newsday (New York, NY)

March 17, 1998, Tuesday, NASSAU AND SUFFOLK EDITION

SECTION: NEWS; Page A06

LENGTH: 655 words

HEADLINE: JURY AWARDS \$4M IN DEATH / VERDICT: DOCTORS FAILED GIRL, 15

BYLINE: Carol Eisenberg. STAFF WRITER

BODY:

Until the summer of 1991, Haquifa Johnson was a bright, sociable 15-year-old who loved to hang with her friends, ride her bike and write short stories.

After she began complaining of chronic stomach and back pain and vomiting, her mother took her to see a doctor at a Health Insurance Plan of Greater New York clinic in Hempstead. Kenyah Abdul-Aziz said she took her daughter there three times that summer, and three times, doctors sent her away without answers - or a referral to a kidney specialist, although blood tests showed dangerous abnormalities that are often a red flag for kidney disease.

*No specialist*  
By the last visit, the teen was so ill, she had trouble walking, a racing heartbeat and a butterfly rash that is a telltale sign of lupus, an autoimmune disease that may attack the kidneys and can be fatal if left untreated. Several weeks after that visit, Haquifa was dead of coronary-respiratory arrest due to acute kidney failure.

Friday, after a two-week trial in State Supreme Court in Mineola, a jury awarded \$4 million to her parents, more than double the sum their attorney had requested, from the Queens-Long Island Medical Group, which employs the doctors under contract with HIP. The jury found the doctors failed to correctly diagnose and treat Haquifa for lupus, in which the body attacks itself as if it were a foreign invader. The disease is chronic and incurable, but is generally not fatal if treated appropriately.

An attorney for the physicians group said it was appealing the decision and declined to comment on the case. A spokesman for HIP also declined to comment. The plaintiffs originally included HIP in the suit but dropped the HMO because under New York court precedents, insurers cannot be held liable for medical decisions.

Although HIP was not a defendant, the Woodbury attorney who represented Haquifa's parents described the case as "a classic HMO horror story."

"They did blood tests on Haquifa initially that showed her kidneys were failing," said the attorney, Michael Aronoff. "But they saw her two more times and never referred her to a nephrologist kidney specialist or for the



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Newsday (New York, NY), March 17, 1998

appropriate followup tests.

"The family doctors who are gatekeepers are told, You don't spend any money unless it's absolutely essential.' Taking a verdict of \$4 million every now and then is cheaper than spending the money on appropriate care upfront."

When Haquifa was first brought to the Hempstead HIP center on July 2, 1991, Dr. Patricia Webley-Bethune listed a number of possible causes for her symptoms, including a collagen vascular disease such as lupus, according to Aronoff.

But the doctor did not order the test used to confirm lupus or follow up appropriately when blood tests came back July 13 showing 19 abnormalities, including a dangerously high level of toxins in the blood that may be a sign of imminent kidney failure, he said.

She was on vacation then, but another doctor telephoned Abdul-Aziz and suggested she have the blood work on her daughter redone, Aronoff said. But no urgency was indicated, according to family members. In fact, Webley-Bethune did not order the tests redone until the third visit, in late August.

Two weeks after her last HIP visit, on Sept. 8, Haquifa was rushed to the emergency room at Mercy Medical Center coughing up blood. There, she was diagnosed with lupus, but her kidneys were so badly damaged that she could not be saved, Aronoff said. She died Sept. 23.

Haquifa's parents said they brought the lawsuit to hold the HMO and its doctors accountable "in the hopes that this wouldn't happen to someone else's child," said her father, Ralph Johnson. After the \$4-million award was announced Friday, Johnson said he drove out to Pinelawn Memorial Park, where Haquifa is buried. "You can never bring Haquifa back," he said. "But I brought her a bouquet of flowers and told her we stood up and fought, and we won."

GRAPHIC: Photo - Haquifa Johnson

LANGUAGE: English

LOAD-DATE: March 17, 1998



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April 13, 1998

SECTION: LAW &amp; JUSTICE; Pg. 19

LENGTH: 227 words

HEADLINE: Parents Of Dead N.Y. Teen Awarded \$ 4 Million In Malpractice Lawsuit

BODY:

A jury in Mineola, NY, recently awarded the parents of a 15-year-old girl \$ 4 million after the teen died when doctors failed to correctly diagnose her illness.

Haquifa Johnson died of coronary-respiratory arrest due to acute kidney failure. A jury found that doctors failed to correctly diagnose and treat the teen for lupus, an autoimmune illness in which the body attacks itself as if it were a foreign invader. Lupus can attack the kidneys. Generally the disease is not fatal if treated appropriately.

Kenyah Abdul-Aziz, Johnson's mother, said that she had taken her daughter to see a doctor at a Health Insurance Plan (HIP) of Greater New York clinic in Hempstead, NY, three times. And, all three times, doctors sent her away without answers or a referral to a kidney specialist though blood tests showed dangerous abnormalities that are often a red flag of kidney disease.

By Johnson's last visit, she had trouble walking, a racing heartbeat and a butterfly rash, which is a telltale sign of lupus.

The jury awarded \$ 4 million to Johnson's parents. The settlement was more than double the sum that their attorney had requested from the Queens-Long Island Medical Group, which employs the doctors under contract with HIP.

Michael Aronoff, the attorney for Johnson's parents, described the case to Newsday as "a classic HMO horror story."

LANGUAGE: ENGLISH

LOAD-DATE: April 13, 1998



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Copyright 1998 Tower Media, Inc.  
The Daily News of Los Angeles

May 2, 1998, Saturday, VALLEY EDITION

SECTION: NEWS, Pg. N1

LENGTH: 681 words

HEADLINE: FREEWAY DEATH COULD GALVANIZE RESENTMENT OF HMOS

BYLINE: Paul Hefner Daily News Sacramento Bureau

BODY:

The horrific, televised suicide of an HIV-infected man angry with his HMO has become a stark, new symbol of frustration with California's health care industry, patient advocates said Friday.

Taking his own life on a Los Angeles freeway Thursday after unfurling a banner that read 'HMOs are in it for the money,' Daniel Jones has hit a nerve with the public - regardless of whether his claims were justified.

State regulators receive from 5,000 to 7,000 complaints a month from HMO patients, although Jones was never one of them.

'I think people have had horrific experiences with HMO bureaucrats. This touched a note,' said Jamie Court, director of the watchdog group Consumers for Quality Care.

'If this is a genuine medical horror story, then we are talking about a symbol of the frustration that too many Americans feel with HMO penny-pinching,' Court said.

The death of the 40-year-old Long Beach man came at the same time that state officials are debating proposals to better regulate California's managed care industry. There are dozens of bills in the Legislature, most of them focused on giving patients more rights.

Many officials didn't want to speculate how such a macabre incident might affect those deliberations.

But others said the tragedy might strengthen the hand of groups pushing to expand patients' rights, which some say have taken a back seat to keeping down the cost of health care.

'I can only liken this to a pendulum. Maybe the pendulum has swung too far,' said Craig Thompson, executive director of AIDS Project Los Angeles. 'This situation in L.A. may help spur some of those reforms getting passed in Sacramento this year.'

Friends and relatives of Jones claimed that his HMO had transposed his records with another patient's and allowed a physician's assistant to oversee



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his care. His sister said Jones once went to his HMO with flu-like conditions and was sent home, only to find his appendix had burst.

"I believe my brother was killed by an HMO," his sister, Janet Jones, told The Associated Press.

A friend of Jones who asked not to be named said Jones had complained that his treatment for HIV consisted mostly of antidepressant medications.

"He was of the opinion that since the HMO knew that he had AIDS they would just let him die," said the friend. "They just gave him wads of Prozac. That's why he did what he did. I understand it fully. I told him you've got to put this in a little perspective and (write) a statement. My God, this is the statement he made."

Jones never reported his complaints to the state Department of Corporations, which oversees HMOs. Though the department receives up to 7,000 complaints a month about managed care providers, Jones was not in the agency's database, a spokeswoman said.

Industry officials expressed sadness over Jones' death, but said it remains to be seen whether there was any wrongdoing by his health care plan. Exactly which HMO he belonged to could not be determined.

"We feel horribly for the family. We feel horribly for him. But we don't know anything that was going on with his care, we don't know that anything was going wrong," said Maureen O'Haren, executive vice president of the California Association of Health Plans.

She insisted that HMOs treat people with AIDS appropriately. "There was a lot of hope for this man," O'Haren said. "It's sad that he chose to end his own life."

Also Friday, Gov. Pete Wilson announced plans to create a new Department of Managed Care to oversee the industry. The plan must be studied by a state panel and considered by the Legislature before going into effect.

Administration officials said the announcement had nothing to do with Jones' death.

To lodge complaints against an HMO, call (800) 400-0815.

#### TV RATINGS UP

The televised suicide drew more than 1 million households to tune in local broadcast television stations between 3:45 p.m. and 4 p.m. Thursday. That was 130,239.2 more households than during the same period last week, according to Nielsen Media Research.

#### NOTES:

Related Story: TV stations considering changes in live coverage.

GRAPHIC: Photo, Box;



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The Daily News of Los Angeles, May 2, 1998

PHOTO: (Color) JONES;  
BOX: TV RATINGS UP (see text)

LANGUAGE: ENGLISH

LOAD-DATE: May 8, 1998



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The State Journal-Register (Springfield, IL)

October 23, 1997, Tuesday, EARLY AND CITY EDITIONS

SECTION: NEWS, Pg. 14

LENGTH: 661 words

HEADLINE: Managed care hearings end with HMO horror stories Lawmakers urged to adopt reform act

BYLINE: PAUL KRAWZAK COPLEY NEWS SERVICE

DATELINE: CHICAGO

BODY:

Emergency room physician Cai Glushak poignantly recalls the woman who came in bleeding profusely in connection with her pregnancy.

The woman, suspecting her condition might need immediate attention, had gone straight to nearby University of Chicago Hospital, where Glushak practices, even though her health maintenance organization had directed her to a more distant facility that was part of its network.

Glushak, discovering she was in the middle of a miscarriage, rushed her to the operating room "and that saved her life," he told the Illinois Senate Subcommittee on Managed Care Wednesday.

Glushak cited the incident as an example of how HMO rules designed to hold down medical costs can cost lives.

If the woman had gone the extra distance to the HMO hospital, if she had not instead disobeyed the HMO instructions, she might be dead, he contended.

Glushak said he later called the woman's HMO physician who "simply said, 'You know, you can never trust what these females tell you over the phone.'"

And though he was shocked by the statement, Glushak admitted there's truth in it.

"I agree with him. You can't figure out from what a lay person tells you over the phone, many times," he said. "Imagine taking these calls day after day and trying to sort it out."

Yet rules of some HMOs, requiring approval before seeking help from a non-network provider, cause patients to delay treatment, sometimes costing their lives, he said.

Glushak argued there's a need for legislation to protect people who seek emergency medical care without the preapproval of their HMO.



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Wednesday's hearing was the fifth and last in a scheduled series held by the subcommittee to seek input on managed care, but Sen. Thomas Walsh, R-LaGrange Park, said he plans to schedule another hearing next month and several more next year.

Walsh said the HMO horror stories suggest areas where the state can enact laws to improve managed care, but he maintains that it is succeeding in holding down medical costs in Illinois and is here to stay.

Of the dozens of health-care providers, public-interest organizations and others who testified Wednesday, many pushed for the legislature to adopt the managed-care reform act, designed to protect HMO patients.

The bill, which passed the House last spring but has been bottled up in committee in the Senate, would strengthen the right of patients to appeal HMO decisions, tap the state health department to oversee managed-care plans, and protect health-care providers from HMO sanctions when they advocate treatment that HMOs don't want to pay for.

Judith Weinstein, associate director of the Health and Medicine Policy Research Group, described the bill as one of the best health reform plans in the nation, adding that all of its elements have been adopted in some form in other states.

"If you are against this bill, you are against the consumer. You are against individuals receiving appropriate care . . . You are anti-human," she declared.

Walsh favors parts of the plan, introduced by Democratic Rep. Mary Flowers of Chicago and Republican Sen. Dan Cronin of Elmhurst, but he worries that the bill as a whole would raise the cost of providing health insurance and cause some employers to drop coverage of their employees.

Advocates of the bill are pressing for Senate President James "Pate" Philip, R-Wood Dale, to allow it to be heard by the full Senate when the veto session starts next week. They also are asking for the legislature to pass health-care legislation before the year ends.

Walsh doubts the plan will get a full hearing before the Senate, but he said portions of it are likely to show up in legislation he will draft for consideration next year.

Walsh also is skeptical the legislature will pass a health-care bill this fall.

Many public interest and consumer groups support the bill, which faces opposition from the managed-care industry and business organizations.

TYPE: NEWS

LOAD-DATE: October 24, 1997



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Copyright 1997 Boston Herald Inc.  
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April 8, 1997 Tuesday THIRD EDITION

SECTION: NEWS; Pg. 011

LENGTH: 214 words

HEADLINE: Legislative panel hears about ups and downs of HMO care

BYLINE: By MICHAEL LASALANDRA

BODY:

Critics told a legislative hearing yesterday that **HMOs** have gone too far in their bid to control health-care costs.

Patients, doctors and other caregivers lined up to recount **horror stories** to a legislative panel that has filed a bill that seeks to ensure that consumers get good managed care.

Dr. Linda Buchwald, a neurologist at Mount Auburn Hospital in Cambridge, said she was dropped by an HMO after she appealed its denial of care on behalf of one of her patients.

Buchwald said the case in question involved a 40-year-old man who was sent home from the hospital the day after he emerged from a coma.

"I said the only way he could go home is if he got home health care," she said. "They denied it. So I appealed it. Then, they dropped me."

The bill would set minimum stays for all hospital procedures, require HMOs to pay for all emergency room care and force the health plans to disclose how they pay doctors.

It also allows the state to hear consumer appeals of care that had been denied and requires the state to issue HMO report cards.

Although there was plenty of support for the bill, there were also lots of patients who testified that they are pleased with their HMOs.

"My HMO saved my life at least three times," said Arthur Stevenson, 58, of Everett.

LOAD-DATE: April 08, 1997



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Las Vegas Review-Journal (Las Vegas, NV)

March 27, 1997 Thursday, FINAL EDITION

SECTION: B; Pg. 8B

LENGTH: 519 words

HEADLINE: Medical horror stories

BODY:

Piling regulations on the HMOs.

Virtually the entire Nevada Assembly has signed on to Assembly Bill 156, legislation spearheaded by Barbara Buckley, D-Las Vegas, which would impose additional state regulations on managed care organizations. The bill, among other things: mandates that doctors or nurses \_ not clerks \_ make decisions to deny coverage; prohibits the paying of bonuses or other financial incentives as an inducement to deny necessary treatment; spells out the time frame in which managed care organizations must respond to requests for emergency treatment; and bans so-called gag orders that prohibit doctors from discussing procedures the organization may not cover. Last month, in front of the Assembly Committee on Health and Human Services, more than two dozen people recounted their health-care horror stories, placing the blame on Nevada managed care operators. One woman accused an HMO of killing her mother. Another complained that her managed care provider wasn't fulfilling its obligation to treat her child, who was afflicted with cystic fibrosis. The heartfelt and emotional testimony no doubt left an impression on committee members. But when it comes to matters of life and death, sickness and health, reason often suffers at the hands of compassion. A more detailed look at the complaints would have turned up facts that cast the issue in a different light. And missing from the hearing was any discussion of precisely how AB156 would address the concerns raised in the testimony. Some provisions in AB156 make sense, even if they are redundant. Protecting whistle-blowers could help expose real abuses, and provisions against gag orders and clerks denying coverage appeal to just about everyone, regardless of the fact that no Nevada managed care organizations impose gag orders and that doctors already are charged with making ultimate decisions about coverage. More troubling, though, are the bill's prohibitions against financial incentives, a tool which provides a means to reward those who control costs. The notion that such incentives push doctors to withhold necessary care in the name of inflating the bottom line doesn't wash, especially given that federal law already mandates these organizations provide member patients with a fair grievance process to appeal decisions. Certainly, the burgeoning growth of managed care organizations has triggered discomfort for some patients and doctors who are unfamiliar with the parameters of individual policies and unaccustomed to additional checks on treatment decisions. But HMOs have been partially responsible for helping slow the rapid increase in health-care costs which prompted considerable consternation just a few years ago. It would be unwise to construct a regulatory apparatus that contributes to reversing that trend. This bill \_ though well-intentioned \_ may indeed do just that by creating regulations in response to anecdotal accounts that may or may not have



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wide validity. While AB156 will likely sail through the Assembly, we hope the state Senate takes a more sober look.

LANGUAGE: ENGLISH

LOAD-DATE: March 28, 1997



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July 20, 1998

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## **HMO Denies Hospital Care For Aneurysm, Then Rehabilitation Costs**

"I was at the lowest point in my life,  
and the insurance companies kicked me in the back."



**Stephanie Ulrich  
Baltimore, MD**

My name is Stephanie Ulrich. I am a 23-year-old graduate student at Southwest Texas State University. I am a teaching assistant and on Jan 26, 1998, I fainted in front of a freshmen survey class. All I remember is waking up in the hospital scared to death. At the hospital, the staff did a CAT scan. The test revealed that I had a basilar artery aneurysm. The hospital discharged me because they did not have "the expertise to look at the films." So I went home. That night I called my aunt in Maryland and she told me to Fed Ex the films to her, so a neurosurgeon could read them. By Thursday, 3 days later, I was on a plane to Washington.

At the hospital in Washington, my aunt tried to get approval from my HMO, but they denied her plea. They called my primary care physician in Texas for a referral for an angiogram that would confirm an aneurysm. He would not issue the referral because he said he was not informed about my hospitalization. However, my aunt and I called his office the day I fainted and informed a member of his staff. Because I was outside my network and my primary care doctor would not issue a referral, my HMO would not okay my admission to the hospital or the angiogram.

However, I had a second insurance because

of my mother's job. Her HMO approved my angiogram. This test revealed that I needed immediate brain surgery. I had the surgery that following day, Friday Jan. 29, and spent three weeks in intensive care. Because I was hospitalized and could not work, Southwest Texas was forced to terminate my position and my HMO dropped me because I was not working.

The doctors at the hospital wanted me to be transferred to the National Rehabilitation Hospital (NRH) at the end of February. The therapists would help me to relearn how to feed myself, tie my shoes, and even walk. My mother's HMO refused to pay the NRH, because they wanted to send me to a nursing home. They wanted to put me, a 22 year old, in a nursing home, because they said that I could not be rehabilitated. They said I was not going to get better. Look at me. I am walking and talking now. I could not do that at the hospital in Washington.

I was discharged from the rehabilitation hospital on April 25. On Monday, April 27, I started a five-day a week, 7 hours a day rehabilitation program. I was in that program for 10 weeks and I am currently doing outpatient therapy twice a week. My mother's HMO has not paid a dime to the rehabilitation hospital, because they feel I am not rehabilitatable. Because of ERISA, I cannot sue my mother's HMO for damages. They are not accountable for their actions.

Throughout this whole illness, it has been an uphill battle with the insurance companies. I was at the lowest point in my life, and the insurance companies kicked me in the back. They had no right to do what they did to me and I pray this will not happen to anyone else. The last thing anyone should worry about is who is going to pay their hospital bills. They should concentrate on getting better and not on fighting the insurance companies. Without the help of my family and friends, I may be dead. I thank them for fighting with the insurance companies and therefore getting me better.

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

July 21, 1998

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## Homecoming King Suffers Neck Injury HMO Quickly Releases And Denies Home Care



**Nick Enriquez  
Glendora, CA**

*As told by mother Mary Enriquez:*

Nick Enriquez was injured in a diving accident on August 13, 1996. Nick's injury was a breakage in the 4th cervical bone in his neck with an injury to his spinal column. Nick had a blood clot in the center of the spinal column and was put in a "halo" to stabilize his neck. The neurosurgeon thought it would be best to wait for surgery so that Nick could maximize his recovery; therefore Nick was transferred to a new HMO hospital. This was done so that Nick could receive therapy in order to maximize his recovery prior to surgery.

Nick was initially covered by an HMO through his father's employer. The plan was an in-patient hospitalization only plan by the HMO, and the outpatient portion was self funded by his employer. Since it was hospitalization only, they were trying to get him out of the hospital even before he had surgery! On the day of the surgery, the therapists at the HMO hospital wanted Nick to make a "home visit" in preparation for coming home!

The neurosurgeon was furious, as he didn't want Nick transported by any way other than ambulance. He had told the HMO, due to the severity of the break, once he had done surgery it would take 8 to 9 months for the neck to fuse. The neurosurgeon wrote many letters to the HMO stating specific reasons why it would be very dangerous for Nick to be released prior to the fusion of his neck. From then on we had to fight.

On February 10, 1997, the HMO's medical director called the neurosurgeon's office and asked him to sign release papers. The neurosurgeon refused, and said by releasing him early he was putting him in mortal danger.

and that it was morally wrong, as Nick could not be transported to therapy, which could be crucial to his recovery.

We contacted several lawyers, however, we could not do anything, unless we had a "corpse". Nick was released in a very medically unstable condition. He was having severe bouts with Autonomic Dysreflexia, had a urinary tract infection and was not doing well.

I added Nick to my HMO plan in order to cover him for benefits not covered through his father's plan. Nick came down with a very serious urinary tract infection, to which he had to be given the medication through an intravenous method.

In February 1998, Nick's case was transferred to another HMO hospital. The reasoning is due to contacts and other bureaucratic reasons. We were immediately in trouble. We had a meeting with the social worker. The meeting went very badly, as they told me all my nursing was to be cut. They would give a companion for Nick, but they would only be there for 3 hours and could not take care of his personal needs. They said if I wanted to I could hire someone which, since I had lost my job, was impossible. And how could I go look for a job, if I had to totally take care of Nick?

The community was in the process of raising funds for my son, for a van, because Nick had a full scholarship to USC in the fall. The HMO management, during the meeting, told me to use the money from the van to pay for Nick's nursing. At the same time they told me that it needed to be set up in a trust, and worded in such a way that it not be used for medical things that MediCal would pay for, so as not to prevent him from getting MediCal.

Since the change of hospitals, they are cutting out his catheters, which have kept him safe, and want him to use another method. The new device can cause more infections, but it is "cheaper". One ironic thing is that the HMO hospital donated \$1000 to Nick's fund, however, is refusing to cover any of the necessary things that he requires. Because Nick's healthcare comes from a private employer, we are unable to recover damages from the HMO. They put Nick's recovery in great risk when they released him in a medically unstable condition, yet they cannot be held accountable for their decision, because of the ERISA loophole.

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

July 22, 1998

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## **HMO Denies Chemotherapy Treatment Patient Forced To Seek Coverage In Sweden**

### **Christina MacPherson**

Christina MacPherson, a mother of three young children and the owner of a small children's clothing store, was diagnosed with multiple myeloma (a form of cancer) in May 1994. Doctors from UCLA, City of Hope, Norris Cancer Center and Fred Hutchinson Cancer Institute recommended that she undergo high-dose chemotherapy.

When authorization for the high-dose chemotherapy was sought from Christina's medical insurer, however, coverage was denied on the purported basis that the treatment was classified as "experimental" and "investigational." No alternative treatments were recommended or offered by Christina's HMO.

Because of the refusal to cover Christina's treatment, it was delayed. She could not afford to personally fund the cost of the treatment herself. However, since Christina was a dual citizen of the United States and Sweden, she was eligible for coverage under Sweden's national health care program. At considerable cost, Christina relocated her entire family to Sweden to avail herself of high-dose chemotherapy in Sweden.

In Sweden, Christina was administered high-dose chemotherapy

supported by her own bone marrow. When that treatment failed, she underwent a second round of high-dose chemotherapy, supported by marrow from a donor. The cost of the treatment in Sweden was just over \$50,000. Had the treatment been rendered in the Los Angeles area where Christina lived, it is estimated that the cost of the treatment would have been more than \$200,000.

Only after Christina's treatment in Sweden had already begun, did the HMO reverse its position and allow coverage for the high dose chemotherapy with autologous bone marrow transplant. The HMO agreed to cover the substantially lower cost of the actual medical treatment in Sweden, but ignored and refused to cover any of the substantial costs involved in Christina's relocation to Sweden, which was necessitated in order to obtain such treatment.

The Courts likewise have refused to enforce Christina's right to reimbursement for relocation expenses. Because Christina received her healthcare through her job, her recovery was limited by the ERISA loophole.

# ERISA Casualty Of The Day

July 24, 1998

# Consumers for Quality Care

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## Injured At Work, HMO Employee Endures Delay In Diagnosis, Opposition To Rehabilitation, Job Loss



**Paul Stutrud**  
Rohnert Park, CA

In the mid-1940s my father came to California to work in the shipyards. He enrolled his family in an HMO. When I got married and had kids, we raised our family in the HMO, too. I never dreamed that years later I would be employed by the HMO's Construction Services Department at the very same hospital whose halls I walked as a kid. For all those years we had pleasant experiences with our HMO, although sometimes the circumstances that brought us there were not. My father's heart attack. My sister's automobile accident. We were always impressed with the quality of care.

When I had the opportunity to transfer out of construction services into engineering with a position at another of the HMO's hospitals, I was very happy. By this time I was in my early 50's and tired of the ups and downs of working construction. I expected to retire from this job. That expectation was suddenly terminated, just as I was, when I was injured on the job. The accident happened the last weekend of 1990 as I was unloading nitrogen cylinders by myself from the back of a pickup truck. I was working alone, a safety issue that had come up a number of times.

The injury I suffered was a herniated disc. I didn't find this out until three months after the accident and had been seen by five different HMO doctors over that same period of time. No x-rays were taken until the last doctor I saw ordered them. The fact that the pain would not go away didn't seem to register with the other HMO doctors, who would each write a prescription for a different pain medication and tell me to take a few more weeks off work.

I spent most of 1991 going through the Workers Comp system and was declared "permanent and stationary" in October, 1991, and thus "qualified" for vocational rehabilitation. I started the rehabilitation school in January, 1992. The school was a "mill" without the required state accreditation. The state ordered a full refund of the tuition, but the HMO refused to co-sign. My HMO refused to allow me to finish my vocational rehabilitation. Seven years later I am still unemployable and without medical or dental coverage and no income. The workers compensation settlement for my back injury was used to pay a portion of my rehabilitation maintenance allowance. When the money was gone, my HMO pulled the plug on my workers comp.

I would have preferred to continue my employment as an engineer. My superintendent insisted that I could not return until I was 100% capable of performing my duties. A year after my injury, I was fired, retroactively to a date a month after my injury.

Because my former employer, my HMO, supplied my healthcare, I have no means to recover damages against the HMO for their delay in care and opposition to rehabilitation, due to the federal ERISA law loophole. Even though my employer and HMO were the same entity, and I was injured at work, I still have no means of holding them accountable.

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

# The New York Times

SATURDAY, JULY 11, 1998

## Hands Tied, Judges Rue Law That Limits H.M.O. Liability

By ROBERT PEAR

WASHINGTON, July 10 — Federal judges around the country, frustrated by cases in which patients denied medical benefits have no right to sue, are urging Congress to consider changes in a 1974 law that protects insurance companies and health maintenance organizations against legal attacks.

In their decisions, the judges do not offer detailed solutions of the type being pushed in Congress by Democrats and some Republicans. But they say their hands are tied by the 1974 law, the Employee Retirement Income Security Act. And they often lament the results, saying the law has not kept pace with changes in health care and the workplace.

The law, known as Erisa, was adopted mainly because of Congressional concern that corrupt, incompetent pension managers were looting or squandering the money entrusted to them. The law, which also governs health plans covering 125 million Americans, sets stringent standards of conduct for the people who run such plans, but severely limits the remedies available to workers.

In a lawsuit challenging the denial of benefits, a person in an employer-sponsored health plan may recover the benefits in question and can get an injunction clarifying the right to future benefits. But judges have repeatedly held that the law does not

allow compensation for lost wages, death or disability, pain and suffering, emotional distress or other harm that a patient suffers as a result of the improper denial of care.

Congress wanted to encourage employers to provide benefits to workers and therefore established uniform Federal standards, so pension and health plans would not have to comply with a multitude of conflicting state laws and regulations.

The United States Court of Appeals for the Fifth Circuit, in New Orleans, reached a typical conclusion in a lawsuit by a Louisiana woman whose fetus died after an insurance company refused to approve her hospitalization for a high-risk pregnancy. The woman, Florence B. Corcoran, and her husband sought damages under state law.

In dismissing the suit, the court said, "The Corcorans have no remedy, state or Federal, for what may have been a serious mistake."

The court said that the harsh result "would seem to warrant a re-evaluation of Erisa so that it can continue to serve its noble purpose of safeguarding the interests of employees."

In another case, Judge William G. Young of the Federal District Court in Boston said, "It is deeply troubling that, in the health insurance context,

Continued on Page A7

Continued From Page A1

Erisa has evolved into a shield of immunity which thwarts the legitimate claims of the very people it was designed to protect."

Judge Young said he was distressed by "the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry," leaving many consumers "without any remedy" for the wrongful denial of health benefits.

Disputes over benefits have become common as more employers provide coverage to workers through H.M.O.'s and other types of managed care, which try to rein in costs by controlling the use of services.

Here are some examples of the ways in which judges have expressed concern:

¶ Judge John C. Porfilio of the United States Court of Appeals for the 10th Circuit, in Denver, said he was "moved by the tragic circumstances" of a woman with leukemia who died after her H.M.O. refused approval for a bone marrow transplant. But, he said, the 1974 law "gives us no choice," and the woman's husband, who had sued for damages, is "left without a remedy."

¶ The United States Court of Appeals for the Eighth Circuit, in St. Louis, said the law protected an H.M.O. against a suit by the family of a Missouri man, Buddy Kuhl, who died after being denied approval for heart surgery recommended by his doctors. "Modification of Erisa in light of questionable modern insurance practices must be the job of Congress, not the courts," said Judge C. Arlen Beam.

¶ The United States Court of Appeals for the Sixth Circuit, in Cincinnati, said that Federal law barred claims against a "utilization review" company that refused to approve psychiatric care for a man who later

# The New York Times

committed suicide. Because of Erisa, the court said, people who sue an H.M.O. or an insurer for wrongful death "may be left without a meaningful remedy."

¶Federal District Judge Nathaniel M. Gorton, in Worcester, Mass., said that the husband of a woman who died of breast cancer was "left without any meaningful remedy" against an H.M.O. that had refused to authorize treatment.

¶Federal District Judge Marvin J. Garbis, in Baltimore, acknowledged that a Maryland man may be left "without an adequate remedy" for damages caused by his H.M.O.'s refusal to pay for eye surgery and other necessary treatments. But, Judge Garbis said, whether Erisa should be "re-examined" and reformed in light of modern health care is an issue which must be addressed and resolved by the legislature rather than the courts.

¶The United States Court of Appeals for the Ninth Circuit, in San Francisco, ruled last month that an insurance company did not have to surrender the money it saved by denying care to a Seattle woman, Rhonda Bast, who later died of breast cancer.

"This case presents a tragic set of facts," Judge David R. Thompson said. But "without action by Congress, there is nothing we can do to help the Basts and others who may find themselves in this same unfortunate situation."

Democrats and some Republicans in Congress are pushing legislation that would make it easier for patients to sue H.M.O.'s and insurance companies. If a doctor makes a

Proposals to regulate managed care have become an issue in this year's elections, and the hottest question of all is whether patients should be able to sue their H.M.O.'s. The denial of health benefits means something very different today from what it meant in 1974, when Erisa was passed. At that time, an insured worker would visit the doctor and then, if a claim was disallowed, haggle with the insurance company over who should pay. But now, in the era of managed care, treatment itself may be delayed or denied, and this "can lead to damages far beyond the out-of-pocket cost of the treatment at issue," Judge Young said.

H.M.O.'s have been successfully sued. A California lawyer, Mark O. Hiepler, won a multimillion-dollar jury verdict against an H.M.O. that denied a bone marrow transplant to his sister, Nelene Fox, who later died of breast cancer. But that case was unusual. Mrs. Fox was insured through a local school district, and such "governmental plans" are not generally covered by Erisa.

The primary goal of Erisa was to protect workers, and to that end the law established procedures for settling claim disputes.

Erisa supersedes any state laws that may "relate to" an employee benefit plan. Erisa does not allow damages for the improper denial or processing of claims, and judges have held that the Federal law, in effect, nullifies state laws that allow such damages.

wrong decision, he or she can be sued, said Representative Charlie Norwood, Republican of Georgia, but "H.M.O.'s are shielded from liability for their decisions by Erisa."

Changes in Erisa will not come easily. The Supreme Court has described it as "an enormously complex and detailed statute" that carefully balances many powerful competing interests. Few members of Congress understand the intricacies of the law. Insurance companies, employers and Republican leaders strenuously oppose changes, saying that any new liability for H.M.O.'s would increase the cost of employee health benefits.

Senator Trent Lott of Mississippi, the Republican leader, said today that he had agreed to schedule floor debate on legislation to regulate managed care within the next two weeks. Senator Tom Daschle of South Dakota, the Democratic leader, who had been seeking such a debate, said Mr. Lott's commitment could be "a very consequential turning point" if Democrats have a true opportunity to offer their proposals.

But Senator Don Nickles of Oklahoma, the assistant Republican leader, said, "Republicans believe that health resources should be used for patient care, not to pay trial lawyers."

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Document 2 of 4.

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USA TODAY

July 15, 1998, Wednesday, FINAL EDITION

**SECTION:** NEWS; Pg. 10A

**LENGTH:** 1123 words

**HEADLINE:** Immune from suit, HMOs crimp fearlessly on care

**BODY:**

When Phyllis Cannon's leukemia went into remission, her doctor scrambled to arrange a bone marrow transplant. Timing in such a case is critical. Once the cancer returns, the treatment is useless.

In less cost-conscious days, the transplant would have been administered with all dispatch and the story would likely have ended happily. But Cannon's health plan, Blue Lines HMO, twice rejected the treatment, claiming it was experimental. More than a month later, however, Blue Lines reversed itself. But a letter to that effect didn't reach Cannon for weeks. She died in November 1992.

A second shock was yet to come one that affects 123 million Americans. When Cannon's husband brought suit against the plan for malpractice, he was stiff-armed by the courts. Blue Lines, like every employer-financed health plan in the country enjoys special legal protection that the worst doctors would envy. No matter how bad its medicine, it is immune from punishment for malpractice. And no matter how much suffering patients endure from that bad medicine, they cannot recover a dime.

It's a privilege the managed care industry will not surrender without a fight. Tuesday, in fact, a group of managed care firms dropped their opposition to a long list of patient-protection measures awaiting action in Congress but pointedly rejected provisions to strip away the malpractice shield.

That's bad news for the many who've traveled the same unfortunate path as Cannon. Among them:

vFlorence Corcoran , whose fetus died from distress in 1989. She was suffering a high-risk pregnancy, and her doctor wanted her hospitalized so the fetus could be monitored around the clock, as had been done in a previous problem pregnancy. But United Healthcare would only cover 10 hours of at-home nursing care. The fetus died when no nurse was around.

vSteven Spain , who suffered testicular cancer in 1990 and was denied coverage for the last of three bone marrow transplants. The health plan, Aetna, later reversed its decision, but not in time to save the patient.

vFrank Wurzbacher , who was castrated in 1995 to prevent the return of prostate cancer. He took that extreme course only after Prudential Insurance mistakenly denied full coverage for an alternative, but expensive, drug treatment. Wurzbacher learned about the mix-up the day he returned from the hospital.

These outcomes are often not accidents, but the result of deliberate decisions made by health plan administrators.

Linda Peeno , a former medical director for a major managed care firm, told Congress how she routinely denied care to save money, and that once this ended in death. "I denied a man a necessary operation that would have saved his life," she said.

Yet neither Peeno nor anybody else involved in these tragedies had to answer for their mistakes or defend their actions thanks to a 24-year-old law.

In an effort to protect worker pensions, Congress passed the Employee Retirement Income Security Act in 1974. The main thrust of the bill was to override the crazy quilt of state pension laws that was eating into retirement nest eggs. But the law was written broadly, covering even employer-provided health insurance. Health plans, the law says, can't be sued for malpractice. Only doctors can.

In 1974, that didn't matter much. Patients got the care they or their doctors felt was needed and insurance for the most part paid the bills no questions asked. Today, cost-conscious managed care plans cover 86% of the workforce. No longer content to sit

idly by while the medical bills roll in, these plans set strict guidelines on medical necessity and appropriate care up front. Doctors and patients who don't follow the rules face stiff penalties.

A great cure for a health system riddled with runaway costs but one that can and does result in tragedy.

So if health plans are making medical decisions, why shouldn't they be legally accountable for their blunders, just like doctors? The managed care industry improbably insists that it isn't in the business of making medical decisions, just decisions about coverage.

Managed care companies and the larger business community also complain that exposing plans to litigation will only boost costs. And those costs will ultimately be borne by patients in the form of higher premiums or lost coverage. More likely the threat of litigation will make front-office bookkeepers as concerned with patient welfare as they are with the bottom line. Costs rise minimally, according to one recent study but patients will benefit from better care.

Despite the obvious advantages of changing the law, Congress appears more likely to appease the insurance industry than to protect the public. The Republican majority is firmly opposed, and generally paints the issue as a handout to greedy trial lawyers.

A more neutral analysis comes from judges, who in case after case have expressed frustration that the law prevents them from delivering justice. As the Corcoran judge put it, letting health plans off the litigation hook "eliminates an important check on the thousands of medical decisions routinely made. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decision making."

"Bad medical judgments," the judge continued, "end up being cost-free to the plans:"

But not, as Phyllis Cannon's survivors can attest, to the patient.

Outdated law

Since the Employee Retirement Income Security Act (ERISA) was passed back in 1974, the health care industry has changed dramatically. The law has not kept pace.

While fewer than 6 million workers were in **Health Maintenance Organizations (HMOs)** which tightly control access to treatments and specialists that year, more than 10 times that number are in **HMOs** now. Meanwhile, the once dominant fee-for-service insurance, where doctors and patients decide on treatment and insurance pays the bills, has all but evaporated.

-- In 1988, 71% of workers were enrolled in fee-for-service plans. Only 18% were in **HMOs** and 11% in Preferred Provider Organizations (PPOs), which let patients see doctors outside plan networks if the patients are willing to pay more out of pocket.

-- By 1994, only 35% of workers were in fee-for-service plans, with the rest in either **HMOs**, PPOs, or Point of Service Plans (POS), which are **HMOs** that let patients go out of network for an additional charge.

-- That trend has continued unabated. As of this year, only 14% of workers are signed up with fee-for-service. Some 30% are in **HMOs**, 34% in PPOs, and 22% in POS plans, according to industry surveys.

**GRAPHIC:** GRAPHIC, b/w, Dave Merrill, USA TODAY, Source:Henry J. Kaiser Family Foundation(Pie charts)

**LANGUAGE:** ENGLISH

**LOAD-DATE:** July 15, 1998

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Copyright 1998 The Roanoke Times & World News  
Roanoke Times & World News

April 11, 1998, Saturday, METRO EDITION

SECTION: BUSINESS, Pg. A6

LENGTH: 247 words

HEADLINE: WOMAN SUES HMO OVER TEST DENIAL  
SAYS DELAY MADE INJURY WORSE

BYLINE: SANDRA BROWN KELLY THE ROANOKE TIMES

BODY:

The test was later approved, but by then she had to have surgery, her lawsuit states.

A Floyd County woman who says the denial of a medical test by her HMO delayed treatment of her back and caused further injury has filed a \$ 50,000 suit against Trigon Insurance Co. and two of its insurance plans.

Tracey H. McDowell, who had health insurance with Trigon's Healthkeepers HMO through her place of employment, Allstate Insurance Co., injured her back June 22 and was sent to a specialist by her primary care physician, the suit states. The specialist ordered an MRI for her on June 24, but the insurance company refused to authorize the test.

Weeks later, after McDowell's condition had worsened, an MRI was approved. It was done Aug. 8. As a result, McDowell had surgery to correct a herniated disc, her lawsuit states.

The delay in treatment caused McDowell to exhaust her sick leave prior to treatment and lose income needed to pay expenses, she said. The suit alleges the refusal to authorize the MRI constituted a breach of the insurance agreement.

State law requires HMOs to have an appeal process for clients to follow when care is denied. McDowell's attorney, Kendall Clay of Radford, said his client went through the process.

The case was first filed in Roanoke District Court, and at the request of Trigon has been moved to U.S. Federal Court for the Western District. It includes Trigon's HMO Virginia Inc. and Healthkeepers Inc. as defendants.

LOAD-DATE: April 14, 1998



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HEADLINE: SOME BADLY MANAGED CARE

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BODY:

She escaped the horror of Nazi Germany as a shy teenage girl. But nothing prepared Lola Jones for this: The horror of managed-care medicine in New York.

HIP doctors at North Shore University Hospital at Forest Hills, who were treating her for a suspected ulcer, allegedly made a gut-wrenching medical mistake. Literally.

They confused the woman's laboratory slide with that of a cancer patient.

They ordered major surgery on Jones.

They needlessly removed three-quarters of her stomach. They also took out her spleen.

They left a 79-year-old Queens grandmother unable to swallow, barely able to speak - and living off liquified nutrients, delivered through an intravenous tube.

For no good reason at all.

This disturbing case arrives amid a growing outcry over HMOs. Patients are complaining that these so-called managed-care outfits seem to care about little but their bottom lines. Lately, New York doctors have been adding their voices to the complaints, saying they, too, feel squeezed.

Legislation has been introduced in Washington and Albany, seeking to improve the medical standards of these health-maintenance organizations - and to give their patients better recourse when treatments are denied. President Bill Clinton's new patients' bill of rights is an overdue step along that road.

But remember the name Lola Jones. Her case is about to become famous in the fight over HMOs.

"I call them Habitual Malpractice Organizations," said Manhattan attorney Pamela Liapakis, who is filing suit today on Jones' behalf. "We're seeing more and more cases like this. It's scary. It really is."



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Lola Jones certainly has something to live for.

An only child raised Roman Catholic in Germany, she was sent to America by her mother in 1939, a week before the Nazis invaded Poland.

Though she already spoke four languages - English included - young Lola was assigned to English classes soon after she arrived in New York. She fell promptly in love with the teacher, Howard Jones, a Brooklyn Law School student who taught part time.

They married Jan. 10, 1943, and had four children. The family lived on 222nd Street in Cambria Heights.

Howard Jones spent most of his career as a government lawyer. In the Rockefeller and Wilson administrations, he was assistant New York State commissioner for human rights.

Like many government workers, his health insurance came through HIP, the Health Insurance Plan, a important model for programs across America.

After her husband's death in 1984, she went back to school for an associate's degree in medical technology, making the City Univeristy dean's list. She taught foreign languages at various senior centers. She doted on her grandchildren and her new great-grandchild. And she stayed with HIP, even paying for extra coverage.

Lots of good it did her.

As older people will, Jones developed various ailments over the years. She has a treatable case of Parkinson's Disease. She broke a hip two years ago. Her weight began to slip.

And last August, she walked into North Shore-Forest Hills with unexplained bleeding. The doctors said she might have an ulcer. They ordered a biopsy.

Word came back from the hospital's Shared Services Laboratory: Stomach cancer.

This was frightening news for Lola Jones. Her children and grandchildren were upset, too.

What none of them knew - not yet - was that a colossal mistake had just been made. She didn't have cancer at all. Her laboratory specimen belonged to an unknown patient who did.

The medical records show that surgeon Edwin Gonzalez and internist Suresh Patel recommended surgery. After much soul-searching and debate, Jones agreed.

"Doctor Gonzalez said, It's the size of a quarter or a half dollar. We think we can operate," Jones' son Frank recalled yesterday.

Frank Jones said he discussed the idea with his mother in detail. She spoke to other family members as well.



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"She asked, Should I do this?' " Frank recalled. "I told her, If you want to live a few years. They will take all the cancer, you can avoid a painful death.' It sounded like a viable approach to her. She said, Let's do it.' She believed she had no choice."

When the operation was over, the son remembered: "Dr. Gonzalez said, I believe we got all the cancer.' "

But then things turned wildly around.

When a post-surgery biopsy came back from the lab, Frank's brother Alan got a truly unsettling telephone call. Dr. Gonzalez had good news and bad news.

The good news was that their mother was out of intensive care. The bad news was this unimaginable mistake. There was no stomach cancer. There was no need to operate. Her stomach and spleen did not need to be removed.

"It's been a distaster since then," Frank Jones was saying yesterday. "Three months later, she still can't swallow. She's still on the feeding tube.

"She's perfectly conscious. Her mind is still totally sharp. But her physical progress is excruciatingly slow."

And even now, the lawyer and the son said, HIP is fighting the treatment that Lola Jones needs.

They wouldn't pay for her to see a Parkinson's specialist at Columbia-Presbyterian Medical Center, the son said. They insisted she be removed from North Shore with no after-care plan, he said. They've refused to cover adequate home-nursing care, he said.

After a pitched battle with HIP, the family finally moved her to Parker Jewish Institute, an independent facility on the campus of Long Island Jewish Medical Center, where she is today.

HIP, he said, has been fighting payment for treatment there. She's been kept on a ward with dementia patients, where she receives little rehab, he said.

"We'd have been much better off if she just had Medicare and Medicaid, if we had never heard of HIP. She'd be home now, with the support she needs, and her loving family around."

Officials at the hospital, which before its takeover by North Shore was known as LaGuardia Hospital, said yesterday they had not yet seen the legal papers. Neither had HIP and its doctors. Spokeswomen for North Shore and for HIP said yesterday since the case is the subject of litigation, they could not discuss it in detail.

"It is our understanding this lawsuit involves doctors who we contract with through their association with Queens Long Island Medical Group PC, among other defendants," HIP spokeswoman Loretta Creggett said.

GRAPHIC: Photo - 1) Lola Jones 2) Newsday Photos by Viorel Florescu - Cancer Patient Linda Gibbs 3) Lola Jones with son Frank



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