

LEVEL 1 - 1 OF 1 STORY

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HEADLINE: Husband Sues HIP in Death / Says HMO's rules helped kill wife

BYLINE: By Roni Rabin. STAFF WRITER

BODY:

Sabina Friedman's first symptoms were a motley mix: lower back pain, night sweats, an eerie galloping heartbeat. The Flushing schoolteacher's first thought was: cancer.

But when the 46-year-old woman consulted her HIP doctor in September, 1990, the physician said her symptoms were related to menopause - and sent her to a psychiatrist. Friedman continued to complain for two years, but even in September, 1992, when she passed blood in her urine, the HIP doctors prevaricated, delaying appointments with specialists, sending her to a hospital that knew nothing of her case and told her to go home, taking weeks to authorize crucial but expensive diagnostic procedures.

By the time an outside surgeon she went to on her own removed Friedman's left kidney, along with a tumor the size of a grapefruit, the cancer had spread to her lymph nodes. She died in June, 1993, leaving four children, then aged 14 to 25.

Friedman's husband, Nathan, is suing the two HIP doctors who treated her, but he isn't stopping there. In an unusual, potentially ground-breaking lawsuit, Nathan Friedman has named HIP, the Health Insurance Plan of Greater New York, as a defendant. Even though insurance companies are immune from malpractice suits because they do not actually practice medicine, Friedman's suit charges that the health maintenance organization's method of paying its doctors interfered with the physicians' medical judgment.

The suit also charges the HMO with making false statements about the quality of medical care it provided and breaching a fiduciary duty to its clients with ads that promised a rigorous quality-control program, early detection of illness and quick referrals to specialists, with appointments made "at the same medical center, sometimes within a single visit."

HIP officials deny the charges, saying they stand by their advertising, and reject the accusation that their doctors' medical practice is affected by financial motives.

But Steven Friedman, Sabina Friedman's 28-year-old son, who has assumed the role of family spokesman, said his family would never have bought health insurance from HIP or trusted HIP physicians had they known of the financial



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arrangements between the HMO and the medical group.

"My father isn't interested in money, he's interested in changing the system," Friedman said. "We want to change the system where a doctor is paid a flat amount per patient, so he has an incentive to see them as little as possible and make fewer referrals to specialists, to reduce costs and maximize profits.

"My mother didn't like the idea of suing," he said. "All she cared about was her children and her family. But she made me promise her this on her death bed, that we would get the message out so this doesn't happen again."

At the heart of the suit is the question of capitation, a system by which insurance companies do not pay the physician each time he or she renders a treatment, but rather, give the doctor a fixed sum per head for each patient who signs up - whether the patient is chronically ill or healthy. HIP, which contracts with large independent medical groups, does not pay physicians individually but allocates its groups a fixed sum for each member who signs up with them. As a result, the group must absorb the cost of extra tests, procedures or visits to specialists.

"The system . . . makes it more profitable for the HIP medical group to do as little as possible for each of the patients signed up for care by its physicians," the court papers charge. With over 90 percent of staff physicians being stockholder-owners in the group medical practice, the papers conclude, "it creates a built-in financial inducement for the owners of the HIP-approved medical group to ignore their patients' needs."

The argument against HIP was dismissed by the lower court, New York Supreme Court in Queens County, but Friedman is appealing. A hearing is scheduled for today before the appellate division in Brooklyn.

Although representatives of HIP predicted the attempt to pull HIP into the lawsuit would fail in the higher court as well, several lawyers who are experts in medical malpractice praised the legal strategy, saying it is innovative and timely. Friedman is represented by attorney Benjamin Vinar of Garden City.

"It's a very creative approach to the legal consequences of cutting the quality of care in order to save money," said Whitney Seymour Jr., a Manhattan lawyer who has filed numerous lawsuits against managed-care companies on behalf of the League of Physicians and Surgeons, an advocacy group for physicians.

Thomas Stanisci, a Mineola malpractice lawyer who is former chairman of the Nassau Bar Association's medical-legal committee, predicted a proliferation of malpractice lawsuits, as doctors hold back on extra tests and care due to pressure from managed-care companies.

"I think these insurance companies are making medical decisions," he said. "If you call their 800 number and they say that you don't need to go to an emergency room, aren't they giving medical advice? Or are they merely stating that in their opinion you don't need a physician?"

HIP officials and attorneys representing the physicians in the Friedman case said they could not comment on the malpractice issues while the case was ongoing. However, HIP spokesman Kevin Davitt said HIP is confident the lower



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court ruling, a terse two-page ruling that rejected a claim for tortious interference against HIP, would be affirmed on appeal. Although Friedman's case does not charge the HMO with medical malpractice per se, previous attempts to name HMOs as defendants in malpractice suits have been rejected universally by the courts in New York state.

"The lower court has pretty much made it clear that the Friedmans' attorney does not have a legal leg to stand on," Davitt said.

GRAPHIC: 1) Newsday Photo- Nathan Friedman, center, with three of his four children, from left, Rafe, Steven and Francine. He is suing HIP and two of its doctors in the death of his wife, Sabina. 2) Photo- Sabina Friedman in 1966

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KUHL v. LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC. (8th Cir. 1993)
999 F.2d 298

Mr. Kuhl had a heart attack. His doctor decided on June 20, 1989 that he required specialized heart surgery. Because the hospitals in his town did not have the necessary equipment for such surgery, the doctor arranged for the surgery to be performed in St. Louis at Barnes Hospital.

When Barnes Hospital requested precertification for the surgery, the utilization review coordinator at Mr. Kuhl's HMO refused to precertify the surgery because the St. Louis hospital was outside the HMO service area. Accordingly, the surgery scheduled for July 6 was cancelled. The HMO instead sent Mr. Kuhl to another Kansas City doctor on July 6 to determine whether the surgery could be performed in Kansas City. That doctor agreed with the first doctor that the surgery should be performed at Barnes Hospital. Two weeks later, the HMO agreed to pay for surgery at Barnes Hospital. By then, the surgery could not be scheduled until September.

When the doctor at Barnes Hospital examined Mr. Kuhl on September 2, Mr. Kuhl's heart had deteriorated so much that surgery was no longer a possibility. Instead, he needed a heart transplant. Although the HMO refused to pay for an evaluation for a heart transplant, Mr. Kuhl managed to be placed on the transplant waiting list at Barnes. Mr. Kuhl died waiting for a transplant.

The survivors of Mr. Kuhl have no damages remedy against the HMO under ERISA. Mr. Kuhl's survivors' state law causes of action were eliminated due to ERISA.

SPAIN v. AETNA LIFE INSURANCE CO. (9th Cir. 1993)
11 F.3d 129, cert. denied (1994)

Mr. Spain was diagnosed with testicular cancer. The recommended course of treatment was three-part procedure which had to occur in a short time period. Although Aetna initially approved the treatment, Aetna withdrew its approval prior to the third part of the procedure.

While Aetna ultimately changed its position and authorized the third part of the procedure, it was not authorized until it was too late to be effective. Mr. Spain died. There are no damage remedies against Aetna under ERISA. Mr. Spain's survivors' state law causes of action were eliminated due to ERISA.

SETTLES v. GOLDEN RULE INSURANCE CO. (10th Cir. 1991)
927 F.2d 505

Mr. Settles was in an employer-sponsored health plan. The employer paid a monthly premium to Golden Rule and the employer was required to give written notice to the insurer

in advance of terminating Mr. Settles' coverage. On October 24, the insurer notified Mr. Settles by a letter that it had terminated his insurance unilaterally. That same day Mr. Settles suffered a heart attack and he died five days later.

The widow sued Golden Rule in state court alleging that the death of her husband was caused proximately by the insurer's unilateral decision to terminate his insurance. The court ruled that ERISA preempted her state claims. ERISA does not provide a damage remedy for her losses.

II. Federal District Court Decisions:

WURZBACHER v. PRUDENTIAL INSURANCE CO. OF AMERICA (E. Dist. Ky. January 27, 1998)

Mr. Wurzbacher received monthly injections of leupron as treatment for his prostate cancer. Under his retiree health plan, the treatment was fully covered (paid 100% of the \$500 charge) and paid for. When Prudential took over as the plan administrator, it changed the coverage stating the plan would now only cover 80% of \$400 (\$320) of the \$500 charge for each injection. Since Mr. Wurzbacher could not afford to pay the additional \$180, he asked his physician for alternatives. In light of the aggressiveness of the cancer, the doctor said the only alternative was castration. The request was approved by Prudential and he was castrated.

When he returned home, he found a letter from Prudential notifying him that it had made a mistake and that the plan would pay the full \$500 for the monthly leupron injection.

The court held that the Wurzbachers' claims for state damages were eliminated due to ERISA. Neither Mr. Wurzbacher nor his spouse have a damage remedy under ERISA for alleged negligence by Prudential in denying the claim.

**ANDREWS-CLARKE v. TRAVELERS INSURANCE CO. (D. Mass. Oct. 30, 1997)
21 EBC 2137, 1997 WL 677932**

Richard Clarke's health plan covered at least one 30-day inpatient rehabilitation program per year when necessary. Travelers refused to approve Richard's enrollment in a 30-day inpatient alcohol rehabilitation program. Instead it approved two separate brief (five and eight days, respectively) hospital stays. Within 24 hours after the second hospital stay, Richard attempted suicide in the garage with the car engine running while he consumed a combination of alcohol, cocaine, and prescription drugs. His wife discovered him by breaking through the garage door. Mr. Clarke was taken to the hospital where he was treated for carbon monoxide poisoning.

At his mental commitment proceeding, the court ordered Mr. Clarke to participate in a 30 day detoxification and rehabilitation program following his release from the hospital.

Travelers "incredibly refused" to authorize admission under his plan. Instead, for his detoxification and rehabilitation, Mr. Clarke was sent to a correctional center, where he was forcibly raped and sodomized by another inmate. He received little therapy or treatment at the correction center. Following his release, he went on a prolonged, three-week drinking binge. He was hospitalized overnight with respiratory failure. After his release from the hospital, he began drinking again. He was found the following morning dead in his car, with a garden hose running from the tailpipe into the passenger compartment.

Mr. Clarke's widow and four minor children sued Travelers and its utilization review provider under state law. ERISA was held to preempt all of these and to provide no remedy. The Court, recognizing "the perverse outcome generated by ERISA in this particular case," called upon Congress for reform.

THOMAS-WILSON v. KEYSTONE HEALTH PLAN EAST HMO (E.D. PA 1997)
1997 U.S. District Court LEXIS 454

In May of 1995, Ms. Thomas-Wilson was diagnosed with Lyme disease. She began receiving intravenous antibiotic treatment on June 6, 1995, which the HMO covered. In August of that year, the HMO denied continuation of that treatment. Since she could not afford to pay herself for the treatments, she stopped receiving them and her condition worsened. She could not work or perform household duties. Her neck and back pain became so severe and persistent that she needed a full-time caregiver.

From September through December of 1995, the HMO required her to undergo extensive testing to determine if she had Lyme disease. In December of 1995, the HMO reinstated coverage for the intravenous antibiotic treatment.

Ms. Thomas-Wilson filed suit alleging that she became severely disabled and endured great pain, suffering, depression, and changes in personality as a result of the interruption of her treatment.

The court found that Ms. Thomas-Wilson's and her spouse's state tort claims against the HMO were preempted by ERISA. There was no damage remedy available under ERISA.

TURNER v. FALLON COMMUNITY HEALTH PLAN, INC. (D. Mass. 1997)
953 F. Supp. 419

Mrs. Turner's HMO refused to authorize cancer treatment. She died. Mr. Turner sued his spouse's HMO for allegedly causing her death by refusing to authorize treatment.

The court held that, even assuming there had been a wrongful refusal to provide the treatment to Mrs. Turner, her surviving spouse's state claims were preempted by ERISA. Mr. Turner has no damage remedy available under ERISA.

FOSTER v. BLUE CROSS AND BLUE SHIELD OF MICHIGAN (E.D. Mich. June 23, 1997)
969 F. Supp. 1020

Ms. Foster was diagnosed with breast cancer and Blue Cross refused to approve the treatment prescribed of high dose chemotherapy with peripheral cell rescue and autologous bone marrow transplantation. Because of this denial, Shelly Foster did not receive the treatment and died. The court, noting that this was a "harsh result," held that the claims of her spouse for breach of contract, bad faith and infliction of emotional distress, negligent misrepresentation and fraud, and wrongful death, as well as any claim under the Michigan civil rights statute, were all preempted by ERISA. Mr. Foster had no damage remedy under ERISA.

SMITH v. PRUDENTIAL HEALTH CARE PLAN, INC. (E.D. Penn. 1997)
1997 WL 587340

Mr. Smith's contract with Prudential through the PAA Trust required pre-authorization for medical treatment before insurance coverage would be provided. After Mr. Smith injured his leg in an automobile accident on January 18, 1995, he needed surgery to reduce his heelbone. When no doctor participating in the Prudential HMO was available, Mr. Smith found a qualified out-of-network doctor to perform the surgery. Prudential would not authorize the surgery since "surgical correction is no longer possible." Mr. Smith filed a state action for breach of contract, negligence, and negligent performance of contract.

The court ruled that plaintiff's claims were preempted by ERISA. Mr. Smith has no remedy under ERISA.

UDONI v. DEPARTMENT STORE DIVISION OF DAYTON-HUDSON (N.D. Ill, 1996)
1996 U.S. Dist. LEXIS 8282

Mrs. Udoni's bone deterioration in her facial bones, caused by osteoporosis, prevented her from eating food. Her bone deterioration caused numerous other problems. Her doctors had to replace her facial bones with bones from her hip.

Under Mrs. Udoni's medical plan, medical conditions were fully covered but treatments to correct conditions of the teeth, mouth, jaws, jaw joints were excluded. The plan's administrator classified Mrs. Udoni's operation as "dental" and denied coverage for surgery.

The court ruled the interpretation of the plan was arbitrary and capricious. The physicians had provided evidence repeatedly explaining the medical necessity and classification of her specific surgery. Recognizing that to remand the case to the administrator would be futile in light of its "continued refusals to consider (or even acknowledge) substantial evidence of the merits" of Mrs. Udoni's claim, a bench trial was scheduled.

ERISA provides no remedy for complications resulting from the deterioration in Mrs. Udoni's physical condition during the coverage disputes. Mrs. Udoni's claim for damages arising from improper denial of benefits were eliminated under ERISA.

BAILEY-GATES v. AETNA LIFE INSURANCE CO. (D. Conn. 1994)
890 F. Supp. 73

Mr. Bailey-Gates was hospitalized in May of 1991 for physical and mental disorders. A managed care nurse for Aetna ordered him released on June 18, 1991. He was released on June 25 and less than two weeks later, on July 4, 1991, he committed suicide.

His survivors sued Aetna for negligently releasing him while he was still in need of hospitalization for his disorders. The court ruled that ERISA preempted his survivors' state claims. Mr. Bailey-Gates' survivors have no damage remedy under ERISA.

GARDNER v. CAPITAL BLUE CROSS (M.D. Penn. 1994)
859 F. Supp. 145

Although Ms. Wileman's tumor from her peripheral neuroectodermal cancer was reduced by 70% from chemotherapy, only a bone marrow transplant could possibly eliminate the cancer. Blue Cross initially denied the request and refused to pre-certify the procedure. Blue Cross reconsidered and agreed to pay for the bone marrow transplant after it heard from Ms. Wileman's lawyer and the Pennsylvania Insurance Department.

Ms. Wileman's condition worsened sufficiently during the delay following the denial. Her doctors decided she was too weak to undergo the bone marrow transplant when they were preparing for the transplant in June of 1993. In September of 1993, Ms. Wileman died.

The court held that ERISA preempted her survivors' state negligence claims against the HMO. Her survivors have no damage remedy under ERISA.

NEALY v. U.S. HEALTHCARE HMO (S.D. N.Y. 1994)
844 F. Supp. 966

Mr. Nealy had been treated by his doctor for an anginal condition. The HMO had assured Mr. Nealy that he could continue the care he was receiving for his pre-existing condition and be treated by the doctors he had been seeing.

After Mr. Nealy enrolled in the HMO, he was not issued an identification card. One week after first seeking an appointment, Mr. Nealy was examined on April 9, 1992, by a primary care physician who refused to refer Mr. Nealy to his former cardiologist. The HMO explained its refusal in an April 29, 1992 letter saying it had its own participating cardiologists. On May 15, 1992, the primary care physician authorized Mr. Nealy to see a cardiologist on May 19,

1992. Mr. Nealy suffered a massive heart attack on May 18, 1992 and died.

The court ruled that Mr. Nealy's surviving spouse's state claims were preempted due to ERISA. Mrs. Nealy has no claim for damages under ERISA.

DEARMAS v. AV-MED (S.D. Fla. 1993)
814 F. Supp. 1103

Ms. Dearmas was injured in an automobile accident, and she was transferred to four different hospitals in three days by her HMO based on the availability of providers participating in her plan at those facilities. As a result of those transfers, as well as other delays in her treatment, she alleged irreversible neurological damage.

The court held that ERISA preempted her state negligence claims against the HMO. Ms. Dearmas has no claim for damages under ERISA.

POMEROY v. JOHNS HOPKINS MEDICAL SERVICE (D. Md. 1994)
868 F. Supp. 110

Mr. Pomeroy required surgery for dilopia (double vision). The HMO denied his claim. Five months later, in September of 1990, suffering from back pain and severe depression, the HMO again denied treatment. After these denials, he became addicted to a pain killer. When he sought treatment for the addiction, the HMO once again denied his claim.

Mr. Pomeroy pursued his benefits under the state Health Claims Arbitration Board and the HMO removed the case to federal court.

The court dismissed with prejudice Mr. Pomeroy's state claims for mental, physical and economic losses due to ERISA preemption. The court also dismissed without prejudice his benefit claim. Mr. Pomeroy has no claim for damages under ERISA.

KOHN v. DELAWARE VALLEY HMO, INC. (E.D. Penn. 1992)
14 EBC 22336

Mr. Kohn entered outpatient drug and alcohol rehabilitation in 1989. His HMO primary care physician admitted him in February of 1990 into an in-patient program. When the 15 days concluded, the therapist determined additional inpatient care was necessary. The HMO not only refused coverage for the additional inpatient care but refused to allow Mr. Kohn's family to pay for that additional care. While attempting to cross the railroad tracks in a drunken stupor, he was struck and killed by a train two weeks after leaving the rehabilitation center.

The court found that ERISA preempted his survivors' claims based on denial of additional treatment. The court also held that a vicarious liability claim against the HMO based on ostensible agency would not be preempted if the HMO doctors committed malpractice. The survivors had no claim for damages under ERISA.

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treatments, and her leukemia went into remission. Subsequently, her insurer amended her policy to state that preauthorization would be denied for an autologous bone marrow treatment if sought after the first remission.

Ms. Cannon's doctor recommended an autologous bone marrow treatment and requested preauthorization from the insurer. When the insurer denied the treatment as experimental, the doctors made a second request which was also denied. Through persistence by the doctor and Ms. Cannon, the insurer reversed its decision and authorized the treatment approximately seven weeks after the first request was made. It was not until 18 days after the decision to authorize the treatment was made that Ms. Cannon learned of the reversal. Two days after notification, she was admitted to the hospital and died the following month.

Ms. Cannon's surviving spouse brought several state law claims. The court held that the state law causes of action were preempted due to ERISA and that there was no remedy under ERISA for the delay in receiving the authorization. The court apologized for the result.

JASS v. PRUDENTIAL HEALTH CARE PLAN, INC. (7th Cir. 1996)
88 F.3d 1482

Ms. Jass was in an employer-sponsored health plan using Prudential Health Care Plan to administer the plan. She had complete knee replacement surgery. A utilization review administrator for Prudential determined that it was not necessary for Ms. Jass to receive a course of physical therapy following the surgery to rehabilitate the knee.

Ms. Jass claimed that her discharge from the hospital was premature since she had not received required rehabilitation and she had permanent injury to her knee.

Ms. Jass had no damages remedy against either the utilization review administrator or Prudential under ERISA. The court found that ERISA preempted any state claim against Prudential for vicarious liability for the doctor's alleged negligence in connection with the denial of rehabilitation.

COMER v. KAISER FOUNDATION HEALTH PLAN (9th Cir. 1994)
1994 U.S. App. Lexis 27358

Although Ryan Comer had been diagnosed with an unusual form of pediatric cancer, Kaiser denied coverage for high-dose chemotherapy and denied authorization for an autologous bone marrow transplant. Ryan subsequently died.

Ryan's parents' state wrongful death action was preempted by ERISA. Ryan's parents' had no damage remedy available to them under ERISA.

Cases 151-175

151. A 39-year-old woman had difficulty getting psychotherapy after she was physically assaulted in front of her home. Whenever the woman called her HMO to question its decisions to deny therapy, the clerk at the other end of the line would repeatedly refer to her as "a mental patient". The HMO's little strategy worked. "I was so humiliated. I eventually paid for my own treatment," the woman said.

(Pham, Alex, "HMOs unveil reform package," *Boston Globe*, Mar. 8, 1997.)

152. A woman on a business trip suddenly experienced a racing heartbeat and collapsed, losing consciousness. The hotel manager called an ambulance, which came and took the woman to the hospital. As soon as the woman came to she called her HMO and received authorization for an emergency admission. The HMO, however, had second thoughts and later denied the admission. The HMO first claimed the woman's problem, a panic attack, was not an emergency. Then the HMO claimed that it never gave authorization. Finally, the HMO said it lost the patient's ER bill. It took 18 months for the HMO to pay the bill.

(Morgan, Peggy and Sarah Robertson, "Can this medical plan be saved?", *Prevention*, April 1997.)

153. An Arkansas woman suffered a broken neck in a car wreck and was rushed to the hospital. Her managed care company refused to pay her emergency room claim because she failed to get preauthorization.

("Too many HMOs stint on emergency-room care," *USA Today*, Apr. 11, 1997.)

154. A 54-year-old man who had just had prostate surgery was told by his HMO that he must leave the hospital within 24 hours of his surgery, or it wouldn't pay a cent. He had to leave the hospital for an empty home even though he was still bleeding and had to wear a catheter to drain his bladder. He couldn't even walk.

(Morgan, Peggy and Sarah Robertson, "Can this medical plan be saved?", *Prevention*, April 1997.)

155. Before an 11-year-old girl underwent surgery for scoliosis, her surgeon authorized a procedure whereby the girl donated three pints of her own blood to serve as a standby supply in case it was needed during the operation. The operation went by without a hitch -- only one pint of the girl's blood was needed. The HMO wouldn't pay for the cost of donating and preparing the other two pints of blood, despite the surgeon's authorization for the donation.

(DeVita, Elizabeth, "The HMO Police," *American Health*, December 1996.)

Cases 51-75

51. In Augusta, Georgia, a Republican member of the state house of representatives told a reporter that an HMO sent his uncle home from the hospital following open-heart surgery even though "his chest wasn't even healed."

(Salzar, James, "Managing the medical market," *The Georgia Times-Union*, Jan. 28, 1996.)

52. Recently, a Washington, D.C. HMO refused to cover the costs of an emergency hospitalization for lymphoma for an AIDS patient visiting his brother in New York. Essentially, the HMO's policy excluding care for foreseeable medical problems outside the HMO's service area forces AIDS patients to choose between visiting loved ones and receiving medical care. A federal appeals court has rejected a lower court's ruling in favor of the HMO.

("Court Rejects HMO's Limitation of AIDS Coverage," *West Hollywood Frontiers*, Jan. 12, 1996.)

53. Wakened in the middle of the night, a woman found her 78-year-old husband coughing up blood. She ran to the phone, but she didn't call 911. Since she had previously made an emergency call which left her with doctors' bills her HMO refused to pay, she dialed her HMO's emergency line. Twelve minutes later, the HMO physician called back to say he was sending an ambulance, but the private ambulance company with which the HMO had a contract sent its driver to the wrong town. Finally, the HMO physician himself had to call 911 and ask for a city-owned ambulance. By the time the ambulance got to the women's home, 40 minutes after the first emergency call, her husband was dead.

(Rabin, Roni, "In Case Of Emergency," *Long Island Newsday*, Feb. 11, 1996.)

54. A New York man slipped and cracked his skull as he was getting out of a taxi. The taxi driver called 911, and the victim was rushed to an emergency room, where he was given stitches, had a fracture set, and received treatment for a possible concussion. The episode wasn't a pre-authorized emergency, so the patient's HMO refused to pay the bills.

(Rabin, Roni, "In Case of Emergency," *Long Island Newsday*, Feb. 11, 1996.)

55. An elderly woman suffered cardiac arrest and was taken to an emergency room where she was stabilized before undergoing surgery. Her HMO paid for the surgery, but for some reason refused to pay the emergency bills.

(Rabin, Roni, "In Case of Emergency," *Long Island Newsday*, Feb. 11, 1996.)

56. A 5-year-old boy who fell from a balcony and hit his head on concrete was brought to an emergency room on a backboard. As hospital workers rushed to give him a spinal X-ray and CT scan, the HMO requested that he be put in a taxi and driven to its medical center. Emergency doctors ignored the request.

(Rabin, Roni, "In Case of Emergency," *Long Island Newsday*, Feb. 11, 1996.)

57. A breast cancer patient was denied coverage for chemotherapy by the self-insured benefits plan of her union. The woman's doctor could get no explanation for the denial. Eventually the woman obtained the needed drugs through a manufacturer's representative -- as a charitable gesture.

(Sherman, William, "Pity These Poor Patients," *New York Post*, Sept. 20, 1995.)

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Fight Managed Care!

The List of Cases Continues to Grow

I have spent the last two years compiling a list of more than 200 managed care horror stories from news sources all over the country. These stories are moving and powerful. Needless to say, the HMO industry hates my cases, dismissing them as "anecdotal". HMO executives, puffed up with righteous indignation, declared months ago that they would start collecting positive managed care stories. Well, what exactly is a "positive" managed care story? Someone got the care he needed and paid for?

I have posted these horror stories on the internet to help get them to as many people as possible. My hope is that our lawmakers feel enough pressure from their constituents to introduce and pass legislation reining in the power of the insurance companies. This collection of stories has already made the rounds on Capitol Hill, and a number of newspaper and magazine reporters have contacted me about them. I feel that this kind of dissemination is necessary. Feel free to copy these cases and distribute them.

I thank everyone who has sent me managed care horror stories and comments via e-mail and fax. Please, if you have any personal horror stories or read of any send them my way. (Personal stories must include real name and return address.) My e-mail address is pico@his.com. My fax number is 301-588-4732.

Stories 26-50. ~ Stories 51-75. ~ Stories 76-100. ~ Stories 101-125. ~ Stories 126-150. ~ Stories 151-175. ~ Stories 176-200 (All not yet posted).

1. A 27-year-old man from central California was given a heart transplant, and was discharged from the hospital after only four days because his HMO wouldn't pay for additional hospitalization. Nor would the HMO pay for the bandages needed to treat the man's infected surgical wound. The patient died. ✕

(Mitchell, Larry, "Butte urged to immunize against potential HMO ills," *The Enterprise-Record*, Jan. 21, 1996.)

2. A four-year-old girl ran a high fever following a five-hour hospital stay for a tonsillectomy (considered an outpatient operation by HMOs.) Her mother took the girl to her HMO pediatrician, who didn't take the girl's temperature, didn't examine her throat, and didn't refer the girl back to the surgeon -- a routine procedure for post-operative problems. The girl died of a hemorrhage at the surgical site. ✕

(Sherman, William, "Tragic tonsillectomy for girl, 4," *New York Post*, Sept. 20, 1995.)

3. A mother in Atlanta called her HMO at 3:30 a.m. to report that her 6-month-old boy had a fever of 104 and was panting and limp. The hotline nurse told the woman to take her child to the HMO's network hospital 42 miles away, bypassing several closer hospitals. By the time the baby reached the hospital, he was in cardiac arrest and had already suffered severe damage to his limbs from an acute and often fatal disease, meningococemia. Both his hands and legs had to be amputated. A court subsequently found the HMO at fault.

(Rabin, Roni, "In Case of Emergency," *Long Island Newsday*, Feb. 11, 1996.)

4. A newborn boy died after an HMO-mandated one-day maximum stay in the hospital -- even though his mother expressed concern about his health prior to the forced discharge.

(Sherman, William, "What his parents didn't know about HMOs may have... Killed This Baby," *New York Post*, Sept. 18, 1995.)

5. A Texas woman with a disabled 11-year-old son was told that her managed care plan was retroactively denying payment for all oxygen, nursing care, respirator supplies, speech therapy, and incontinence supplies because, the case manager said, "Your son costs too much money." The case manager is then quoted as saying that the boy's parents should "put him in an institution in Wisconsin, and since your husband works for an airline, go fly to visit him." Of course, the managed care plan would not pay for the institutionalization. X

(Letter to the California Nurses Association, in response to "Patient Watch" advertisements placed in 1996 in a number of national and local newspapers: name of writer available upon request to CNA.)

6. A Medicare HMO beneficiary with symptoms of pneumonia and a heart attack was denied admission to a hospital, with the concurrence of his HMO primary physician. The man died on the way to see the doctor. X

(Rosenthal, Harry, "HMOs not popular with Medicare recipients," *Today's Sunbeam*, Jan. 7, 1996.)

7. A Washington, D.C. woman complaining of a post-surgery sore throat and nausea went back to the hospital for treatment. Her HMO allowed a relatively inexperienced physician's assistant to examine her and prescribe some medicine and bedrest. The woman died at home that night. She was suffering from a punctured esophagus received during surgery a little more than a week earlier. X

(Hilzenrath, David S., "Costly Savings: Downside of the New Health Care," *Washington Post*, Aug. 7 1995.)

8. A Milwaukee HMO and a medical laboratory were ordered to pay a \$10 million settlement to two families after pap smear misreadings led to the deaths of two women. According to testimony at a Congressional hearing on health care fraud, the owner of the lab also served on the HMO's board of directors, and was given his competitor's bids in advance. The lab later pleaded no contest to reckless homicide. X

("No Contest In Pap Smear Misreadings," *Washington Post*, Dec. 7, 1995.)

9. A woman took her son to her HMO network doctor, saying the boy had a broken leg. The doctor did not X-ray the leg, and insisted twice that it wasn't broken. Only after the woman took her son to an emergency room was an X-ray ordered. The break was diagnosed and set. X

(Ress, David, "Getting to the nitty-gritty," *Richmond Times-Dispatch*, Mar. 18, 1996.)

10. A 15-year-old girl with a serious knee injury was taken by her parents to a PPO orthopedic surgeon. The surgeon said there are two kinds of surgery for such an injury, traditional scalpel surgery and state-of-the-art laser surgery, which is considered the most effective method. The insurer would not pay for the more expensive laser surgery. A company claims supervisor was quoted as saying, "We are not obligated contractually to provide Cadillac treatment, but only a treatment."

(Tomczak, Garrett, "Ignorance isn't bliss on HMOs," *Minneapolis Star Tribune*, Mar. 23, 1996.)

11. To help harried doctors cope with managed care arrangements, Harvard Medical School offers a

course providing tips on "streamlining" a comprehensive physical exam to save time. One suggestion is to skip the usual practice of looking in the patient's ears if the real concern may be something else.

(Uhlman, Marian and Susan FitzGerald, "Is your doctor looking out for you? Or your insurer?" *Philadelphia Inquirer*, Mar. 24, 1996.)

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X 12. A New York man twice got authorization from his HMO to go to the nearest emergency room for mysterious stomach pains. After discharge, he was told his plan wouldn't pay the \$3,220 bill because the care was "not preauthorized." The New York Insurance Department's Office of Consumer Affairs forced the company to pay the bill.

(Sherman, William, "Play By The Rules," *New York Post*, Sept. 19, 1995.)

13. In February 1991, a man with a high fever and suffering night sweats went to his HMO primary care doctor, who took less than five minutes to pronounce the man's ailment the common cold. Still sick and losing weight, the man later visited an out-of-network doctor who ordered a blood test and sent the man to the hospital. The man ended up spending a month in the hospital receiving treatment for hepatitis. The HMO refused to pay the \$6,300 bill because the man broke the rules and went out of the network to receive proper medical care.

(Rubinowitz, Susan, "Council panel told very sick have a lot to sweat about," *New York Post*, Apr. 2, 1996.)

14. An Oklahoma neurologist performed a CT scan on a patient suffering headaches, revealing an abnormality in the brain. The doctor recommended a magnetic resonance arteriogram, which required a one-night stay in the hospital. The patient's HMO denied payment on the grounds that the test was investigative. The doctor wrote the patient saying, "I still consider that a magnetic resonance arteriogram is medically necessary in your case..." The HMO wrote to the doctor. "I consider your letter to the member to be significantly inflammatory," the HMO's medical director wrote. "You should be aware that a persistent pattern of pitting the HMO against its members may place your relationship with [the HMO] in jeopardy."

(Trafford, Abigail, "For Some Doctors Today, Mum's the Word," *Washington Post Health*, Mar. 12, 1996.)

15. A 12-year-old girl had to wait half a year for a back operation to correct severe scoliosis. The reason: the HMO rejected the parents' bid to have a specialist perform the procedure, insisting instead on an in-network surgeon. After taking six months to determine that no one in its own network was capable, the HMO relented.

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(Sherman, William, "Girl waited 6 months for spine surgery," *New York Post*, Sept. 19, 1995.)

16. A New York Health Department investigation criticized an HMO and its doctors for not admitting a man who failed several cardiograms and who underwent severe bouts of angina prior to his heart attack. At one point during the man's suffering, doctors recommended a dose of Tylenol and sent him home.

(Sherman, William, "Pity These Poor Patients," *New York Post*, Sept. 20, 1995.)

17. An 82-year-old woman was forced by her Medicaid managed care plan to take a generic blood pressure medication instead of the brand name medication she had taken for years. She suffered an allergic reaction and passed out. Doctors at the emergency room where she was taken said a second dose would have been fatal.

(Jouzaitis, Carol, "Medicaid is no issue in Tennessee -- it's dead," *Chicago Tribune*, Feb. 8, 1996.)

18. A 2-year-old boy suffered severe seizures and was admitted to the hospital with a 104.2 fever. The HMO wouldn't pay the \$1,124 cost of overnight hospitalization. The HMO paid the bill after being ordered to do so during binding arbitration by a state agency.

(Sherman, William, "Pity These Poor Patients," *New York Post*, Sept. 20, 1995.)

19. A healthy 2-year-old boy was taken to a local hospital after a fall, with a stick lodged between his upper lip and gums. Once there, health care personnel repeatedly misdiagnosed the boy's condition, and, mindful of the HMO's cost-consciousness, refused to authorize an \$800 CT scan that would have confirmed that he was developing a brain abscess. As a result of this poor treatment, the boy was left blind and brain damaged.

(Anagnos Liapakis, Pamela, "The Malpractice Epidemic: Don't Let the Industry Get Away with It," *Trial*, February 1996.)

20. A woman who fell on the street and smashed both sides of her jaw was told by an oral/maxillofacial surgeon that she must undergo surgery to repair the damage and alleviate the pain. Four other specialists concurred. The woman's HMO would only pay for repair of half of her jaw. No explanation was given.

(Sherman, William, "Managed-care firm wants half-measure," *New York Post*, Sept. 21, 1995.)

21. An HMO refused to let a highly experienced neurosurgeon operate on a 30-year-old woman's spinal cord tumor, insisting that its own, relatively inexperienced, doctor perform the operation. The first neurosurgeon even agreed to waive his usual \$12,000 fee, given the life-and-death nature of the tumor, leaving the insurance company responsible only for hospitalization costs. The HMO still refused.

(Burke, Cathy, "Dying woman denied doc she needs," *New York Post*, Sept. 21, 1995.)

22. A woman had an inner ear operation which required carving down the bones near her ears. Following the operation, her doctors noticed draining problems and ordered overnight hospitalization. Her HMO refused to pay, insisting that all care be provided only on an out-patient basis.

(Sherman, William, "Casualties of the System," *New York Post*, Sept. 21, 1995.)

23. A woman whose exploratory surgery for ovarian cancer was approved by her HMO had that approval mysteriously withdrawn after she had already been prepped for the operation. Not until 30 months had passed did she finally get approval for the procedure. Doctors found and removed the malignant growth on her ovary.

(Hiltzik, Michael A. and David R. Olmos, "A Mixed Diagnosis for HMOs," *Los Angeles Times*, Aug. 27, 1995.)

24. When a 23-year-old diabetic asked her California HMO why it wouldn't cover the cost of blood-sugar testing supplies, the company's chief executive told a newspaper reporter that the company provides all benefits required by the state. He suggested that the patient "try and get a law passed requiring the kind of coverage she wants."

(Marsh, Barbara, "A Diabetic's Dilemma," *Los Angeles Times*, Aug. 27, 1995.)

25. A 48-year-old Arizona woman diagnosed with multiple sclerosis obtained a referral from her primary care physician to go to a special treatment center. She visited the center three times. Her HMO denied her claims for the visits. A request to cover the cost of her catheters was also denied. The reason: her primary care doctor did not follow proper procedure in granting the referral.

(Madrid, David, "Woman 'punished' for having chronic disease," *The Tucson Citizen*, Jan. 9, 1996.)

The next 25 horror stories...

(Hiltzik, Michael A., "Emergency Rooms, HMOs Clash Over Treatments and Payments," *Los Angeles Times*, Aug. 30, 1995.)

41. Even after doctors recommended inserting special tubes into a 15-month-old baby's ears to relieve abnormal pressure and pain, the girl's HMO refused to cover the cost of the operation. In a desperate bid, the girl's mother called the local newspaper to publicize her ordeal. After being contacted by reporters, HMO officials said they "made a mistake." The operation was authorized.

(Madrid, David, "Fighting for health care," *The Tucson Citizen*, Jan. 9, 1996.)

42. In 1995 the Florida Attorney General's office decertified 21 of the state's 29 Medicaid managed care plans, citing widespread incidences of poor care.

(Himmelstein, David U. and Steffie Woolhandler, "U.S. Health Reform: Unkindest Cuts," *The Nation*, Jan. 22, 1996.)

43. A Minneapolis woman went to her HMO primary care physician complaining of headaches and vomiting. The doctor would not refer her to an imaging center because, according to news reports, he was afraid the "HMO would kick him out." Finally, the woman went to the Mayo Clinic where an MRI revealed that she had a brain tumor the size of a large fist.

(Schechter, Heidi, "A Cancer Journal," *Minneapolis-St. Paul Magazine*, February 1995.)

44. A 44-year-old woman complained to her HMO doctor of abdominal pain, bowel irregularity and other problems. A routine test called a sigmoidoscopy would have revealed the problem. The doctor, though, had had many such recommendations denied by the HMO, and so didn't bother to recommend it in this instance. The patient eventually had to have emergency surgery while on vacation to remove a tumor that had blocked her colon.

(Hilzenrath, David S., "Costly Savings: Downside of the New Health Care," *Washington Post*, Aug. 7, 1995.)

45. A New York psychotherapist treating a 10-year-old boy was concerned about signs of heavy drug use. She suspected heroin. In fact, an HMO psychiatrist had prescribed 30-milligram doses of Prozac for the child, a higher amount than what adults usually receive. The psychotherapist recommended suspending the drug treatment long enough so that she could talk to the boy, but the psychiatrist, intent on keeping costs down for the HMO, persuaded the boy's mother to keep up the drug use in lieu of therapy.

(Pollack, Ellen Joan, "Managed Care's Focus On Psychiatric Drugs Alarms Many Doctors," *Wall Street Journal*, Dec. 1, 1995.)

7/13/98 ✓ 46. Physicians report that HMOs have gag rules limiting their ability to discuss all viable treatments with patients. In 1995 one group of doctors in Ohio received a letter from an HMO that says, "Do not discuss proposed treatment with [the HMO's] members prior to receiving authorization." The letter goes on to forbid doctors to discuss the procedure by which they get such authorization. An HMO spokesperson was quoted saying, "It's a very unfortunate statement, isn't it?"

(Pear, Robert, "Doctors Say H.M.O.'s Limit What They Can Tell Patients," *New York Times*, Dec. 21, 1995.)

Handwritten notes and arrows on the right side of the page, including a large bracket and the phrase "100% of one these doctors".

47. A Florida ratings firm recently completed a national study that analyzed the expenditure-to-premium ratio of HMOs. It found that, on average, HMOs spend 17 percent of premiums on administrative and marketing costs. (Administrative costs for Medicare amount to 4 percent). "Too many managers in the HMO industry have their hands in the cookie jar," the ratings company's president is reported as saying. "They pay out too much in salaries, bonuses and other administrative expenses, but not enough to take care of their members' health."

(Lavey, John, "Study measures state HMOs' care expenditures," *Nashville Business Journal*, Jan. 12, 1996.)

48. Patients who fight their HMOs for adequate care are not trying to get blood from stones. According to a Salomon Brothers analyst, nine of the biggest publicly traded HMOs are sitting on cash reserves of \$9.5 billion. Chief executives at the seven largest HMOs pocketed cash and stock awards averaging \$7 million in 1994.

(Anders, George, "Money Machines: HMOs Pile Up Billions in Cash, Try to Decide What to Do with It," *Wall Street Journal*, Dec. 21, 1994.)

7/13/98 ✓ 49. A former HMO medical reviewer is still haunted by decisions she made to deny care to patients. She was quoted in a special report published in U.S. News & World Report: "If there was any way at all to claim that something requested was experimental or nonstandard, we took it. We looked for ways not to cover treatment," she said.

(Brink, Susan, "The cancer wars at HMOs," *U.S. News & World Report*, Feb. 5, 1996.)

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50. In March, 1995, House Speaker Newt Gingrich called for an unprecedented congressional investigation of the managed care industry. "We need hearings on managed care because anytime you have an accumulation of power comparable to [that in] some of the communities in which managed care is now [and] has a very large penetration, you need to have some kind of government review of what are the procedures, what are the systems, what are the terms of employment, what are some of the conditions of secrecy, etc."

(Chen, Edwin, "Gingrich Calls for Investigation of Managed Care," *Los Angeles Times*, March 29, 1995.)

Another 25 Horror Stories...

58. A 65-year-old Philadelphia woman who needs oxygen treatment for her emphysema is in essence imprisoned in her own home because her HMO won't pay for lightweight oxygen tanks -- despite the fact that physicians at the University of Pennsylvania Medical Center have tried for months to convince the insurer that elderly patients live longer with lighter oxygen equipment.

(Uhlman, Marian, "Medical second-guessing: Insurance companies call the shots," *Philadelphia Inquirer*, Feb. 4, 1996.)

59. A woman whose daughter was born without a right forearm was told by her HMO that it would pay for only one artificial limb -- ever. That policy was quickly changed following contacts by newspaper reporters.

(Uhlman, Marian, "Medical second-guessing: Insurance companies call the shots," *Philadelphia Inquirer*, Feb. 4, 1996.)

60. A 46-year-old woman consulted her HMO primary care physician and complained of lower back pain, night sweats and an irregular heartbeat. The doctor told her her symptoms were related to menopause and sent her to a psychiatrist. She continued to complain about the same problems for two years, and even when she passed blood in her urine the HMO doctor delayed appointments with specialists and instead sent her to a hospital that was completely unfamiliar with her case. The hospital sent her home. Finally, the patient went to an outside surgeon on her own. The surgeon operated and removed her left kidney and a tumor the size of a grapefruit. By then it was too late; the cancer had spread to the patient's lymph nodes and she died soon after.

7/14/98

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(Rabin, Roni, "Husband Sues HIP in Death," *Long Island Newsday*, Feb. 27, 1996.)

61. A woman went in for an annual mammogram. After waiting three months for the results of her test, the woman called her HMO physician, who said the radiologist would send the results to the HMO to be included in her medial record. The HMO told her that they had received the test results and that everything was normal. Notifying patients of negative results would be too costly, the HMO administrator told the woman. Abnormal results are communicated to patients on a post-card... because it's cheaper than a first-class letter.

("A non-profit HMO means more patient services," *Temple Telegram*, Feb. 18, 1996.)

62. Two weeks after she signed her first premium checks for herself and her employees, a small-business owner tore a ligament in her right knee while playing tennis. In pain and barely able to walk, she consulted the list of HMO-approved orthopedists. None she called could see her within a week. Under HMO rules, her condition wasn't serious enough to warrant a visit to the emergency room, so she ended up paying extra to visit a physician outside her plan. She had to fight to get approval for an MRI, and even then the HMO paid only part of the bill. It refused to pay any of the cost of a knee brace.

(Sherman, William, "Health mismanaged care," *Vogue*, Feb. 1996.)

63. Late last year a three-member arbitration panel awarded over \$1 million to the family of a 34-year-old schoolteacher who died of breast cancer. A California HMO was the defendant. Testimony given during arbitration hearings showed that the HMO tried to "influence or intimidate" the woman's oncologist and his superior with "argumentative" phone calls. In the opinion of the panel, "(the) HMO's actions, which were designed and intended to interfere with an existing doctor/patient relationship, constitute extreme and outrageous behavior, exceeding all bounds usually tolerated in a civilized society."

70. A three-month-old girl was diagnosed with leukemia. A bone marrow transplant, with her older sister as the donor, was recommended. The HMO would only approve the operation if it were performed at a hospital in another state that had been designated by the HMO to do all such transplants in the region. The child's physicians asked the HMO to approve a location closer to the family's home, citing the father's inability to leave his job for extended periods, and other family reasons. The HMO refused, complaining about the physicians' interference with "the client-carrier relationship." [!] The baby was taken out-of-state for six months, the older sister was sent to live with relatives in another part of the country, the mother took a pay cut to work at a job near the hospital, and the father lost his job. In coping with the HMO's unrelenting policy, the family lost its home, its savings, and ended up receiving Medicaid.

(Herbert, Bob, "Tortured by H.M.O.," *The New York Times*, Mar. 15, 1996.)

71. A doctor examining a patient thought a skin growth looked suspicious and so recommended a biopsy. The HMO declined coverage. The doctor then sent a letter to the HMO saying a biopsy was medically necessary. Another doctor, asked to give a second opinion, agreed and also sent a letter. The HMO still refused. After nine months of fighting with her insurance company, the patient paid for the biopsy out of her own pocket. She had a malignant melanoma. The HMO then paid for her surgery and treatment.

(Austin, Elizabeth, "Mass medicine," *Shape*, May, 1996.)

72. A large southern California HMO serving Medi-Cal enrollees repeatedly has been cited for care deficiencies. One family practitioner who recently resigned her association with the HMO was quoted saying, "It was awful. There weren't enough physicians. You would go home at night and go to bed with the shakes. You'd pray to God that things -- like lab tests -- got done."

(Dalton, Rex, "Push for HMO care for the poor falters," *San Diego Union-Tribune*, Mar. 20, 1996.)

73. A woman organizing an anti-HMO referendum in California blames negligence at an HMO-owned hospital for letting her 61-year-old mother languish four hours in an emergency room while a blood clot starved her body of oxygen. "They parked her and let her die," the woman said. "She had no call button. She had no monitors, nothing, and this is the level of care they want to foist on the rest of the country."

(Sakson, Steve, "Highly Criticized, HMOs Face Wave of Restrictive Legislation," Associated Press, Mar. 15, 1996.)

74. An HMO initially tried to force a woman to have her broken and infected leg amputated rather than pay for the more expensive treatment that eventually saved it. The woman is now a vociferous anti-HMO crusader.

(Sakson, Steve, "Highly Criticized, HMOs Face Wave of Restrictive Legislation," Associated Press, Mar. 15, 1996.)

75. In Maryland, state health officials in 1996 levied a \$55,000 fine against an HMO for tricking and manipulating poor people into enrolling in the plan. And last year, an investigation by the state's attorney general's office uncovered HMO marketers paying Baltimore social workers to turn over the confidential names of Medicaid recipients. More than two dozen people were found guilty of crimes ranging from bribery and forgery to Medicaid fraud. As a result of these kinds of widespread abuses, the state General Assembly began considering a proposal that would eliminate HMO marketing to Medicaid recipients.

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(Sugg, Diana K., "Md. HMO is fined \$55,000," *Baltimore Sun*, Mar. 25, 1996)

Another 25 horrors...

Cases 76-100

76. New York Health Department investigators found out firsthand how difficult it is for poor people to get medical care through a Medicaid HMO. After penetrating a barrier of constantly busy phones, incorrect numbers, and physicians who were not accepting new patients or who had left a particular plan, undercover investigators posing as Medicaid recipients found that 60 percent of the obstetricians they called at one HMO could not provide a routine appointment for a pregnant woman; 40 percent of the pediatricians called could not fill an appointment to vaccinate a baby

("Tales From the HMO Crypt, Part 76," *Consumers' Research*, Feb. 1996.)

77. A Michigan man saw his primary care HMO physician for an allergy problem and was referred to an allergist. The patient paid his \$10 co-payment. Six months later both doctors were contacting him complaining that his HMO wouldn't pay up. The HMO said the doctors sent the bills to the wrong place, which they denied. The HMO told the enrollee that he shouldn't be dealing with billing problems, despite his doctors telling him to handle it. A four-month frenzy of phone calls and letters followed. After nearly a year of headaches for the patient and the doctors, the HMO relented and paid the claims.

(Jodon, Bob, "The time the HMO didn't work," *Adrian Telegram*, Mar. 3, 1996.)

78. In its own annual report to stockholders last year, one of the largest HMOs in the nation reported that an average claim took 86 days to pay in 1994, up from 68 days in 1992. A statistical analysis of the complaints filed against the same HMO with the New York State Insurance Superintendent shows that the average bill for emergency out-of-network care took 14 months to pay.

(Fein, Esther B. and Elisabeth Rosenthal, "Delays by H.M.O. Leaving Patients Haunted by Bills," *New York Times*, Apr. 1, 1996.)

79. A woman whose twin sons were born with a severe nervous disorder that puts them at risk of heart or lung failure every time they go to sleep was told by her doctor that home nursing care was necessary to keep her children alive. The care was denied by her HMO because the HMO bureaucrats decided it wasn't "medically necessary." The woman sued and won, forcing the HMO to pay for the care.

(Olmos, David R., "Twins' Mom Wins Fight Over Home Care," *Los Angeles Times*, Mar. 7, 1996.)

80. A Missouri woman was diagnosed with a malignant breast tumor. Radiation treatment was prescribed and successfully eliminated the cancer. The treatment claim was denied by the woman's HMO as not medically reasonable. It took the woman two years to convince the company to pay the claims.

(Kravetz, Andy, "Group pushes for single payer health-care system," *Columbia Missourian*, Feb. 26, 1996.)

81. Because of complex HMO rules, a woman suffering severe pelvic pains and cramps on a Sunday evening was unable to see her gynecologist until Wednesday afternoon. Before arriving for the scheduled examination the doctor's office called to say the HMO hadn't yet approved the visit. The woman told the scheduler that, ready or not, she was coming in for her examination. And she did. Yet, it had to take three days until she could be told her pain was caused by an infection in her uterus and her Fallopian tubes, for which antibiotics were prescribed.

(Smokes, Sandra, "HMOs: Into what are we getting ourselves?," *Syracuse Herald-American*, Feb. 25, 1996.)

(Rubsamen, David S., "HMO's Costly Attempt to Interfere With a Doctor/Patient Relationship," *Physicians Financial News*, Feb. 15, 1996.)

64. An HMO patient who was suffering from post-surgical nausea asked for a new and highly successful anti-emetic drug, but her request was denied. According to an account given by the patient's daughter, the response from the nurse was: "We have had great success with this new agent in improving patients' response to the post-operative nausea of anesthesia. However, the pharmacy restricts its use because of cost."

(Lascara, Mary Jo, "Bad medicine," *The Virginian-Pilot*, Feb. 19, 1996.)

65. An HMO gatekeeper physician diagnosed a patient with recurring epididymitis and referred him to an HMO urologist. The patient came back to the original physician a year and a half later, dying of a still undiagnosed testicular cancer. The urologists' earlier tests had indicated a mass, but the specialists took no further steps to determine if the mass was cancerous. Neither the test results nor the urologists' reports were sent to the primary care physician.

(Prager, Linda O., "Gatekeepers on Trial," *American Medical News*, Feb. 12, 1996.)

66. A woman was treated by her HMO orthopedist for the abnormal swelling of nerve roots along her spine. The HMO would not pay the \$4,000 fee, calling the unfortunate woman's malady a "body distortion" which of course means any surgery to correct it was merely "cosmetic."

(Sherman, William, "Play By The Rules," *New York Post*, Sept. 19, 1995.)

67. A woman who underwent a mastectomy had reconstruction done on the affected breast during the same surgery. The patient needed reconstruction performed on the unaffected breast because following the mastectomy it hung lower than the other. The HMO refused to pay the cost of the second reconstruction, calling it cosmetic. After considerable effort, the patient succeeded in forcing the HMO to pay for the surgery. The woman's struggle led to the introduction of legislation in the Maryland House of Delegates and Senate that would mandate coverage for such reconstructive surgery. HMOs opposed the bills.

(Chapman, Claire, "Cancer survivors, insurers at odds over breast reconstruction," *Prince George's Sentinel*, Feb. 8, 1996.)

68. A 35-year-old California woman complaining of pelvic pain, diarrhea, and stomach cramps was given a number of tests by her HMO physicians who did not refer her to a gastroenterologist until it was too late. Eventually, she saw a specialist who diagnosed rectosigmoid carcinoma and found that the tumor had perforated her colon. The patient died six months later. The woman's family blamed the HMO's capitation policy and initiated a malpractice lawsuit against the HMO physicians. A Ventura County Superior Court jury found the physicians guilty of malpractice.

(Frieden, Joyce, "Capitation on Trial in Calif. Malpractice Case," *Family Practice News*, Feb. 1, 1996.)

69. Apparently, disclosure laws are only for the little people. In 1995, a Republican state senator in Arizona pushed through a law that requires HMOs to disclose whether doctors under contract with them receive bonuses as incentives to limit care and control costs. Of the 14 HMOs under the law, 12 filed incomplete forms, according to the Arizona Insurance Department. After the department sent out a second round of letters in January pressing for more details, only seven responded more fully.

(Snyder, Jodie, "HMOs oppose proposal for tighter regulations," *Phoenix Gazette*, Feb. 27, 1996.)

listed no such specialist. The father and mother made the decision to go out-of-network to find a surgeon with a proven track record with this kind of operation. The HMO called the parents -- while the girl was still in intensive care -- to tell them that it would not pay any of the medical bills. Eleven months later an arbitrator ordered the HMO to pay the hospital and surgeon bills -- everything but the couple's legal expenses, which by then had amassed to five figures.

(Letter to the California Nurses Association, in response to "Patient Watch" advertisements placed in 1996 in a number of national and local newspapers; name of writer available upon request to CNA.)

97. A woman with badly infected plantar warts was referred to a dermatologist by her HMO physician. The dermatologist's intuition told him that the woman should see a podiatrist before he attempted to remove the warts. When he called the primary care physician to get the referral, the two doctors didn't discuss medical issues; instead, the primary care physician asked, "Whose capitation is this going to come out of -- yours or mine?"

(Greenberg, Michael, M.D., "Moment of truth leads to escape from capitation 'gulag'," *American Medical News*, Mar. 11, 1996.)

98. A man with a complicated liver cancer condition went to his general practitioner who took it upon himself to treat the cancer for three months, all the while the tumors grew and the patient's calcium count reached dangerously high levels. The physician at first diagnosed the cancer as a parathyroid tumor and said he would have to "read up on it." Finally, he gave up, sending the patient to an oncologist who was shocked upon seeing him for the first time. The patient, who was immediately hospitalized, said, "I can see no justifiable reason outside of perks and bonuses from the HMO carrier that [the primary care doctor] did not send me to a specialist."

(Letter to California Nurses Association, in response to "Patient Watch" advertisements placed in 1996 in a number of national and local newspapers; name of writer available upon request to CNA.)

99. A man had a pinched nerve and needed back surgery. The condition was so bad that he was losing the use of his foot and was actually dragging it. Delaying an operation could cause "serious damage," said his orthopedic specialist. The patient's health plan, however, stuck rigidly to its guidelines. The doctor was told that the patient's condition had only persisted for four weeks and that he had to wait the recommended six weeks. The physician is quoted as saying that the HMO "failed to appreciate that the guidelines were designed to be used as exactly that, i.e., guidelines for proper, timely and appropriate care. My patient needlessly suffered for two more weeks."

(Protos, John, "Ten Things Your HMO Won't Tell You," *Smart Money*, March 1996.)

100. A Florida man took his wife to the emergency room. She had been suffering from stomach pain and was perspiring. The HMO told the emergency room doctor that it wouldn't pay for the visit and suggested that the patient take antacids and be sent home for the weekend. The patient's husband got his wife admitted to the hospital by saying she was covered under his supplemental insurance plan, even though she wasn't. Doctors operated and removed a blockage in her stomach.

(Cohen, Sarah, "So, what's a little fib between foes, anyway?", *St. Petersburg Times*, Apr. 8, 1996.)

Yet another 25 true horror stories...

82. A Harvard researcher studying the conditions that make HMOs successful came to a surprising conclusion: quality of patient care has no bearing on a company's success. "One of the plans had a terrible reputation for quality," the researcher was quoted as saying. "It had a high level of grievances and turnover. Yet it was one of the fastest-growing and most successful HMOs."

(Zaldivar, R.A., "Health:cost vs. quality," *San Jose Mercury News*, Mar. 31, 1996.)

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83. A woman who had a breast lump biopsied on the advice of her doctor was refused coverage by her managed care plan after the report came back benign. Because the lump was benign, the managed care organization classified the biopsy as "unnecessary."

(Laster, Leonard, M.D., "Managed care translates to 'Let the patient beware'," *American Medical News*, Feb. 19, 1996.)

84. One of Texas's largest medical-malpractice insurers in 1996 asked for a 22.9-percent rate increase, citing growing losses from rising misdiagnoses among physicians in HMOs and other managed care practices. Signifying that that was just the first wave of such rate hikes, another Texas carrier in 1996 sought a 32-percent increase, and a large Chicago company sought a 45-percent rise.

(Bass, Frank, "Insurer Seeks Rate Rise, Citing HMOs," *Dow Jones News Service*, Mar. 6, 1996.)

85. HMO guidelines in use throughout the country recommend denying payment for the removal of more than one cataract unless the patient is young and needs both eyes to work.

(Myerson, Allen R., "Helping Health Insurers Say No," *New York Times*, Mar. 20, 1995.)

86. The same HMO guidelines provide stroke victims only three days hospitalization -- even if they still can't walk following their three inpatient days.

(Myerson, Allen R., "Helping Health Insurers Say No," *New York Times*, Mar. 20, 1995.)

87. These HMO guidelines consider mastectomies outpatient procedures.

(Myerson, Allen R., "Helping Health Insurers Say No," *New York Times*, Mar. 20, 1995.)

88. An HMO asked that a woman who suffered a heart attack be moved from her hospital to one with which the HMO had a contractual arrangement. The first hospital said the patient was in no condition to be moved. She later died in the first hospital. The HMO would not pay any hospitalization costs, saying the deceased woman's heart attack was the result of a pre-existing condition.

(Sherman, William, "Casualties of the System," *New York Post*, Sept. 21, 1995.)

89. A man admitted to his wife that he felt an emotional attachment to a woman who worked in his office. He was upset by these feelings and scheduled an appointment with an HMO therapist. The therapist, fulfilling his role as gatekeeper, nipped the problem in the bud on the first visit by advising the patient to leave his wife. The wife, obviously upset with this advice, scheduled her own appointment and was told by the therapist, "Your husband wants to be single, so let him be single."

(Meehl, Joanne H., "Managed Marriage," *Washington Post*, Mar. 26, 1996.)

90. After getting authorization from her HMO, a New York woman took her child to a doctor for the removal of a tick from the child's head, a perfectly routine medical procedure. Following the doctor's instructions, the woman brought the child back in a few days to have the single stitch removed. The HMO refused to pay for either visit because the second visit was not pre-authorized.

(Sherman, William, "Play By The Rules," *New York Post*, Sept. 19, 1995.)

91. A large California HMO came under fire in 1996 for twice sending policy statements to its doctors saying it is "not recommending nor endorsing routine, universal vaccination" for chicken pox with a new FDA-approved vaccine. State law requires HMOs to pay for the vaccination, but this policy of non-recommendation effectively reduced the company's financial burden. The HMO expressed concern that the vaccine may have side effects. Its decision, however, contradicted the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control and Prevention's advisory committee on immunization practices.

(Green, Jay, "PacifiCare takes hits over shot," *Orange County Register*, Apr. 2, 1996)

92. In an example of how privacy is being lost in the managed care environment, a woman seeking an appointment with a psychiatric therapist for a crisis relating to an incident of childhood incest was required by her HMO to first call a toll-free number and speak with a gatekeeper. The gatekeeper asked the patient, "Can you tell me how many times you were abused?"

(Riley, John, "When You Can't Keep a Secret: Insurer's cost-cutters demand your medical details," *Long Island Newsday*, Apr. 1, 1996.)

93. An Arizona woman attending college in Washington broke her arm and went to an emergency room for treatment. Her parents' HMO said that it would pay for the initial treatment but that all follow-up care must be administered by the patient's primary care physician in Arizona. When the patient explained that she was not on vacation, but enrolled in an out-of-state college, she was told it didn't matter, the HMO would only pay for follow-up treatment in Arizona.

(Cisak, Carol J., "Patients at whim of unreasonable HMO rules," *Gilbert Tribune*, Mar. 23, 1996.)

94. A woman slipped in her tub and injured her elbow. At 10:30 p.m. the woman's mother arrived and took her to an emergency room for X-rays. The arm was not broken and the emergency room doctor gave the patient instructions on how to care for her injury. Her primary care physician called her a couple of days later and told her he would not authorize payment by her HMO because he hadn't been called before she went to the hospital.

(Fields, Lillie, "Deciding Who Pays," *St. Louis Post-Dispatch*, Apr. 4, 1996.)

95. A man in Texas called his HMO's toll-free "help line" for a referral after he had experienced trouble breathing. No one answered. He went to an emergency room and was treated. The HMO refused the \$174 cost, saying the problem, which turned out to be bronchial disease, cannot be considered an emergency. The HMO relented after a state inquiry was initiated.

(Sherman, William, "Pity These Poor Patients," *New York Post*, Sept. 20, 1995.)

96. A 9-year-old girl was diagnosed as having a rare form of kidney cancer. The girl's pediatrician recommended that her parents take her to a pediatric specialist for surgery. The parents' HMO, however,

Cases 101-125

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 101. A 46-year-old woman was rushed to a Detroit emergency room in full cardiac arrest. Her husband had called 911 after she collapsed while getting out of a car. Despite efforts to save her, she died after 30 minutes at the hospital. After a few months, the bereaved husband received a call from the woman's HMO. The company wouldn't pay for the emergency room visit because the patient hadn't received prior authorization.

(Henry, Gregory L., "Emergency Care Under Managed Care: A Fatal Distraction?", *Health Systems Review*, April 1996.)

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102. A woman was sent home from the hospital by her managed care company 24 hours after giving birth. Once home, the mother became alarmed that the baby wouldn't breastfeed, falling asleep after only a few minutes of feeding. The mother called a nurse at the hospital for some advice, but nothing the nurse said helped. After two days, the managed care company sent a nurse to the woman's home. The mother voiced concern over the baby's yellow skin and eyes, but the nurse said he was fine. Doubting the nurse's opinion, the mother took her child to her pediatrician. Before even crossing the room to examine the baby the doctor said, "Get him to a hospital." The jaundice was so bad that there was risk of severe brain damage. Furthermore, the child was dehydrated and lost more than a pound because he hadn't eaten properly.

(Gilbert, Susan, "4 Things You Must Know Before Your Next Health Checkup," *Redbook*, January 1996.)

103. A 32-year-old woman arrived at an emergency room complaining of severe abdominal pain. Her physician told her two days earlier that, despite her tubal ligation, she was pregnant. The emergency room nurses called the woman's HMO to obtain prior approval before she was examined by a doctor. The HMO gatekeeper denied authorization. the doctor decided to see the woman anyway and discovered that she had an ectopic pregnancy -- a life-threatening condition requiring emergency surgery. The doctor spent the next six months arguing with the HMO over who should pay the bill.

(Henry, Gregory L., "Emergency Care Under Managed Care: A Fatal Distraction?", *Health Systems Review*, April 1996.)

104. A 56-year-old HMO member was rushed to an emergency room with signs of a dangerous blood clot in her leg. She was classified by nurses as an urgent case, but was not seen by a doctor until four hours later. She died that day. It took three years and \$22,000 of the family's money before a malpractice claim against the HMO could even get to arbitration. In a unanimous verdict, three arbitors found against the HMO.

(McGuire, Rick, "Cost containment adds to malpractice burden," *Medical Post*, Mar. 19, 1996.)

cancer, at the age of 40.

(Smith, Amber, "Misdiagnosed Cancer Kills Local Man," *Syracuse Herald-Journal*, Mar. 25, 1996.)

111. After noticing a small lump in her breast, a 38-year-old woman visited her HMO gatekeeper physician. The physician ordered an ultrasound and mammogram. Both showed negative results. The physician, however, neglected to tell the patient that the ultrasound report suggested that a biopsy needed to be performed to study the suspicious-looking lump more closely. He also neglected to tell the patient that under the HMO's capitation policy he made more money by not referring her for extra treatments. Only when another mammogram was performed two years later, and the lump was found to have grown, was a biopsy finally ordered. By that time, the tumor was too large to remove completely by surgery.

This sounds like Walprach, et al but maybe treatment disclosures

(McCall, Tracy, M.D., "Some HMOs Are Bad News (Is Yours?)," *Redbook*, August 1996.)

112. In Texas, a surgeon performing a hysterectomy discovered that the patient also had a fibroid tumor. The woman's physician contacted her HMO to get authorization for surgery to remove the tumor, but never heard back from the company. The day before she was scheduled to go into surgery, the HMO denied coverage without giving a reason. The woman had to get ahold of photographs of the tumor taken during her earlier hysterectomy and hand deliver them to her HMO's utility review committee. A week later the HMO authorized the procedure.

(Spaulding, Cathy, "Patients, doctors: 'HMOs save money, but at whose expense?'," *Lewisville Leader*, Aug. 14, 1996.)

This story may be other example

113. A woman who had a three-and-a-half pound pelvic tumor removed was seen by her HMO's "concurrent utilization reviewer" two days later, as she was eating her first post-operative meal in the hospital. The HMO's employee couldn't see why the patient should stay in the hospital for five to seven days, as a number of obstetrical surgeons had recommended. The HMO employee telephoned one of the HMO's physicians and together they decided --without physically examining the patient -- that she had gotten all the hospital care she needed. The woman's surgeon refused to discharge her and had her stay in the hospital for an extra night -- a cost the HMO wouldn't cover.

(Herbert, Bob, "When an HMO gets carried away with the rules," *New London Day*, Aug. 10, 1996.)

114. An HMO serving 8,500 of the poorest residents in Syracuse, New York, reserves the right to refuse emergency room visits unless patients first call for approval. Yet, according to a SUNY Health Science Center study, more than half of the HMO's patients don't have telephones. Because of this telephoning policy, the study noted, one Medicaid HMO found reason to refuse payment to a downstate New York hospital

for five emergency deliveries because the mothers neglected to receive prior approval to have babies.

(Smith, Amber, "Bottom-Line Medicine," *Syracuse Herald-American*, Aug. 4, 1996.)

15. A four-month-old girl underwent surgery to remove a cancerous eye. The child's doctor explained that a prosthetic eye would be necessary every six months or so for the next few years to prevent the child's head from growing lopsided. Furthermore, the doctor explained, without the eye, the girl would be susceptible to chronic infection and discharge. The HMO refused to pay for more than one false eye. Only after the doctor sent a letter to the HMO stating, "I will not be held medically or legally responsible for the final outcome should this be denied by you," did the health plan relent.

(Smith, Amber, "Baby with rare cancer needs artificial eye; HMO says it won't pay but does anyway," *Syracuse Herald-American*, Aug. 4, 1996.)

116. A woman who had a giant tumor removed from her sinus region in 1980 was left with a long jagged scar down the center of her face. Doctors had put a new nose on her face, reconstructed with material taken from her hip. Over the years the patient's skin tightened, crooking her nose to the left. In 1994, the patient asked her surgeon to center her nose. Her HMO called the surgery "cosmetic" and denied reimbursement. Only after the state insurance commissioner sent a letter of inquiry to the HMO asking, "On what basis has [the HMO] determined reconstructive surgery was cosmetic in nature?" did the plan reverse itself and authorize payment.

(Smith, Amber, "HMO ignores law, withholds payment," *Syracuse Herald-American*, Aug. 6, 1996.)

117. The Nebraska mother of an 11-year-old girl was told by her new Medicaid HMO that her daughter would no longer be allowed to see the Omaha pediatrician who treated her rare and sometimes painful growth disorder. The child's new HMO-approved pediatrician didn't have the specialized training needed to treat the disorder or to prescribe the necessary medication. As a result, the child suffered her malady for months without her needed medication.

("Lincoln woman recounts nightmare in dealing with new plan," *Grand Island Independent*, Aug. 5, 1996.)

118. An 83-year-old woman who underwent brain surgery was sent to a rehabilitation facility at the insistence of her HMO after only two days in the hospital. At the rehabilitation facility, she was left in a wheelchair without restraints. She fell and broke her leg, ending up in the hospital once again. After leg surgery, the woman was kept in the hospital for three days, but the HMO forced her out to another rehab facility.

(Iverson, Howard, "An Rx for health care," *Beverly Citizen*, Jul. 17, 1996.)

119. California investigators issued a scorching report damning one of the state's largest HMOs for shoddy emergency medical service. A number of cases cited in the report by the Department of Corporations indicates that "the plan may be unreasonably denying coverage for emergency services." In one case, a patient suffering from acute appendicitis was taken to a hospital outside the HMO's system and admitted for emergency surgery. Doctors at the hospital told the HMO that it would be risky to transfer the patient, but the health plan refused to provide coverage at an out-of-network hospital.

(Kanigel, Rachele, "Several Kaiser policies get harsh criticism from state," *Oakland Tribune*, Aug. 29, 1996.)

120. An Oregon HMO was recently fined \$15,000 by the state Department of Consumer and Business Services for improperly denying emergency room claims. According to the state investigation report, the HMO had determined whether to pay for emergency room visits solely by examining emergency room records. According to the state's report, these records rarely provide the information necessary for deciding approval or denial of a claim.

(Hoover, Erin, "State fines HMO for denial of claims," *Portland Oregonian*, Aug. 25, 1996.)

121. A woman who took her two daughters to her doctor for treatment of strep throat was told by an HMO clerk that costs for both the visit and the antibiotic prescribed by the doctor would be denied because the bacterial infection was "a pre-existing condition."

(DeCarlo, Tessa, "Making managed care work for you," *Glamour*, September 1996.)

122. A woman left paralyzed from a pregnancy-related complication has had a number of treatments denied by her HMO. Following initial diagnostic tests, the HMO would not allow further testing on the patient's brain, saying that a simple visual diagnosis by a doctor is sufficient to determine progress. The HMO also turned down occupational therapy recommended by a neurologist, and an eye examination prescribed by an ophthalmologist.

(Adams, Robin, "HMO does provide care, but denies treatment too," *Lakeland Florida Ledger*, Aug. 1, 1996.)

123. One California managed care organization recently stated that it would pay for no more than five hours of epidural pain relief for labor pains. Doctors object, stating that some labor pains can go on for more than 20 hours.

(Lagnado, Lucette, "But Who Will Pay for the High Cost of Relief?", *Wall Street Journal*, Aug. 20, 1996.)

124. An HMO executive was quoted in the Des Moines Business Record, saying, "We see people as numbers, not patients. It's easier to make a decision. Just like Ford, we're a mass-production medical assembly line, and there is no room for the human equation in our bottom line. Profits are king."

(Berko, Malcolm, "The real story about HMOs," *Des Moines Business Record*, Sept. 2, 1996.)

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125. A teen-age California girl receiving periodic blood transfusions to help prevent stroke and other problems associated with her sickle-cell anemia, had her treatments stopped after her mother was forced to join an HMO. The HMO hematologist said that the transfusions weren't necessary. The girl's mother went to two other independent hematologists who both recommended the transfusions continue. The HMO wouldn't relent. The girl suffered a stroke and died.

(Herbert, Bob, "Death by HMO," *Rome, Georgia News-Tribune*, Sept. 1, 1996.)

And still another 25 horror stories...

Cases 126-150

126. A pregnant woman was hospitalized after a radiologist told her she had a placenta previa. Her HMO doctor disagreed with the radiologist and told the woman everything was fine, despite her continual bleeding. Ten days after her due date, the patient hemmorrhaged and was hospitalized for an emergency C-section. After the surgery, the HMO demanded that the woman be transported to a hospital 80 miles away. The ambulance came to transport the patients, but didn't have the equipment necessary to transport the infant, so attendants gave the child to the father to hold. Upon arrival at the hospital, the baby was refused admission, so the father took the child to his mother's home, another 40 miles distant. Haggling for eight hours over the phone, the father finally succeeded in gaining admission for his child. After a series of misdiagnoses for spinal meningitis and other non-existent problems, the hospital finally discharged both the baby and the mother, telling the parents that everything was fine. The child is today mentally disabled. Even two years after their troubles, the parents were still not able to see their child's medical records, even after numerous requests to the HMO.

(Nixon, Kathy, personal communications via e-mail, Nov. 12, 1996.)

127. A 34-year-old diabetes patient received a kidney transplant in 1987. In 1994 her body began to reject the kidney. At the time, her HMO doctor realized she was having trouble, but it took three days to complete blood tests to evaluate her kidney function and have the results sent to a transplant specialist for review, and another week to secure approval from HMO officials for the patient to get drug treatment to stop rejection. By that time, it was too late, and the patient lost her kidney.

(Perl, Rebecca, "Left Behind by Managed Care?", *The Washington Post*, Dec. 3, 1996.)

128. In 1994, a former HMO medical reviewer wrote a paper about managed care for a graduate course in ethics. Here is an excerpt: "I sat at my desk, contemplating the paper given to me by the nurse, who had reminded me, in her dutiful way, that this was a 'very expensive' case. I knew well by now what this euphemism meant: You better find a way to deny this. Medically the case was clear, with no grounds upon which I could issue a denial based on necessity... I was left only with finding a loophole that would justify the denial of payment based on coverage limitations. That this man, who I would never know, would fail to get his heart was of less importance to me at that moment than the accolades I would get when word spread that I saved the company several hundred thousand dollars."

(Anders, George, Health Against Wealth, Houghton Mifflin, New York, 1996, p. 53.)

129. A 40-year-old man suffering from cryoglobulinemia, a blood-plasma disorder that can damage internal organs, was told by his new HMO that he could no longer see

Handwritten notes: 2/14/98, This case comes from Anders' book, 3/6/98, MARR. 6. 1998 3:05PM ETHICS STANDARDS NO. 068 P. 29/40

a rheumatologist for his condition. The patient could only go through a primary-care doctor who, the patient alleged in a subsequent court case, stymied his efforts to see a specialist. A New York state jury found the HMO responsible for the man's deteriorating condition, awarding him a \$1 million verdict.

(Anders, George, Health Against Wealth, Houghton Mifflin, New York, 1996, p. 80.)

130. A doctor treating a child's eye infection prescribed an antibiotic that can be applied painlessly. The HMO wouldn't pay for the drug, citing a more painful, but cheaper alternative. The doctor had no choice but to relent. He is quoted as saying, "To me it matters a lot whether a four-year-old is in pain, but to the HMO it's just money. They don't see the child, and they don't care."

(Anders, George, Health Against Wealth, Houghton Mifflin, New York, 1996, p. 87.)

131. A 64-year-old Pennsylvania man suffering heart attack symptoms was driven to the hospital emergency room by his son-in-law. Doctors confirmed that he was indeed having a heart attack and saved his life. The HMO refused to pay the charges of \$20,254.90. Why? The patient didn't get preauthorization to have a heart attack and went to an out-of-network hospital. The state public health program administrator wrote a letter to the HMO, ordering the company to pay the patient's bills. In the letter he stated that the public's interest in saving the patient's life "far outweighs Aetna's limited interest in teaching Mr. Popiden a lesson to use a participating hospital even in an emergency."

(Anders, George, Health Against Wealth, Houghton Mifflin, New York, 1996, p. 144.)

132. A 1996 survey of Chicago HMOs found that only three out of 25 plans explicitly told their members that it was all right to phone 911 in a crisis.

(Anders, George, Health Against Wealth, Houghton Mifflin, New York, 1996, p. 148.)

133. A woman with a high-risk pregnancy was ordered hospitalized by her doctor. The doctor feared a repeat of the woman's earlier pregnancy when he had to order a caesarean delivery after the fetus went into distress at 36 weeks. The woman's HMO denied the request for hospitalization for the second pregnancy on the grounds that it wasn't necessary. The company instead authorized home nursing visits. When no nurse was on duty at the woman's home, the fetus went into distress and died.

(Mariner, Wendy, "Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field," *American Journal of Public Health*, June 1996.)

134. A Kansas City man suffered a heart attack. While he was recovering, several physicians recommended that he undergo special heart surgery at Barnes Hospital in St. Louis. The man's HMO refused to authorize coverage because Barnes Hospital was

not in its service area. The patient's heart quickly deteriorated and doctors recommended a heart transplant at Barnes. The HMO refused. The patient died.

(Mariner, Wendy, "Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field," *American Journal of Public Health*, June 1996.)

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135. In 1991, a young woman was diagnosed with pulmonary hypertension. Without a lung transplant, doctors told her, she would live less than two years. However, the fact that she had a mild case of Lupus (an autoimmune disorder) gave the HMO the loophole it needed to deny coverage. This denial of life saving care was done by an HMO-appointed doctor who never saw the patient, who disregarded the opinion of her primary care physician, and who never requested a copy of her medical transcripts. After a local television news program broadcast the woman's plight, the HMO relented.

(Cromwell, Mary, "HMO Denies Lung Transplant, Patient Told to Launch Fundraising Campaign for Life Saving Care," *Casualty of the Day, California Nurses Association*, Oct. 30, 1996)

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136. A 63-year-old woman noticed a mole on her ankle. Her HMO doctor assured her it was nothing and told her not to worry. After the mole changed shape and color, the woman again brought it to her doctor's attention. The doctor again dismissed it. Still, the woman expressed concern and still the doctor did nothing. The woman requested a new doctor, a request her HMO took six months to grant. By that time it was too late -- the "mole," a malignant melanoma, had spread. The woman died a year later.

(Bancroft, Montague, "HMO Ignores Cancerous Mole, Delays Patient Request to Change Doctors, Patient Dies," *Casualty of the Day, California Nurses Association*, Oct. 29, 1996.)

137. A day-old baby was diagnosed with a rare illness called Erb's Palsy. The baby's pediatrician and an orthopedic specialist at the hospital both recommended that the parents take the baby to a pediatric physical therapist for consultation and therapy planning. The parents' HMO turned down their request for a pediatric referral three times, instead authorizing a referral to a regular physical therapist, who confessed to the parents that he had never heard of Erb's Palsy. The parents had to go out of network, at their own expense, to get proper care for their child.

(Carnell, Debra, "HMO Determines Care is Not Needed," personal account posted at the WNET web site, Mar. 24, 1996.)

138. A man was bleeding internally from a ruptured esophageal varices. He called his primary physician to get authorization for an emergency room visit. The nurse told the man to sit tight, that the doctor could see him in six days. The man instead decided to go to the emergency room, where ER physicians gave him a seven-unit blood infusion.

(Robbins, Don, personal e-mail communication, Jan. 17, 1997.)

139. A woman went to her HMO hospital with severe swelling in her right calf. She was told it was "just a muscle strain" and was sent home. Eight days later she returned, still complaining of swelling and pain. She was given Motrin and sent home. Less than a month later, the woman suffered a massive pulmonary embolism that had originated in her right calf.

("HMO Shuns Diagnostic Test; Patient Nearly Dies of Pulmonary Embolism," *Casualty of the Day, California Nurses Association*, Oct. 29, 1996.)

140. Doctors diagnosed a six-month-old boy with cerebral palsy. Even though the boy could not walk, or even crawl, by his second birthday, the parents' HMO deemed a wheelchair "medically unnecessary." Therapy was terminated, and then reinstated only after the parents underwent a protracted appeals process.

(Hopper, Leigh, "HMO users urge attention to complaints," *Austin American-Statesman*, Mar. 26, 1996.)

141. A 3-month-old baby girl was taken by her parents to an HMO pediatrician with a cough and fever. The doctor, suspecting Cystic Fibrosis, called the HMO to request approval for a sweat test, which costs around \$50. When detected early enough, Cystic Fibrosis, though chronic, is treatable. The HMO refused to authorize the test. Two weeks later, the girl was admitted to the hospital with two collapsed lungs and severe pneumonia. She died a month later.

(Wooldridge, Jamie, "Infant Dies After HMO Fails to Approve \$50 Test," *Casualty of the Day, California Nurses Association*, Oct. 24, 1996.)

142. A woman with severe abdominal pain was taken to an emergency room where she sought admission to the hospital. Her HMO physician diagnosed her over the phone and had her sent home, concluding that she had "some sort of virus." A few days later the patient visited her physician with obvious signs of jaundice. The doctor put her on antibiotics and sent her home. Three weeks later the patient was again in the hospital and, according to her daughter, was "the color of a daffodil." An ultrasound test was taken, revealing gallstones. It was too late. The woman died.

(Meiser, Jana, personal e-mail communication, Jan. 22, 1997.)

143. A Maryland man called his HMO, concerned that the plan would not pay for his newborn baby's daily plasma transfusions. According to testimony submitted to the Maryland House of Delegates, the HMO's gatekeeper told the man that his family would have to come up with the \$300 a day needed to pay for the transfusions. Not to worry, the gatekeeper said, as soon as the family expended its savings, it would qualify for Medicaid.

(Kurtz, Josh, "Maryland health care reform still under the knife," *Montgomery Gazette*, Feb. 28, 1997.)

144. A woman receiving treatment for cysts on her ovaries was forced by her husband's employer to move from their health plan to an HMO. She was told that in order to receive continued treatment, she would have to schedule an appointment with her new primary care physician who would have to give his authorization. However, her new primary care physician couldn't see her for three months, despite warnings from the patient's OB/GYN that the cysts could grow and rupture without treatment.

(Saba, Mary Ellen, personal e-mail message, Feb. 9, 1997.)

145. In 1992, a senior citizen, enrolled in a Medicare HMO, was diagnosed with colon and lung tumors and was scheduled for surgery with a cancer specialist. The specialist, however, never showed up for the operation. The HMO allowed a less experienced surgeon to handle the procedure. Several months later, the patient was told she still had cancer in her lung. Her HMO doctors told her to get her affairs in order, that she only had a couple of weeks left to live. She disenrolled from the HMO and sought treatment from a top-notch oncologist in New York, whom she credits with saving her life.

(Jouzaitis, Carol, "More Seniors Turning to HMOs," *Chicago Tribune*, Mar. 9, 1997.)

146. A man hospitalized and dying of AIDS told his family and his doctor that he wished no extreme measures be taken to save his life. His only wish was that he not be taken off a respirator -- he dreaded suffocating to death. Once the man lapsed into a coma the medical director of his HMO called a pulmonary specialist at the hospital who coincidentally had just applied for membership in the HMO. The medical director pointed out the "Do Not Resuscitate" order written by the patient's primary care physician and demanded that the patient be taken off the respirator. Without consulting the patient's family or physician, the pulmonary specialist disconnected the respirator. The patient struggled for breath -- and died of suffocation.

(Swartz, Mimi, "Not what the doctor ordered," *Texas Monthly*, March 1995.)

147. A man suffering a flare-up of an ulcerative colitis condition called his HMO physician for an appointment. When he got to the doctor's office, he was told the only person who could see him was a physician's assistant. The assistant denied the patient's request for a referral to a gastro-entriologist and prescribed cortisone enemas. A week later, the man's symptoms worsened. Another physician's assistant prescribed still more enemas. The man's case worsened still. Finally, a trip to the emergency room revealed a toxic megacolon. The gastro-entriologist at the hospital told the patient, "If only you had seen me sooner." A week later the patient underwent a colectomy and J-pouch surgery.

(Peabody, Rodger, personal e-mail communication, Mar. 28, 1997.)

148. A Medicare beneficiary in New York City signed up with a Medicare HMO, attracted by the lack of a monthly premium. Shortly after, she fell and suffered a traumatic brain injury. She required an emergency procedure to drain fluid from her brain. Her doctors recommended that she go to a rehabilitation facility for follow-up treatment. Her new HMO refused to authorize treatment at the recommended facility, and instead suggested that the patient go to a skilled-nursing home. But the HMO eventually decided against that, too. The HMO said she needed only oral medications and assistance with daily activities, which it does not pay for.

("Can HMOs help solve the health-care crisis?" *Consumer Reports*, October 1996.)

149. A mother was told that her newborn baby boy needed a series of corrective surgeries for a cardiological problem. The parents' HMO, however, wouldn't authorize the surgery at the hospital recommended by the baby's doctors. Instead, it urged the parents to take their child to a hospital 100 miles away. When the parents balked, the HMO then suggested a closer hospital, but one with considerably less experience with the particular surgical procedure the child required. The parents decided to leave the HMO and give their child the treatment his doctors said he needed. However, due to the HMO's wavering, too much time had elapsed between the time of the doctors' recommendations and the surgery. The two-month-old boy died. For months after his death, the HMO continued sending the parents letters demanding payment for certain "deductibles" and other items.

(Sherman, William, "Managed-Care Casualties Enough to Make You Sick," *New York Post*, Sept. 18, 1995. Included in March 20, 1997 press release from Rep. Charles Norwood's Congressional office.)

150. A 21-year-old South Carolina man received severe head injuries in a car crash, and remained semi-comatose after brain surgery. Following his surgery, the man was able to open his eyes, wiggle his toes, straighten his legs, and respond to questions. However, his HMO ruled that he be placed in a nursing home and denied rehabilitation, in spite of the recommendation of two physicians that he was indeed a candidate for rehab.

("Today's Problems," press release from Rep. Charles Norwood's Congressional office, Mar. 20, 1997.)

Another 25 horrors stories (not all posted)...

156. A Florida man was diagnosed with prostate cancer after obtaining a free screening from his local hospital. The man immediately disenrolled from his HMO whose primary care physicians had ignored symptoms of the cancer and had refused to send him to a specialist. Earlier this year the patient filed a class-action lawsuit against the HMO on behalf of "all Florida Medicare beneficiaries who... were tricked and misled through a scheme of material omissions into enrolling in and/or joining (the HMO)."

My

(Longenecker, Gayer, "Class-Action Suit Against Humana Based On State Law," *Eli's Medicare Risk Report*, Mar. 31, 1997.)

157. A Virginia man, diagnosed in 1988 with severe depression, began suffering suicidal thoughts in the fall of 1996. His psychiatrist tried to have him admitted to a hospital in his home town of Richmond. To the doctor's surprise, the patient's HMO would only authorize out-patient shock treatment at a Fairfax, Virginia, hospital -- hours away. The patient was also told he would have to switch doctors, something most psychiatric experts believe is dangerous for suicidal patients.

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(Gogek, Jim, "Mental Illness and Mismanaged Care," *The Washington Post*, Apr. 22, 1997.)

158. A child broke a foot as a result of a fall. The child's parent called her HMO's medical advice number and was instructed by the advice nurse to go to an emergency room. The HMO later denied payment of the claim.

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("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

159. An HMO enrollee who was experiencing complications related to insulin shock was authorized by the HMO advice nurse to seek emergency care. The HMO later denied the claim due to lack of medical records. The notes in the HMO files indicated, however, that the medical files had never been requested. The HMO still denied the claim.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

160. An HMO enrollee experiencing severe headaches and vomiting called the HMO's medical advice line after discovering that the urgent care center was closed. The enrollee was instructed to go to an emergency care facility for treatment. The HMO later denied the claim.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

161. A Texas HMO enrollee experiencing severe stomach cramps was told by a

gatekeeper nurse to go to the emergency room, yet the HMO denied payment. When the Texas Department of Insurance asked a claims examiner at the HMO to search for claim data for the enrollee, it was discovered that the data did in fact reflect that the enrollee had been instructed by the advice nurse to seek emergency care.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

162. The parent of an 11-year-old child called 911 because the child was experiencing severe bleeding, dizziness, and weakness. The parent's HMO denied the claim even though the paramedics who responded to the 911 call wrote letters on behalf of the parent to inform the HMO that emergency treatment had been necessary.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

163. A woman who was eight months pregnant slipped and fell on her stomach. Upon experiencing abdominal pains the woman, fearing for the health and life of her unborn child was rushed to the hospital by her husband. Their HMO denied the claim.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

164. A child fell off a jungle gym, causing head injuries and severe head bleeding. The child was taken to the emergency room for treatment and stitches. The HMO denied payment of the claim.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

165. A man was found by a colleague in a state of disorientation and slurred speech, and appeared to be fading in and out of consciousness. The man, who appeared to have overdosed on prescribed medications, was taken to a hospital for emergency treatment. The man's HMO denied the claim.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

166. A Texas man was diagnosed with brain cancer. According to the state agency investigating the incident, notes in the patient's file indicate that approximately one year before brain cancer was diagnosed, symptoms such as headaches, sweating, dizziness, migraines, double vision, and decreased visual acuity had been reported by the patient.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

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167. An 11-year-old child was taken by his parent to a managed care primary care physician for sore throat, high fever and vomiting. The physician diagnosed the symptoms as a stomach virus. The next day, the child's parent again took the child to the physician because the symptoms were persisting. According to the parent, the doctor appeared perturbed that the parent had brought the child back, and instructed that the child be given fluids. The parent took the child to an out-of-network doctor who diagnosed tonsillitis.

("Report Concerning Kaiser Foundation Health Plan of Texas, Inc.," *Texas Department of Insurance*, Mar. 3, 1997.)

168. Social workers and therapists told the mother of a 13-year-old boy that she should seek inpatient treatment for her son, who was suffering from severe depression and addiction to illegal drugs. Even a state magistrate weighed in, ordering the mother to seek admission for her son who, in the opinion of the judge, needed the security of a controlled environment in a psychiatric hospital. The mother's managed care organization, however, had other ideas. It would authorize only outpatient treatment following a brief 48-hour hospital stay. Less than three weeks after he was discharged from the hospital, the boy, who had turned 14 a week earlier, took his mother's car around midnight and raced down a rain-drenched dirt road at 80 miles an hour. He was killed when the car spun out of control and slammed into a tree. The boy's psychologist was quoted saying, "Six years ago he would have been in the hospital -- absolutely -- for a minimum of 30 days. Children like Stephen were hospitalized so that they could be contained and so there was a chance to focus on the problem. It was considered medically necessary six years ago."

(Boodman, Sandra G., "Managed Care Comes to Mental Health," *Washington Post*, May 6, 1997.)

169. A Florida man visited his HMO's clinic complaining of abdominal pain. During visits to the clinic over a two-day period, the man was diagnosed by three different physicians who each advised a different medical strategy: fasting, laxatives, and a high fiber diet. Several days later the patient returned, still complaining of pain. An HMO surgeon decided to operate for suspected appendicitis. During the operation, however, no appendicitis was found. The surgeon decided to remove part of the patient's small intestine on the belief that the patient's inflamed-bowel condition was the result of a rare form of cancer. A pathologist later found the inflammation was due to Crohn's disease, which normally is treatable by medication. The operation left the man with chronic bowel problems, including explosive diarrhea four to six times daily. A jury awarded the patient \$750,000 after finding the HMO guilty of negligence.

("Florida Jury Awards Patient \$750,000, Finds PCA Clinic Was Negligent In Care," *BNA's Managed Care Reporter*, May 7, 1997.)

170. For more than four years a Virginia man sought treatment for his daughter's

nausea and severe recurring headaches. HMO doctors prescribed adult-strength narcotic pain medication, but did not consult a neurological specialist. Finally, in May of 1996, at the request of the girl's school psychologist, HMO doctors ordered an EEG and MRI, which revealed a tumor that had invaded over 40 percent of the patient's brain.

("ERISA Governs Challenge To HMO Policy Encouraging Physicians To Limit Care," *BNA's Managed Care Reporter*, May 14, 1997.)

171. A woman in Oklahoma tripped and fell, breaking her great right toe. It was repaired. Two and one half months later after constantly complaining of pain in her chest and hips it was discovered that she had also broken five ribs in the fall. Tests indicated that problems were also occurring in her spine. For the next six months a doctor "guessing game" started. First the diagnosis was fibromyalgia, then lupus, and finally rheumatoid arthritis. Three managed care doctors were involved. Finally, driven by constant pain, the patient went out for a second opinion. The doctor she personally sought out diagnosed her problem with the use of an MRI, a diagnostic tool not used by her managed care physicians. She had a herniated and shattered lumbar disc. But by then it was too late. Despite an operation to repair her back, the patient is now disabled, incontinent and confined to a wheelchair.

(Keeling, C.E., "D. Gazel was denied an MRI for 8 1/2 months. Now she is disabled," *Empower (The Managed Care Patient Advocate, web site)*, Oct. 2, 1996.)

172. Physicians recommended that a 38-year-old Maryland man who had just come out of a two-month coma remain in a rehabilitation hospital longer than the maximum allowable stay provided by his HMO. The HMO, however, would only pay for a less expensive alternative -- a nursing home.

(Pekkanen, John, "What You Need to Know About HMOs," *Reader's Digest*, February 1996.)

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173. An HMO denied home health care services, a covered benefit, to a multiple sclerosis patient, calling such care "not medically necessary." The medical reviewer made the decision to deny the care on the basis of a nurse's "inquiry". According to subsequent court testimony, the nurse never noted that the patient had problematic bowel management; had been hospitalized for a massive permanent decubitus; required twice-a-day wound care; and suffered shortness of breath, atelectasis, quadriplegia, and osteoporosis that caused fractures and permanent splintering in both legs. The court, in awarding \$24,000 in damages to the patient, said the HMO acted "whimsically" in denying care.

("HMO Lacked Knowledge in Home Care Denial," *CCH Home Care Provider's Guide*, May 1997.)

174. After being hospitalized during a trip for chest pains, a man visited his primary

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(Cohen, Sarah, "So, what's a little fib between foes, anyway?", *St. Petersburg Times*, Apr. 8, 1996.)

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