

LEVEL 1 - 203 OF 626 STORIES

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The Arkansas Democrat-Gazette

March 06, 1998, Friday

SECTION: EDITORIAL; Pg. B8

LENGTH: 888 words

HEADLINE: Managed health care is a mess

BYLINE: Robert Samuelson

BODY:

As to managed care, I am not a happy camper. Our family's original **health maintenance organization (HMO)** underwent two mergers. After the first, our children's fine pediatrician was promoted to another center. Our kids got a new doctor. My personal physician then left.

We ultimately switched plans, but this change hasn't gone smoothly, either. I selected a primary doctor; by the time I wanted to see him, he had left the plan. I found a new doctor and scheduled a checkup. Then I got a bill for part of the exam, which the insurer refused to pay because my card listed the original doctor. Naturally, I'm fighting the insurer and doctor over this few hundred dollars.

Welcome to managed care. It's a mess. My troubles are hardly life-threatening. But they illustrate, even in their triviality, the frustration, anger and confusion that now plague managed care. Patients, doctors, hospitals, drug companies and insurers have been thrust abruptly into new relationships--often unwillingly. A decade ago, most health insurance was fee-for-service. Doctors' bills went to insurers and were usually paid. This undisciplined system fed an explosion of health costs. Now, more than 80 percent of workers belong to managed-care plans.

A backlash was inevitable. Patients have lost some freedom to select doctors and see specialists. Doctors' incomes are squeezed, while their decisions--for tests, procedures--are reviewed and sometimes overruled. Hospitals and drug companies compete fiercely for huge volumes of business. Complaints and blunders were unavoidable.

In a democracy, these imperfections were bound to resonate politically. One survey estimates that elected officials in California alone received 200,000 complaints last year. About 50 bills have been introduced in Congress for new regulation. Media coverage has turned more hostile. Managed care's obsession with costs is said to reduce quality and deny patients needed care.

All this is, up to a point, desirable. Openness is one way our society discovers abuses. Though the process is messy, it beats secrecy. Some problems will correct themselves. With time, most **HMOs** and doctors will learn how to deal with each other less combatively. Some preapprovals for tests or procedures will be discarded as silly. **HMOs** that continue to offend patients will lose them. Extra regulation could improve the climate.

One sensible idea is to allow some independent appeal for **denied treatment**. Economist Alain Enthoven of Stanford, one of the godfathers of managed care, correctly notes: "Managed care could not exist without (regulation). There have to be rules to sustain public confidence."



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But there's a rub: The backlash could become an overreaction that breeds foolish regulation. On balance, managed care has been constructive. Its largest achievement has been to slow soaring health costs. In 1992, the Congressional Budget Office predicted that health spending would grow to 15 percent of national income (gross domestic product) by 1995 and 18 percent of GDP by 2000. Instead, it has stayed at roughly the 1992 level, 13.4 percent of GDP. This may seem meaningless, but each percentage point of GDP is about \$ 80 billion of spending.

People have received salary gains that, otherwise, employers would have paid as health insurance. Is America sicker as a result? Probably not. Fee-for-service medicine had huge waste. And to think it was superior medically is "nostalgia mongering," as Michael Millenson of the consulting company William M. Mercer says.

In a new book, *Demanding Medical Excellence*, Millenson recalls countless cases of bad medicine before managed care. In the 1950s and 1960s, doctors routinely removed children's tonsils, despite evidence (now accepted) that the surgery was often useless. Studies of heart-bypass surgery in the late 1980s showed wide differences in outcomes--a reflection of doctors' varying competence. And even under fee-for-service, insurers wouldn't cover many experimental treatments. Paradoxically, managed care has focused attention on "quality" precisely because it is thought to threaten quality.

None of this makes me happier with my health plan. But it's important to separate personal peeves from national policy. A lot of the backlash against managed care reflects inconvenience, not medical failure. Some opposition is also self-interested. Not coincidentally did doctors' incomes stagnate in the mid-1990s when managed care surged. In 1993, the average doctor earned \$ 189,000; two years later, that was up only 3 percent. "Patients' rights" often means "provider protection." Various requirements would prohibit health plans from excluding doctors and hospitals--or would mandate certain benefits (from screening for breast cancer to care for newborns).

Though they sound good, these proposals would move us in the wrong direction. Some are not sensible medicine; others would handcuff health plans' ability to negotiate with doctors and hospitals. Americans can't have everything they want: unlimited choice of doctors and treatments, complete insurance for everything, and reasonable costs.

As Enthoven observes: "If the politicians and public refuse to accept any limits on anybody's care, costs will soar again." It's that simple.

Robert Samuelson is a columnist for the Washington Post.

LANGUAGE: ENGLISH

LOAD-DATE: March 13, 1998



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LEVEL 1 - 204 OF 626 STORIES

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.

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LOAD-DATE: March 8, 1998



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Asheville Citizen-Times (Asheville, NC)

April 6, 1998, Monday

SECTION: Local; Pg. A1

LENGTH: 2029 words

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

BYLINE: By Clarke Morrison STAFF WRITER

BODY:

Betty Milton was scared out of her wits.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

Staff writer Mark Blaine contributed to this report.

GRAPHIC: Photos of Harold Fletcher

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Atrocity of the Month

How An HMO Changed My Life

This month we are publishing one of our patient complaint letters. Sadly, we receive too many letters like this.

I wish to express my concern with those individuals who believe they are secure in having a Health Maintenance Organization for their families.

I too thought I was secure. I received medical benefits through my employer who provided us with a HMO plan.

We used our small town, local physician for colds and minor ailments and paid for his services because it saved us time. Otherwise we would have to travel for an hour and a half to use our HMO. But, we knew if something unforeseen happened we would be taken care of. Or so we thought.

October 28

It was on my day off when I noticed my husband raking five swings and sitting down, five swings and sitting down. He was having chest pains and shortness of breath in between. Nitroglycerin did not relieve the pain. I called our local physician who advised me to take him to the emergency room and he said he would call a cardiologist.

My husband was examined and the cardiologist wanted to do an angiogram. He called our HMO and advised them of my husband's condition, but our HMO refused to authorize the angiogram and advised us to go down to the HMO and THEY WOULD TAKE CARE OF HIM.

We left the hospital and went home and packed our bags and then called the HMO to advise them we were on our way.

After we arrived, my husband was placed in a treatment room in the emergency department. He was examined briefly by the ER physician and routine hematology and blood chemistry, along with x-ray and EKG were done.

His history included being a diabetic, smoker, overweight, and a family history of heart disease. We told this to the ER physician and also told him about our earlier visit at our local hospital.

At 12:45 AM, the ER physician came in and told us we could go home or find a motel for the night and come back in the morning. My mouth dropped. I was shocked. I knew my husband was very ill. I asked the ER physician if he spoke to a cardiologist. He replied, "No, to an internist." So, I picked up the phone in and called my sister-in-law, then our local physician, and finally the cardiologist. The cardiologist said, "Linda, your husband needs an angiogram and he needs hospitalization." I said that I knew that, but asked if he would tell this to the ER physician. He said, "Sure." I passed the phone to the ER physician and they spoke. After hanging up the phone, the ER physician replied, "I already woke him up once and I'm not waking him again." Then he walked out of the room saying, "It's not my decision. He doesn't meet the criteria for admittance."

I then proceed to help my husband get dressed and we walked out to the hallway. Upset, yes! I was upset and told the ER physician that there are two doctors stating my husband needs an angiogram and

hospitalization and your telling me to take him home. I also told him I was going to complain about the treatment we received. I said that we pay \$500 a month for medical insurance and you are refusing my husband hospitalization. (This is at 1:15 AM)

As we approached the door going outside, my husband grabbed his chest as if he was hit with a sledgehammer. I helped him sit down. I could see he was short of breath and pale. I told him he'd be okay and I ran to the nursing station for help.

The doctor we had seen was sitting there talking on the phone. I said, "My husband's having chest pains and shortness of breath and I have no medicines with me." I asked for one nitroglycerin or procordia. The doctor responded, "I can't do that." I ran back to my husband and nobody came, nobody. (Approximately 10 minutes)

Then a nurse approached us and I said to him, "I was told to come here and you tell me to go home. It doesn't make sense." Then some of the hospital staff, along with the ER doctor came out and watched from some 20 feet away. They just watched and said nothing. They did not offer oxygen, nitroglycerin, or even a gurney. NOTHING!

Then a girl wearing green scrubs steps forward and says, "If you really want us to admit you, we will." All kinds of things were going through my head by this time. I could see some long, dark hallway and getting a call in the morning that my husband had died. I couldn't leave him there. So, I said, "I am taking him back to the doctors that know how to help him."

October 29

We called in the early morning to complain and spoke with the HMO's cardiologist who stated, "He refused hospitalization and left AMA." My husband tried to explain to this physician what actually happened, but he started having chest pains and shortness of breath while talking. I took the phone and told the HMO cardiologist this and also told him that I was taking my husband to the hospital. He said, "Lady, you can take him anywhere you want, we're not covering it."

We arrived at our local hospital and my husband had a heart attack. He was gray and weak. They put him into a wheelchair. The HMO was called again for authorization to treat him and again they refused.

October 30

The angiogram was performed and five blockages were found. The HMO was again called for authorization for transport; still they refused. My husband was transported by ambulance to another hospital October 30th and a triple bypass was performed on October 31st.

It took many attempts, but we finally received the medical records and found that the HMO had falsified them.

My HMO has refused to pay all medical bills, claiming my husband did not meet the criteria for emergency services. The money probably went to the CEO of the company as a bonus or to the HMO's ER physician for saving the organization money.

It's been almost five years since all of this occurred. Now we are being sued one or two of the providers. The arbitration hearings are set for October and December. Our credit has been affected and my leisure time is used writing letters. We have approximately \$50,000 in outstanding medical bills.

I must tell you, protect yourself and your loved ones! It's not what the commercials say -- Quality Care. That's a lie. Research your symptoms first, and if you still question the care, get a second opinion. If you feel it's a matter of life or death and the HMO refuses to hospitalize you GO ELSEWHERE. You can't bring the dead back. Request your medical records. COMPLAIN to the HMO and request arbitration. Get a good attorney. Complain to the Department of Insurance, they regulate HMOs. Write letters letting people know what these HMOs are doing.

Linda Riedel
Lakeport, CA
The HMO is Kaiser Permanente

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Atrocity of the Month

The following stories are excerpts from ones sent to Physicians Who Care by a practicing physician who has first-hand knowledge of these cases.

1. A pulmonary specialist saw a young boy. Following her evaluation she felt the child might have a brain tumor. She told the "gatekeeper" to give a referral for a Cat scan because she suspected that the patient might have a brain tumor. The "gatekeeper" refused to give the referral and several weeks later the patient died of a brain tumor.
2. A 23-year-old pregnant woman died of a ruptured colon secondary to a misdiagnosis of carcinoma of the colon as colitis on colonoscopic biopsy. The biopsy slide was erroneously diagnosed by the pathologist as colitis. There was poor follow-up of the patient in spite of rectal bleeding. The "gatekeeper" (primary care physician) did not give her a referral for a follow-up colonoscopy.
3. A young girl was having respiratory problems and her mother had a hard time getting through to the pediatrician's office. Finally, when she did get through, the secretary told her to come in that afternoon. By mid-morning the young girl stopped breathing. The mother tried to call the doctor's office, but the line was busy. This girl died of acute epiglottitis. However, the real cause of death is the HMO requirement of notifying or getting permission from the primary care physician a patient may go to the emergency department.

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HMO Denies Payment For Emergency Treatment

When a little boy who was just 2 years old suffered a seizure and was running a 104.2 fever, he was admitted to the hospital. He stayed overnight until his temperature dropped and doctors felt he could go home, he was discharged.

For months, the HMO refused to pay the \$1,125 hospital bill, fighting several appeals. Finally, during a binding arbitration by a state agency, the HMO reimbursed the hospital.

Should patients have to fight for medical care when it is so obviously needed?

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Delayed Heart Surgery

The New York Post reported on a case where a man suffered a heart attack after doctors at his HMO delayed surgical intervention even though he was in almost constant pain. The man had also failed stress and lab tests. He had obvious and documented signs of severe heart disease.

An investigation by a state Health Department found that the HMO physicians elected to treat the man with medicines rather than admit him to a local hospital for heart bypass surgery. The records showed the man had requested the operation on several occasions.

During a two-week period, the man made eight visits to the HMO, failed several cardiograms and even suffered a painful angina attack during a stress test. Yet, the doctors still did not admit him to the hospital. At one point, they told him to take Tylenol.

After those two-weeks, the doctors drove the man to a hospital where he was immediately admitted to the intensive care unit. Soon after his admission, the man suffered a heart attack.

After undergoing the bypass operation he needed in the first place, the man finally recovered.

The HMO has been sharply criticized by the Health Department investigators. They noted that the documentation of the case was very complete and it wasn't necessary to interview the man himself. One investigator said, "We do not know the danger inherent in obliging him to relive his near-death experience."

The HMO would not comment on the case.

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No Coverage for Cystic Fibrosis?

USA TODAY (front page, April 12-14 weekend issue) reported that an HMO refused to provide coverage to an unborn child because the child had a gene for cystic fibrosis. The HMO offered to pay for an abortion.

Regardless of one's beliefs about abortion, can anyone support the idea of an HMO making abortion decisions? This is an area that managed care companies have no right to intrude upon. Financially pressuring a woman into an abortion is an extreme case of cost savings. As we have pointed out else where in these pages, HMOs are trading lives for dollars. This case deserves our atrocity of the month.

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Atrocity Of The Month

The Associated Press reported on April 16, 1996, that according to a recently filed lawsuit, a man (Jim Cerep) died on the bathroom floor while an HMO gatekeeper twice refused to grant permission to call an ambulance.

The defendants in the suit are The Geisinger Health Plan and Dr. James J. McKenna. The attorney representing the Cereps said this suit may change the way health maintenance organization operate.

Mr. Cerep of Scranton suffered a seizure and was involved in a minor car accident about a year before his death. At that time, he was taken by ambulance to Community Medical Center in Scranton for tests. The HMO refused to pay nearly \$2800 in medical bills because the hospital was not a Geisinger facility.

The attorney, Mr. Joseph Lenahan, reported that Dr. McKenna warned the family at that time to contact him in the event of any future seizures before seeking medical care.

In May 1994, when Joyce Cerep heard her husband collapse against the bathroom door, she called Dr. McKenna and he told her that it was not an emergency. According to Lenahan she called back three minutes later and begged for permission to call an ambulance, but again McKenna refused.

As Jim Cerep lay dying on the bathroom floor, Dr. McKenna told Joyce Cerep he did not feel this was a medical emergency and to wait at least a half-hour before calling for help.

Mrs. Cerep called again 14 minutes later when she could no longer hear her husband breathing. Dr. McKenna was unavailable, and Mrs. Cerep called the ambulance, which arrived two minutes later. However, paramedics found Cerep, 33, dead. He had suffocated.

Mr. Cerep was survived by his wife and two children, a 9 year old son and a 2 year old daughter. He was the owner of a small tavern in Scranton.

Joyce Cerep blames herself for not call 9-1-1 sooner reported Lenahan. He says she is not out for the money, but just wants to make sure this doesn't happen to anyone else.

There was no comment from Dr. McKenna. A spokesman for Geisinger, Bob Bomboy, said company officials had not seen the lawsuit. He added that Geisinger health system does not practice medicine at the expense of the patient. He also said that when more information is available, they will respond to the allegations.

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Delay That Meant Death

U.S. News & World Report recently printed the story of Joyce Ching's losing battle with cancer because of delayed treatment as determined by a California jury.

Ching was 32 years and a new mother when she began having abdominal pain and rectal bleeding in August. She went to her primary care physician, chosen from a list provided by a health maintenance organization operated by Metropolitan Life Insurance Company. Three months later, her pain and bleeding remained unexplained and unabated. Her husband, David, demanded action. A barium enema x-ray (cost \$261) proved inconclusive. After three more office visits, the rest of the year's payments for Ching to the HMO was used up. Joyce Ching was now a liability to the HMO physician group she had chosen and her undiagnosed colon cancer would kill her 20 months later at the age of 34.

David Ching and his attorney, Mark Hiepler, believed that the doctor put off an order for a sigmoidoscopy (a test in which a lighted tube is used to inspect the lower colon) partly because the physician group would have had to bear the \$450 cost. Last November, a California jury decided the delay of the test and a subsequent referral to a gastroenterologist cost Joyce Ching her life. The jury awarded her family \$2.9 million.

According to this report, while no one can see into a doctor's heart, new physician-payment arrangements with managed care organizations flip the old doctor-patient pact on its head by creating incentives to deny, rather than provide, care.

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Toll-Free Managed Care (HMO) Complaint Hotline

Families USA Study Examines Executive Compensation ^{NEW}

Recent HMO News (3/31/98)

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Atrocity of the Month (June 98)

Atrocity of the Month (July 98)

Hall of Shame

National Legislation

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HMO Questions

HMO Humor (Apr 98)

Glossary of Acronyms

Glossary of Terms

Comments from Physicians New!

Physician Complaints

Patient Complaints

Reader Comments

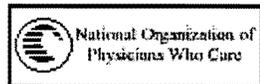
Printed Petition

Join Our Volunteer Staff

Special notice to Cigna and Healthsource Subscribers

Other Pro-Patient Organization Links

Other Interesting Links



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May 1998 Atrocity of the Month

This story came to Physicians Who Care from a patient seeing this page on the Internet. We felt it worthy of sharing with others. From time-to-time we relate stories that we receive from patients who have difficulties with their managed care companies.

My name is Gary and through my employer I am enrolled in a managed care plan, the most expensive plan a non-executive employee can have.

Here is a brief history of my condition prior to being struck by the out-of-control car. I have been a quadriplegic since 1979. I have some use of my arms, otherwise I am completely paralyzed and unable to care for myself, except for feeding, shaving and brushing my teeth myself with a little help. Even with my condition, I was able to drive an electric wheelchair, drive a specially equipped van and work full time. I have an unrelated family that lives with me to help with my attendant care. I have no family members that can help me with my care or other affairs.

In August 1997, an out of control automobile struck me while I was sitting on the sidewalk in my wheelchair. I suffered fractured left and right shoulders, broken right humerus, fractured right pelvis, broken femur and fractured right tibia. I also suffered many scrapes, cuts and bruises. Approximately twelve hours total of surgery were spent on two operations to set and repair the broken humerus and femur. I now have a permanent stainless steel rod in my right leg from my knee to my hip.

I was taken to a hospital immediately after the injury. This was where the two surgeries were performed. This is also where I stayed recovering in intensive care for 6 days when I was transferred to a more prestigious hospital and placed into a private room. This hospital only has private rooms. I don't know who decided I was ready to go from intensive care in one hospital to a private room in another. The hospital did not have the staff available to care for me properly in a private room. I had to hire a private duty nurse out of my own pocket for two very bad days when I had a high fever and required a blood transfusion. We tried to get authorization, but my primary care physician was very difficult to reach and we could not wait. When we finally made contact with someone we were told that private duty nursing was not covered in a hospital. I would not have needed private duty nursing if I had been kept in the first hospital in intensive care.

My caregivers stayed over several nights to help me. They were also there every day. One day I had severe congestion in my lungs. Being a quadriplegic and not being able to sit up, I could not cough to clear it. I probably would have drowned from the congestion if my caregivers were not there to get help immediately to suction me and to help me cough. I was afraid to be left alone and they were afraid to leave me alone.

After a week and another blood transfusion and after my temperature normalized, I was in the process of being discharged. I had the option of going into a convalescent home or going home while I waited for my numerous broken bones and fractures to heal. Then I would be ready for therapy. My social worker advised us that my condition would rapidly deteriorate in a convalescent home because they would not have the staff available to properly care for me. I could do nothing for myself (bathing, feeding, or repositioning in bed). With two fractured shoulders and a badly broken right arm, I could not even use the call button. According to my managed care plan, there is no limit on private duty nursing and home health care in network. There is a \$25,000 limit on private duty nursing and home health care out of network and a 60-visit limit on short-term rehabilitation out of network. It is obvious I should have qualified for and received all these things without question.

The reason for this long explanation is to paint a crystal clear picture of how really bad my condition

was after the initial injury and when I was released from the hospital to go home. Going home with the proper twenty-four hour around the clock care was chosen over being sent to a convalescent type home. There it would have cost the insurance company several hundred dollars a day for my care and I would not have received the attention I needed. The rehabilitation center I was at in December and January charged \$495 per day for example.

I was promised that adequate home health care would be provided. What I had authorized, on the other hand, was one CNA coming three days a week for one hour each day. I had to pay out of my own pocket for two additional hours a week. I also had to pay my caregivers what I could out of my own pocket for the rest of the twenty-four hours a day, seven days a week care the managed care company did not provide.

What the managed care company provided was hardly adequate care for someone who is almost completely paralyzed. As a result of being put on an inferior air mattress, loss of weight, and occasionally lying for too long on my shoulder, I ended up getting a painful bedsore on the back of my left shoulder. Once I got on the right air mattress at the rehabilitation center, the sore started to heal. I still have to wear a protective patch on it.

When I did get a chance to speak to my case manager to voice my opinion that the managed care company should be paying for my care, I was told that they would not pay because my caregivers are not licensed and custodial care is not covered. It was convalescent care. While my caretakers are not licensed, they know my care better than anyone else. It was not as if they were untrained or unqualified and a danger to my health. So how could this be a valid reason for the managed care company not to pay them for taking care of me? On the custodial care issue, by definition custodial care is defined as routine care to maintain the current physical condition. Before the accident I was paying for and receiving from my caregivers approximately three hours per day of custodial care. The managed care company's plan does not cover custodial care. Convalescent care is defined as care received while recovering from an illness or injury. From the second the car struck me and until I have fully recovered from the injury and am released from my doctors' care, I have and will be receiving convalescent care. The insurance plan does cover convalescent care.

I have one more issue. This issue is regarding the managed care company delaying and refusing to pay for physical therapy. After the accident, I was bedfast for four and a half months receiving no therapy at all per doctors' orders. In mid-December, 1998, I went to a rehabilitation center to give my caretakers a break. I also went to get a second opinion on my injuries (which I still have yet to receive almost three months later). I finally started receiving minimal therapy two weeks later. After I started sitting up in my wheelchair after another couple of weeks, in-house therapy practically stopped. The physical therapy department was also short of staff. This was part of the problem. I never even set foot or wheels in the physical therapy gym for any type of therapy. I had planned to stay at the rehabilitation center for two or three months but could not see the point in it with the minimal therapy I was getting there. I suggested being discharged to my therapist and she agreed and in late January 1998, I was discharged.

Before I was discharged from the rehabilitation center, I was promised that arrangements were being made for physical therapy to start when I got home. This turned out to be untrue. Nothing had been arranged. In fact, it took a week before a physical therapist came to do an evaluation, then it was almost two weeks later that I received my first of four total therapy sessions. I made a lot of progress with my therapist. After the last session, the therapist indicated that he would recommend more therapy. He also indicated that every day I did not do therapy I would lose a lot of what I had gained. After considering the known facts of my condition and treatment, I have only received four authorized physical therapy sessions in the seven weeks that I have been home. I was promised adequate follow-up physical therapy when I came home. The lack of adequate structured physical therapy has caused me a lot of unnecessary pain and stress. It has also unnecessarily delayed my recovery, my return to work resulting in lost wages and my return to as near a normal life as possible.

In an appeal letter to the managed care company, after waiting several weeks with no therapy, I got new x-rays and saw my orthopedist in early March 1998. He ordered more therapy by the next day. About 10 days later the therapy finally started. I am now scheduled to get nine more visits.

What I am asking the managed care company to do is this:

1. Pay for the two days of private duty nursing I required at the prestigious hospital as described previously when I was put on the regular floor after being transferred from intensive care unit.
2. Pay for some of the costs of my having my caregivers stay with me while I was helpless in the hospital for the same reason above.
3. Pay for the two additional hours of CNA home health care per week I received for about a three and a half-month period. There is not an in-network limit.
4. Reimburse me for the costs of convalescent care I paid my caregivers.
5. Pay a reasonable amount for the convalescent care my caregivers have provided and will provide until I am released from my doctors' care to return to work.
6. Provide adequate physical therapy coverage in order to speed up my recovery (finally happening now).
7. Put into effect rules (guidelines at least) to see that this kind of thing does not happen to other severely injured or ill Plan members. A flag should be raised and there should be a standard comprehensive response for primary care physicians and case managers.

[[HMO Page Home](#)]

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April 1998 Atrocity of the Month

From time to time we publish complaints that we have received from patients. Below is another of those complaints we recently received.

*****I ALMOST DIED BECAUSE OF HMO INCOMPETENCE*****

After I graduated from college and lost insurance coverage through my parents plan, I joined an HMO. Several months later I began to develop major signs of depression: total insomnia, twitching, memory loss, weakness, numbed emotions, and most noticeably, paranoia about my health. I became convinced that I had M.S. The more I read about M.S, the more I obsessed over it.

During this two-week period, I made two trips to the HMO's urgent care center. The doctors there were rushed, non-communicative, and uncaring. They missed the signs of my depression. One doctor gave me a prescription for Valium.

Although I was convinced at the time that my symptoms were M.S related, I decided to make an appointment with one of the HMO's mental health providers because I was literally going crazy from lack of sleep. This woman was *HORRIBLE.* She smoked in her office and told me that the only reason she did her job was to earn money.

At my wits end, I kept calling the HMO begging for help. The phone system was a nightmare to navigate. The employees which took my calls after endless holds were rude and did nothing to help me. I made another appointment with my primary care doctor.

After I described in detail the symptoms, he concluded they could be neurological or they could be psychological. He said that I, (a severely depressed person who couldn't even sleep or eat) would "need to be more aggressive in pursuing counseling." He said he would refer me to a neurologist, but that the referral would take about 2 weeks to process. I asked him what I was supposed to do about my symptoms in the meantime. He told me to take a hot bath. I told him "I can't go on like this, I'm getting desperate. " He shrugged his shoulders and left the room.

That night, I planned my own suicide. The next morning I cut my wrists (deeply enough to require 20 stiches) and lay in the tub waiting to die. Eventually, the blood clotted. I didn't know what else to do, so I called 911.

I spent the entire day in a Hellish E.R surrounded by patients from a nearby dentention center who were chained to their beds. Finally, after 10 hours the ER staff got approval from the HMO to admit me to a psych hospital. I spent 2 weeks there, where I was diagnosed with clinical depression. They started me on medication and had a neurologist examine me in order to rule out M.S. Incidentally, the HMO would not pay for this consult since I was admitted to a PSYCHIACTRIC not a regular hospital.

I continued therapy after leaving the hospital, with a non-HMO provider and eventually recovered....But I still believe that I almost died because of the HMO's collective incompetence.

*******Please post this!!!!******* If it makes even one person think twice before joining an HMO, it will gratify me!!!!

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March 1998 - Atrocity of the Month

This letter from a concerned mother came to Physicians Who Care via the Internet. She relates her distress as follows.

My son has an undiagnosed degenerative neurological condition. It started just before he turned two years old, he is now five and a half. We have had the same insurance provider, Cigna HMO, the entire time.

I have gone from one Cigna primary care provider to another Cigna primary care provider trying to find a doctor who would at least attempt to find out what is wrong with my son, but have been unsuccessful.

The first doctor told me that my son's neurologist and were imagining things -- that there is nothing wrong with him! The latest doctor refused to order a group of metabolic lab test that I requested based on research I had done (since the doctors obviously weren't trying). I was told "Oh, I'm sure his last doctor already did those." Well, no he hadn't because he was also a Cigna doctor.

My son is now legally blind, developmentally delayed, has hyperreflexia, clonus at the ankles, tremors, dystria, positive Babinski signs, hypertonia and has the motor skills of a two-year-old. He recently suffered two stroke-like episodes.

Could this be treatable? Could the progression be stopped or slowed down?

Do we have any idea about what we should expect for the future? NO! Because the HMO would rather let him die than spend money to find out what is wrong or potentially have to spend money to treat it.

"These stories are printed as they were reported to Physicians Who Care. They have not been verified or researched."

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February 1998 - Atrocity of the Month

The following letter was sent to Physicians Who Care via the Internet. This individual relates a few the problems we often hear from patients.

I want to register my extreme dissatisfaction with Prudential Healthcare of Central Florida. Since my enrollment last year, I have:

1. Been forced to see the "student" of a physician's assistant for the treatment of pneumonia;
2. When my condition worsened and I begged for an appointment with a "real doctor", I was told by the receptionist that I "had already been seen";
3. Recently, I was told that the blood pressure medication (acebutolol), which was covered last year, would no longer be covered under any circumstances. (I have been on 13 other blood pressure medications and they were either ineffective or caused horrible side effects.

My attempts at appeal through PruCare have all been denied.

If this is the future of health care in America, then we won't have to worry about war, pollution, or global warming. We'll all be dead before any of those things can affect us.

"These stories are printed as they were reported to Physicians Who Care. They have not been verified or researched."

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Family of man who died while awaiting treatment gets settlement from HMO

Dateline Dallas: The Associated Press reported on December 17, 1997 the story of an HMO agreeing to pay \$5.35 million to a family who claimed that medical cost-cutting led to a man's death from untreated heart disease.

Kaiser Permanente's North Texas HMO to cut hospital expenses by 45 percent, plus an HMO official's speech that stressed putting "the bottom line" first, led to the 56-year-old man's death, alleged awyers for the family of Ronald Henderson.

After a test jury in a novel nonbinding minitrial, the HMO agreed to the settlement, but said it would have awarded the family more than 10 times that amount if the case had gone to an actual trial.

The experimental two-day procedure in District Judge John M. Marshall's court is aimed at encouraging out-of-court settlements.

According to the family, Kaiser doctors discharged Henderson from a hospital without referring him to a cardiologist. Evidence was also presented showing that Kaiser's medical-advice nurses gave him bad instructions by telephone.

Randall Moore, the family lawyer, said the case was brought "to take note of our belief that too many people are dying in their system."

Kaiser denied wrongdoing and argued that Henderson was an overweight smoker who did not obey doctors' orders. Its lawyers denied that cost-cutting had anything to do with the Irving man's death and accused the family's lawyers of trying to divert attention from specific medical issues.

David O'Grady, Kaiser spokesman, said the settlement was not an admission of wrongdoing, but "enables us to return our focus to providing our members quality health care -- to move from the courtroom back to the exam room."

Kaiser expressed displeasure with the minitrial process, saying the "verdict was not a real verdict, the damages are not real damages, this was not a real trial."

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Recent Calls

The Physicians Who Care managed care hotline responds to many requests for help each month. Recently, a number of the complaints have been received regarded pediatric care in the managed care setting. As children have not attracted a great deal of attention, it seems appropriate to share the concerns of some of the parents who have called for help.

Case #1: The child is 6 years old and was born with inner ears not being fully developed. He was first fitted with hearing aids at the age of 2 1/2. The HMO refused to pay the hearing aids, so the family struggled and paid for them. Now the child is 6 and starting to school and will soon need new hearing aids at a cost of approximately \$600 each. The HMO has again denied reimbursement for them stating that hearing loss is a natural process of aging. (Age 6 is old enough to be going deaf?) The family says they just don't know where the money is going to come from.

Case #2: A distraught mother called to say that her daughter who is 6 years old has alepecia areata (hair loss). As the diagnosis is "balding", the insurance company has denied treatment, as baldness is a natural aging process. (Again, is age 6 old enough to be baldheaded?) The family is appealing the denial of coverage.

Case #3: A little girl was born with spinabifida. For 6 years the insurance company paid for her braces, orthodontics, catheters and other supplies. Now all of this is being denied and the family cannot get a copy of the denial letter. They are appealing to their State Insurance Commissioner for help.

If you, your family or friends have had a problem with a managed care company, please let us know. You can send us e-mail from this page.

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ERISA Casualty Of The Day

July 16, 1998

no specialist


Consumers for Quality Care

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



**Misac Negosian
Sunland, CA**

According to Mr Negosian's report:

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

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

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

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

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

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

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

July 7, 1998

phone: (310) 392-0522

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women's
speechists
access

HMO Refuses Cancer Treatment For Top Performing Employee



Janice Bosworth
Simi Valley, CA

As told by husband Steve Bosworth

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

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

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

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

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

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

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

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

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

ERISA Casualty Of The Day
June 2, 1998



**Consumers for
Quality Care**

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Child With Brain Tumor Denied Access to Specialist



Sarah Pedersen

San Mateo, CA

As told by her mother, Brenda

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

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

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

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

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

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

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

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

June 24, 1998

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HMO Fails Bone Cancer Patient



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

As told by her daughter Norma Lowe

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

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

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

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

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

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

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

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

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

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

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

ERISA Casualty Of The Day

June 26, 1998

Consumers for Quality Care

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



Charla Cooper
San Francisco, CA.

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

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

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

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

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

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

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

June 18, 1998

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no DISCUSS Treatment

Cancer Patient Denied Treatment With Highest Recovery Rate



**Edward Mycek
La Quinta, CA**

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

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

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

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

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

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

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

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

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

June 9, 1998

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Emergency

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



(Barbara)

Barbara Garvey
Chicago, Illinois
R.I.P.

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

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

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

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

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

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

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

ERISA Casualty Of The Day
June 1, 1998

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



Stephen Keller
Pacifica, CA.

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

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

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

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

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

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

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

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

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

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

ERISA Casualty Of The Day
May 11, 1998

ERISA
sve 

**Consumers for
Quality  Care**

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



Florence Corcoran
Slidell, Louisiana

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

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

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

monitors and care of the hospital, the baby died.

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

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

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

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

ERISA Casualty Of The Day
May 8, 1998

ERISA (USA Today story today)
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Baby Blind Because of HMO Denials



Madison Scott
Orange County, California

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

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

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

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

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

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

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

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

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

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Access No: 9300065375 ProQuest - The New York Times (R) Ondisc
Title: DOCTORS SAY H.M.O.'S LIMIT WHAT THEY CAN TELL PATIENTS
Authors: ROBERT PEAR
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Length: Long (1297 words)
Subjects: MEDICINE & HEALTH; DOCTORS; HEALTH MAINTENANCE
ORGANIZATIONS; ETHICS; HEALTH INSURANCE; BONUSES

Abstract: Doctors across the US say that HMOs routinely limit their ability to talk freely with patients about treatment options and HMO payment policies, including financial bonuses for doctors who save money by withholding care. In interviews over the past three weeks, many doctors said such restrictions interfered with their ethical and legal duty to provide patients with information about the benefits, risks and costs of various treatments.

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Article Text:

WASHINGTON, Dec. 20 -- Doctors across the country say that health maintenance organizations routinely limit their ability to talk freely with patients about treatment options and H.M.O. payment policies, including financial bonuses for doctors who save money by withholding care.

In interviews over the last three weeks, many doctors said such restrictions interfered with their ethical and legal duty to provide patients with information about the benefits, risks and costs of various treatments.

Ill feeling over the restrictions is growing as more and more Americans join H.M.O.'s and employers encourage their use to control costs. Typically, H.M.O.'s offer a wide range of services in return for a fixed monthly premium. They recommend a select list of doctors and hospitals, and patients must pay more if they go outside that network.

H.M.O.'s may limit access to certain tests and treatments and require doctors to obtain permission from the H.M.O. to offer them. Doctors may receive bonuses or other financial rewards from the H.M.O. if they control costs and help restrain the use of health care.

But patients are often unaware of these financial arrangements because many contracts between doctors and H.M.O.'s prohibit the doctors from disclosing them. Increasingly, doctors are objecting to these confidentiality clauses, which they call 'gag clauses,' and they say that patients are entitled to such information.

For their part, health maintenance organizations say that some of the restrictions are intended to protect trade secrets and proprietary information. Susan M. Pisano, a spokeswoman for the Group Health Association of America, which represents managed care companies, said another purpose was to 'discourage doctors from disparaging H.M.O.'s and encourage them to discuss their concerns about payment and treatment policies with doctors and physician managers in the health plan, rather than with patients.'

Dr. Christine K. Cassel, president-elect of the American College of Physicians, which represents 85,000 internists, said: 'Managed care can be beneficial for patients, but patients need to understand the financial arrangements. To my dismay, gag clauses are becoming more common.'

Whitney North Seymour Jr., a lawyer for the League of Physicians and Surgeons in New York, said the confidentiality clauses muzzled doctors who wanted to be advocates for their patients.

A typical clause is found in the contract of Choice Care in Cincinnati, which says, 'Physician shall take no action nor make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, plan sponsors or the public in Choice Care, or in the quality of care which Choice Care enrollees receive.'

U.S. Healthcare, which describes itself as the largest operator of H.M.O.'s on the East Coast, has an almost identical clause in its agreement with doctors. David F. Simon, senior vice president of U.S. Healthcare, said the purpose was to protect patients, to make sure they were 'not put in the middle' of economic disputes between doctors and the company.

A recent notice to doctors working for the Kaiser Permanente H.M.O. in Ohio says, 'Do not discuss proposed treatment with Kaiser Permanente members prior to receiving authorization' from an outside company that sets guidelines for the treatment of patients. In addition, it says that doctors should not discuss the procedure by which they get such authorization.

Asked about this instruction, Jenny M. Hovinen, a spokeswoman for Kaiser Permanente of Ohio, said, 'It's a very unfortunate statement, isn't it?' But she said it was part of an elaborate effort to guarantee high-quality care by making sure doctors were aware of the best treatments before discussing them with patients.

Sometimes doctors want to recommend a treatment not covered by the H.M.O. in which a patient is enrolled. Sometimes they want to refer patients to specialists not affiliated with the plan, because they believe that the best care is found elsewhere. Their ability to do so may be severely limited by a confidentiality clause.

'These gag clauses intimidate physicians and discourage them from talking openly to patients about the need for specialty care and the role of managed care companies in limiting tests and treatments,' said Neil Weisfeld, deputy executive director of the Medical Society of New Jersey. 'It's more like managed silence than managed care.'

Doctors who obey such restrictions run legal risks and may be sued for malpractice. Carol L. O'Brien, a lawyer at the American Medical Association, said: 'A physician can be held legally accountable for a patient's injury or death if the doctor provides substandard care because of financial constraints imposed by an H.M.O. Juries have awarded hundreds of thousands of dollars in damages in cases where doctors failed to put the patients' interests first.'

The association's ethics authority, the Council on Ethical and Judicial Affairs, declared recently that doctors should inform patients of 'all relevant financial inducements,' including incentives to limit care.

Doctors in New York have filed a lawsuit challenging a confidentiality clause, on the ground that it 'destroys the physician's liberty to convey needed information to patients concerning H.M.O. operations.' The lawsuit, by the League of Physicians and Surgeons, says the restriction 'stifles discussion of quality of care issues and H.M.O. practices that are harmful to patients.' The case was argued last week before a state judge, who has yet to issue a decision.

Other contracts say that doctors may not make 'disparaging remarks' or 'derogatory remarks' about H.M.O.'s. Some contracts say that if doctors are dropped from a particular health plan for any reason, they may not contact their patients to inform them of that fact. The H.M.O.'s apparently fear that such doctors will encourage patients to leave one health plan and follow the doctors to another.

The doctors' complaints illustrate the tension between them and H.M.O.'s as health plans try to monitor and regulate the doctors'

behavior.

Dr. Daniel A. Gregorie, president of Choice Care in Cincinnati, defended the confidentiality clause as a way to prevent doctors from sharing their frustrations with patients.

'Physicians are angry, frustrated and, to some extent, depressed because the world as they've known it is changing rapidly and radically,' Dr. Gregorie said. 'But physicians should not take out that frustration in a nonconstructive way by sharing it with patients. That does not help the patients. It just makes them more anxious about the care they are receiving.'

An editorial being published on Thursday in The New England Journal of Medicine says that some H.M.O.'s use financial rewards and penalties to force doctors to skimp on care and then try to prevent them from speaking out. A co-author of the editorial, Dr. David U. Himmelstein, had a contract to treat patients of U.S. Healthcare in the Boston area, but the company terminated the agreement 'without cause' last month. The doctor had criticized the H.M.O. at an industry conference a few weeks earlier.

Dr. Himmelstein, an associate professor of medicine at Harvard, is a founder of Physicians for a National Health Program, which advocates a Government-financed system of national health insurance like the one in Canada.

Mr. Simon, who works at the headquarters of U.S. Healthcare in Blue Bell, Pa., said: 'This is a tempest in a teapot. Dr. Himmelstein was not dismissed because of his political views, which have been known for many years. His services were no longer necessary to serve our members in New England, given the expansion of our network of doctors in the last year.'

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Title: COSTLY SAVINGS: DOWNSIDE OF THE NEW HEALTH CARE; FOR A FEW PATIENTS, REFORM MAY CARRY A CHILLING PRICE
Authors: David S. Hilzenrath, Washington Post Staff Writer
Source: Washington Post, Final Edition
Date: Monday Aug 7, 1995 Sec: A SECTION p: 1
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Illus: Photograph
Subjects: Managed care; Health insurance; Cost control; Health maintenance organizations; HMOs; Health care policy; Reforms
Abstract: As cost-conscious insurers transform the health care system, some experts are applauding them for bringing greater efficiency to medicine. But many patients and medical professionals argue that the system is cutting corners as well as costs.

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Article Text:

Costella Prince Thompson was feeling wretched when she went to a Group Health Association Inc. urgent care center on March 12, 1992. Since undergoing general anesthesia for arm surgery a little more than a week earlier, she had experienced a sore throat and a cough along with diarrhea, chills, nausea and vomiting.

At the health maintenance organization, the 53-year-old D.C.

schoolteacher was examined by a physician assistant, who prescribed some medicine and sent her home with instructions to stay in bed for four days.

A day later, Costella Thompson was dead. An autopsy revealed pneumonia and other serious problems that the physician assistant had missed, apparent complications of her surgery.

A District jury faulted the care Thompson received at GHA, but decided four months ago that the HMO was not to blame for her death.

As cost-conscious insurers transform the health care system, some experts are applauding them for bringing greater efficiency to medicine. But many patients and medical professionals, citing cases such as Thompson's, argue that the system is cutting corners as well as costs.

Silver Spring physician Bernard A. Heckman sees Thompson's case as an example of the potential trade-offs society faces in its push for more economical health care. 'The emphasis on cost containment is going to bring about a deterioration in overall quality of care,' he said.

There is little if any authoritative data to show whether the quality of medical care is getting better or worse overall -- in fact, there is little consensus as to how to measure quality, experts say. But the first signs are appearing that Americans will have to accept compromises when they seek medical services:

A recent survey by the Robert Wood Johnson Foundation found that sick patients enrolled in 'managed care' -- the rapidly growing form of health insurance that tries to contain spending on medical services -- had many more complaints about their care than sick patients with traditional 'fee-for-service' insurance coverage.

Managed care patients were at least 40 percent more likely than fee-for-service patients to report that they had problems getting needed treatment, were unable to see a specialist when needed, were unable to get needed diagnostic tests and had to wait a long time for routine appointments.

At one Fortune 500 company, 26 percent of the people who sought treatment for mental health or substance abuse problems through the employee benefits program received no care within three months of requesting it, largely because of delays in authorization or other administrative problems, according to James Wrich, a Chicago consultant who was hired by the company to evaluate the program. The benefits plan required therapists and patients to get treatment approved in advance by a managed care contractor, which reduced expenses by about 30 percent.

Generally, 'you had to have a serious crisis . . . in order to get help,' said Wrich.

At California Pacific Medical Center in San Francisco, organ transplant specialists have turned down patients who might have been given transplants in the past even though they had poor prospects for recovery, said Barry Levin, vice chairman of the hospital's department of transplantation. Without transplants, these patients have no chance of survival, he said.

Because health insurance plans now cap payments for the surgery and follow-up care, 'the sicker the patient is, the less chance you're going to have . . . of making a profit or breaking even on the case,' Levin said. 'You unconsciously or even consciously begin to look at patients differently.'

One HMO doctor refused to see a woman who repeatedly sought an appointment for chest pains, said Margaret E. O'Kane, president of the National Committee for Quality Assurance, an accrediting agency that monitors quality control in HMOs. Traditional health insurers pay doctors a fee for each office visit, which critics say encourages unnecessary care. But the HMO paid this doctor a fixed monthly fee to provide all of the patient's primary care, whether the doctor saw the patient or not -- an increasingly common approach.

In Easton, Md., physician Donald T. Lewers, a trustee of the American

Medical Association, said one health insurance plan refused to pay for Pravachol, the drug he had been prescribing to control a retired factory worker's high cholesterol. The insurer insisted that the woman instead use Mevacor, made by a different manufacturer, even though Mevacor had proved less effective for this patient when she had tried it several years ago, Lewers said. Unable to pay for Pravachol out of her own pocket, the patient switched to Mevacor in February, which placed her at increased risk of heart attack or stroke, Lewers said.

A spokesman for Merck & Co., which makes Mevacor and administers this patient's prescription drug benefit through a subsidiary, said the plan would cover Pravachol if the doctor wrote a note that it was medically necessary. Lewers said the company representative who asked him to switch the prescription did not mention that option.

'We'll have to make some sacrifices and pay a price for less costly medical care,' said Stanford University health economist Alain C. Enthoven, who sees the health care revolution doing more good than harm. 'That means everybody can't have everything all the time. . . . In some cases that may reduce the quality of care.'

At a June meeting in Jackson Hole, Wyo., a group of large employers who have helped lead the drive for less expensive health care resolved that they would develop better ways of tracking changes in their employees' health. The current focus on costs 'could be ruinous to the health care system' unless it is balanced by greater emphasis on medical results, said Dwight N. McNeill, an employee health benefits manager for GTE Corp. and a coordinator of the group's efforts.

Even some of the most vocal critics of the cost-cutting measures agree that the health care system must be made more efficient. Rising medical bills have become a heavy burden for society, pricing private health insurance beyond the reach of millions of Americans, threatening to overwhelm the government health insurance programs for the poor and the elderly, and diverting money from other priorities.

Neil Schlackman, medical director of U.S. Healthcare Inc., a large HMO company based in Pennsylvania, said the nation has been consuming so much unnecessary, inappropriate and potentially harmful medical care that it is possible to improve quality while cutting costs.

'I think we're still [cutting] fat,' Schlackman said, echoing the view of many in his industry. 'There's a huge opportunity still available before we get into muscle and bone.'

The Denial of Service

The driving force behind health care cost-cutting has been big employers' search for less expensive ways to provide health benefits for their workers -- and the rise of managed care health insurance plans such as HMOs to do the job.

Where traditional insurers simply paid their customers' medical bills, managed care plans often require doctors to get approval before ordering certain tests or procedures. They steer patients to doctors and hospitals that accept their reimbursement rates and meet their standards. Patients who seek care elsewhere must pay a larger percentage of the charges or the entire cost themselves.

'In the overwhelming majority of HMOs as far as we can tell, the denial of needed services is not a major problem,' said Bruce C. Vladeck, administrator of the Health Care Financing Administration, which oversees federal insurance programs for the poor and elderly. But, speaking generally, he added, 'We have a long history . . . of really fundamentally abusive or dishonest plans where the denial of service has been part of the get-rich-quick strategy.'

Managed care plans covered 65 percent of workers insured through mid-size and larger employers last year, up from 29 percent in 1988, according to the consulting firm KPMG. Doctors who lose favor with those

health plans on grounds of cost or quality may be cut off from large blocs of patients and major sources of income.

One mental health professional said she has become hesitant to accept severely ill patients or see patients more than once a week as a result of warnings that Mid Atlantic Medical Services Inc. (MAMSI), a Rockville-based managed care company, has issued about 'utilization' -- jargon for services delivered or resources consumed. 'It makes me very cautious to take patients who require any kind of intensive treatment,' she said, speaking on the condition that she not be identified.

She was referring to messages such as an Aug. 9, 1994, letter to Mid Atlantic mental health providers in which Assistant Medical Director Mark D. Groban said: 'Those providers who maintain significantly higher utilization than their peers will have additional utilization management review of their MAMSI case load to ensure that only high quality and medically necessary care is being delivered. . . .

'We have a large waiting list in each of our mental health specialties and see no reason to ask providers to work with us in a model that is uncomfortable for them.'

D.C. malpractice attorney Jack H. Olander said he believes a cost-sensitive atmosphere contributed to Group Health Association's failure to diagnose the colon cancer afflicting his client, Lilia M. Reyes.

Beginning in October 1991, Reyes, a program manager for the U.S. Conference of Mayors and a mother of two, complained to GHA of abdominal pains, bowel irregularities and other problems. By early 1992, when blood was detected in her stool, she told her GHA doctor that she feared she had colon cancer, according to court records of a malpractice suit.

At a trial last year, expert witnesses for Reyes testified that at the outset of Reyes's treatment she should have been given a sigmoidoscopy, which almost certainly would have revealed her problem. A cancer specialist called to testify by the HMO said that test would have been 'acceptable' but not 'necessary.'

Physician Karen Bledsoe, an employee of the HMO at the time, diagnosed Reyes's problem as irritable bowel syndrome. Bledsoe testified that, before she could refer a patient to a specialist for a sigmoidoscopy, she would have to submit a form for review by GHA's chairman of internal medicine. She said she was denied such requests in some other cases.

Reyes's cancer was diagnosed in August 1992 when she underwent emergency surgery while on vacation in Florida. A tumor had blocked her colon. One of Reyes's experts testified last November that he 'would be surprised if she is still alive in a year.'

Reyes, 44, said in an interview that she gave up her traditional health insurance and enrolled in GHA in 1991 because the premiums were lower. 'Sometimes you try to cut corners thinking you're going to be saving some money, and ultimately you end up paying just an incredible price for it,' she said.

In December, a D.C. Superior Court jury ordered GHA to pay damages of \$2 million. The case is on appeal. A spokesman for Humana Inc., which bought GHA and renamed it Humana Group Health Plan Inc. last year, declined to comment on the Reyes and Thompson cases, as did lawyers who represented GHA.

The Quality Equation

HMOs have the potential to greatly improve the practice of medicine because they can collect data on what works and what doesn't for large numbers of patients and help standardize patient care, analysts and industry executives say. U.S. Healthcare, for example, sends doctors and patients periodic reminders for vaccinations, mammograms and other screenings. Last year, the Pennsylvania-based company began sending

letters to all the suspected diabetics in its HMOs and their physicians, saying the patients should get annual eye exams because diabetes would put them at higher risk of developing a retinal problem. The percentage of suspected diabetics receiving eye exams rose to 41.6 percent in 1994 from 35.9 percent in 1993, the company said.

On balance, Stanford's Enthoven said, care is improving as managed care systems bring independent quality control to doctors' historically autonomous medical practices.

However, the effects are difficult to quantify. 'We don't have very much information on how the system is performing,' said O'Kane, the National Committee for Quality Assurance president.

The financial payoff for the public is easier to see. The cost of employer-sponsored health benefits, which was rising an average of 17.1 percent in 1990, declined an average of 1.1 percent last year, according to a survey by the consulting firm A. Foster Higgins & Co. Some health plans are offering to cut large employers' rates by as much as 10 percent next year, benefits consultants said.

Various financial interests cloud the debate over what is happening to quality and access. Many of the harshest critics of the health care revolution are doctors and nurses whose incomes are threatened. But many of the revolution's strongest exponents -- the leaders of the managed care industry -- are profiting greatly from the cost-cutting. They pay themselves, their employees and their shareholders with money they squeeze out of the system.

A Pressure to Discharge

Hospitals are caught in the squeeze, and one result is pressure to send patients home quicker.

For example, from 1984 to 1994, the average length of hospital stays declined from seven days to three days for simple mastectomies, from 11.8 days to eight days for heart attacks, and from 2.6 days to 1.6 days for normal deliveries, according to HCIA Inc., a health care information company.

Many newborn babies and their mothers are being sent home within a day of delivery. A study released in May by Augusto Sola, director of neonatal clinical services at the University of California, San Francisco, linked the declining length of hospital stays to an increasing number of cases in which newborns have developed a rare form of brain damage.

Sola said it could cost \$40 million to keep newborns hospitalized long enough to prevent just one case of brain damage, but he added that there might be a more economical alternative involving heightened follow-up care after infants leave the hospital.

In the pursuit of efficiency, hospitals, HMOs and doctors' offices have been assigning certain responsibilities to less highly skilled, less highly compensated personnel. One goal is to free the more highly trained professionals to focus on the more complicated work.

Critics say the strategy may increase the likelihood of error.

At an Indiana hospital, a nursing assistant recorded an infant's temperature during a routine check of vital signs, but she did not realize that the reading was dangerously low and did not alert other members of the staff, according to her supervisor.

At Group Health Association, the physician assistant who examined Costella Thompson the day before she died 'could not be expected to know any better,' but the HMO erred by allowing him to treat Thompson's 'life-threatening illness,' Heckman, a gastroenterologist, said in a deposition for a lawsuit filed by Thompson's widower, Duane E. Thompson.

According to an autopsy report, Thompson was suffering from a punctured esophagus, an internal abscess that extended from the surrounding tissue to her lung, and pneumonia. The puncture apparently occurred when a tube was inserted in Thompson's throat during her March 4 operation.

Physician assistants, certified professionals whose formal training is less extensive than that of doctors, are typically paid about half as much as family physicians and play an increasingly important role in health care. Although once considered with trepidation, physician extenders, such as physician assistants, nurse practitioners and midwives, are now seen as a means to boost practice productivity, an American Medical Association publication reported in February.

A D.C. Superior Court jury in April found that two doctors and a nurse committed malpractice in Thompson's surgical and postoperative care. The jury concluded that Group Health Association 'departed from the standard of care' in Thompson's case. But it ruled that GHA's lapse was not a 'proximate cause' of her death and assessed no damages against the HMO.

By the time Thompson saw the physician assistant, her illness 'was too far advanced and too serious to have been reversed,' Kenneth T. Larsen Jr., former chairman of the Department of Emergency Medicine at Greater Southeast Community Hospital and an expert witness for the HMO, said in a deposition.

THE COSTS OF MANAGED CARE

As more people in the U.S. moved into managed care plans . . . 1991:
Managed care -- 47% Conventional coverage -- 53%
1994: Managed care -- 65% Conventional coverage -- 35%

SOURCE: KPMG surveys of employer-sponsored health benefits, which reflect employers with 200 or more workers.

Caption:

(This graphic was not available)

The average cost of employer-sponsored health benefits grew more slowly in 1992 and 1993 and then declined last year.

Rate of increase or decrease in average total benefit cost
1991 -- 12.1% 1992 -- 10.1% 1993 -- 8.0% 1994 -- -1.1%

SOURCE: Foster Higgins national survey of employer-sponsored health plans, which reflects employers with 10 or more employees.

Caption:

(This graphic was not available)

But certain complaints seem more common among managed care patients than among patients with conventional coverage.

Complaints:

Had problems getting necessary treatment:

Conventional coverage -- 13%

Managed care -- 22%

Unable to see specialist when needed in past year:

Conventional coverage -- 15%

Managed care -- 21%

Unable to get needed diagnostic tests in past year:

Conventional coverage -- 17%

Managed care -- 24%

Had to wait a long time for routine appointment:

Conventional coverage -- 7%