General welfare is being trampled by HMO human rights violations

by Linda Everett

On July 31, Democratic Presidential pre-candidate Lyndon LaRouche released a campaign statement that called for making it an "imprisonable offense for HMOs and the individuals heading them, to carry out medical policies which result in death and further suffering for individuals who are sick. It is a crime against humanity to immunize such criminals against civil suits."

Yet, with only a few exceptions, the Republican majority in Congress, led by Conservative Revolution fanatics and driven by the managed care industry itself, appears intent on closing the 106th session of Congress by *expanding* the ability of managed care and health maintenance organizations (HMOs) to carry out murderous policies.

We report here briefly on the current battle for patients' rights in Congress. Following this, we present documentation on how the system of managed care is itself a threat to the public good, and how, at every level, clear patterns are evident that its policies are harming and killing entire classes of the citizenry. Finally, we show how a 1974 Federal law now provides complete immunity for insurers, managed care plans, and HMOs.

With this, we hope to demonstrate that managed care—which is in fact a policy of *managed death*—must be scrapped, and that the United States must be returned to a health care delivery system serving the needs of a growing nation.

Background to the current crisis

The recent period of free-market-driven privatization and deregulation globally is characterized in the United States by the era of "managed care"—which has nothing to do with health insurance or the delivery of health services. Americans have been told that managed care, delivered by a health maintenance organization, or any variety of plans offered by managed care plans and insurers, helps save the nation billions of dollars in health care costs, by eliminating "unnecessary" tests, hospital visits, and other treatments. The enrollee's primary care physician is often the "gatekeeper," who has been offered financial incentives to deny services and limit access to expensive specialists and tests. The plans derive profits by denying medical treatment and contravening physicians' expert opinion about what is medically necessary.

Since 1973, when Congress authorized the first Federal subsidies to HMOs, cutting health care costs and expanding health care coverage have been the pretext for taking down the formerly highly regarded U.S. health care system. Now, 44 million Americans—more than ever before—are uninsured. Moreover, managed care has created a new and growing class of about 30 million underinsured people, who, although they are "covered" by such plans, are routinely denied the services ordered by their doctors.

Managed care is a monstrous looting operation, aimed at diverting the $1 trillion the nation spends annually on health care, into the coffers of the Wall Street and London-based financier oligarchy. In the Medicare program alone, the Inspector General of the U.S. Department of Health and Human Services found that managed care plans had grossly, wittingly, and artificially inflated their annual administrative costs to Medicare for years, by $3-4 billion.

Managed care plans systematically destroy vital health care delivery infrastructure, thereby causing further deprivation of medical services. Managed care's pervasive practice of underpaying, not paying, or delaying payment to hospitals that provide approved services, is driving many hospitals to the brink of closure, or past that brink. These HMO policies are a major reason why, according to Moody's Investors Service, not-for-profit hospitals will suffer more bankruptcies and defaults over the next few years, because they are unable to make bond payments and are forced to seek relief from creditors.

In this "booming" economy, a state-of-the-art community hospital in the heart of Virginia's Hunt Country, for example, which has the third-highest percentile of insured residents in the country, is facing closure or takeover, because managed care plans refuse to pay for hospital services. It has already closed a vitally needed counseling center, because of $10 million in unpaid debt from managed care plans.

In New York, it is routine for plans to contract with the state to provide services to prisoners or Medicaid recipients; take the premiums and skip town; or declare bankruptcy, paying as little as 25¢ on the dollar of what they owe hospitals and doctors for their services. Then, as in dozens of other

states, state government agencies must pick up the pieces. One plan alone, Blue Cross Blue Shield, owes Maryland hospitals $155 million for three years of services. Moody's states that "no hospital, including larger systems, is immune to the fiscal pressures currently affecting the industry."

Managed care is also cited as central to "a major downsizing"—one that rivals the cutbacks of the early 1980s—which "is under way in the hospital industry," with hospitals of all sizes slashing their staff to stay afloat" (*Modern Healthcare,* December 1998). The crisis is causing some regions' hospital-to-population bed ratios to collapse to pre-World War II levels (see Richard Freeman, "If You Get Sick, Will You Have a Hospital?" *EIR,* June 18, 1999). The impact on patient care is no less dramatic (see Linda Everett, "Managed Care and Nursing: Back to the 19th Century," *EIR,* June 18, 1999). Three patients died in 1997 at one acute care Kaiser HMO hospital alone, after it reduced its emergency room to stand-by status and closed its other area emergency rooms completely.

HMO and managed care enrollment grew from about 6 million in 1980, to 140 million today. By some estimates, as many as 85% of the U.S. public and private insured population is enrolled in some form of managed care, as are 95% of all employer-sponsored plans.

The issues before Congress

A 1974 Federal law known as ERISA (Employee Retirement Income Security Act), which exempts employee benefit plans from state regulations, is being systematically misused by group managed care plans and HMOs, in order to protect their operators from liability when their wrongful denial of care results in harming patients. The Senate Democrats' Patients' Bill of Rights would have lifted the ERISA exemption, making such plans legally accountable for their actions by making it possible for patients to sue them. But, on July 15, with the exception of Republican Sens. John Chaffee (R.I.) and Peter Fitzgerald (Ill.), the Republican majority killed the Democrats' bill and replaced it with the their own HMO Protection Act (see Linda Everett, "Senate GOP backs HMOs, Defeats Patients' Rights," *EIR,* July 30, 1999). Sen. Don Nickles (R-Okla.) and the Conservative Revolution's Sen. Phil Gramm (R-Tex.) continually rant the HMO industry's line: that allowing doctors to decide what is medically necessary care would drive up health care costs.[1]

But, the cost of this HMO regime to the nation, and to its workforce, is too high. For example, when an HMO did not respond appropriately to one enrollee's neurological emergency, the worker—and breadwinner for his family—was left with total permanent quadriplegia (*Pappas v. U.S. Healthcare*).

The battle to protect patients' lives is currently in the House of Representatives, where the Democrats' Patients' Bill of Rights (H.R. 358), sponsored by Reps. John Dingell (D-Mich.) and Richard Gephardt (D-Mo.), along with Charlie Norwood (R-Ga.) and Greg Ganske (R-Iowa), is an open revolt against the Republican Party leadership's protection of HMOs. Democrats have also proposed bills that allow patients or their families to sue HMO plans under various circumstances. The day before Congress recessed in August,

LaRouche: Stop HMOs' crimes against humanity

In a statement issued on July 31, Democratic Presidential pre-candidate Lyndon LaRouche called for a popular campaign against those U.S. congressmen who are protecting HMOs from being held responsible for any crimes they commit against participants in their health plans. "My campaign is going to develop a list of those who are defending the HMOs," LaRouche said. "It should be an imprisonable offense for HMOs, and the individuals heading them, to carry out medical practices which result in death and further suffering for those who are sick. It is a crime against humanity to immunize such criminals against civil suits. Yet that is precisely what the Republicans in the Senate did, and others are threatening to do in the House."

LaRouche said, "The head of an HMO organization should be personally liable for damage caused by his organization's cost-cutting and other practices. Such an individual is worse than a drunken driver. . . . I've been warning against the HMOs' Nazi-style practices for years now—and now it is becoming crystal-clear. To defend the General Welfare clause of the U.S. Constitution, to defend the Constitution itself, the HMOs have got to be stopped."

1. Senators who protected the HMOs and their human rights violations were: Spencer Abraham (Mich.), Wayne Allard (Colo.), John Ashcroft (Mo.), Robert Bennett (Ut.), Christopher Bond (Mo.), Sam Brownback (Kan.), Jim Bunning (Ky.), Conrad Burns (Mont.), Ben Campbell (Colo.), Thad Cochran (Miss.); Susan Collins (Me.); Paul Coverdell (Ga.), Larry Craig (Id.), Michael Crapo (Id.), Mike DeWine (Oh.), Pete Domenici (N.M.), Michael Enzi (Wyo.), Bill Frist (Tenn.), Slade Gorton (Wash.), Phil Gramm (Tex.), Rod Grams (Minn.), Charles Grassley (Iowa), Judd Gregg (N.H.), Chuck Hagel (Neb.), Orrin Hatch (Ut.), Jesse Helms (N.C.), Tim Hutchinson (Ark.), K.B. Hutchison (Tex.), Daniel Inouye (D-Hi.), Jim Jeffords (Vt.), Jon Kyl (Ariz.), Trent Lott (Miss.), Richard Lugar (Ind.), Connie Mack (Fla.), John McCain (Ariz.), Mitch McConnell (Ky.), Frank Murkowski (Ak.), Don Nickles (Okla.), Pat Roberts (Kan.), William Roth (Del.), Rick Santorum (Pa.), Jeff Sessions (Ala.), Richard Shelby (Ala.), Bob Smith (N.H.), Gordon Smith (Ore.), Olympia Snowe (Me.), Arlen Specter (Pa.), Ted Stevens (Ak.), Craig Thomas (Wyo.); Fred Thompson (Tenn.), Strom Thurmond (S.C.), George Voinovich (Oh.), and John Warner (Va.).

these Congressmen produced as-yet unpublished, bipartisan compromise legislation that would secure 160 million Americans harmed by plans, the right to sue their HMOs.

House Speaker Dennis Hastert (R-Ill.) has consistently blocked any and all action on any bill that includes a right-to-sue provision. He is being assisted by other Republican members who reportedly oppose any such provisions, including Rep. Tom DeLay of Texas, the Conservative Revolution's Dick Armey (Tex.), Bill Thomas (Calif.), and House Education and Workforce Committee Chairman William F. Goodling (Pa.). Rep. John Boehner (Ohio) led GOP attempts to defuse support for HMO lawsuits with a package of eight bills offered by Reps. Kay Granger (Tex.), Fred Upton (Mich.), Sue Kelly (N.Y.), Don Sherwood (Pa.), Patrick Toomey (Pa.), Ernest Fletcher (Ky.), and James Talent (Mo.).

Meanwhile, Hastert wants to bring the Senate GOP-passed bill to the House floor for a vote—knowing, as the George Washington University School of Public Health emphasizes—that the bill gives HMOs more rights than ever.

Crimes against the most vulnerable

HMOs and managed care plans are setting health care policy nationally, determining who gets what, if any, treatment, based on a genocidal interpretation of what is "medically necessary care." As the international financial crisis intensifies, HMOs are in an end-game strategy, increasing their denials for services and payments alike. A July 1999 Kaiser Family Foundation-Harvard University School of Public Health survey found that 86% of doctors and 82% of nurses say managed care decreased their patients' ability to see medical specialists; 83% of doctors and 85% of nurses say managed care decreased the amount of time they spent with their patients; and 72% of doctors and 78% of nurses say managed care decreased the quality of care for people who are sick. Nine out of ten doctors say their patients' plans denied them services in last two years. Some 61% of doctors said that each week, they see plans denying prescriptions for medication. Between one-third and two-thirds of doctors say that health plans' denial of drugs, hospital stays, tests, or referrals to specialists or mental health services, have caused adverse health consequences for patients.

Crude statistics or actuarial tables of mortality rates resulting from managed care policies are not yet available, but on every level, there are clear patterns that those practices are demonstrably harming and killing entire categories of Americans—the most vulnerable aged, indigent, mentally ill, disabled, and children, among them. As the Kaiser Commission on Medicaid notes, low-income Americans have a greater need for health care, are more likely to be in poor health, have more disabling conditions, and have higher mortality rates than higher-income Americans. Yet, "fiscally responsible" state leaders slashed hundreds of thousands of indigent people from eligibility for Medicaid—the Federal-state insurance program for 42 million low-income Americans—as Pennsylvania Governor Tom Ridge did in May 1996. People with mental, physical, or developmental disabilities make up 16%, or about 6 million, of non-elderly Medicaid enrollees, and account for 37% of total Medicaid expenditures, due to their extensive and complex long-term acute care needs. Just as Hitler targetted Germany's most vulnerable citizens, so these enrollees were targetted by "fiscal conservatives"—and the results were devastating, when 36 states were told that they must enroll in some form of managed care plans.

Target: the mentally ill

A 1997 Federal review by the Health Care Financing Administration of Montana's Medicaid program for its mentally ill beneficiaries found that, after a managed care plan took over, the number of inpatient days dropped by 96%, residential services dropped 85%, partial hospitalization visits dropped 45%, intensive outpatient services dropped 25%, and outpatient visits dropped 76%. The plan denied most of the doctors' authorization for treatment, and denied doctors' payments for services provided. States couldn't or didn't monitor plans, or worse, signed contracts with the HMOs that gave them total authority to decide what treatment was needed, and what was covered. The plans had the right to disenroll mental patients who were "disruptive"—yet, the primary symptom of someone who is psychotic, is disruptive, bizarre, and delusional behavior! Hundreds of thousands of mentally ill people who were eliminated from treatment which the Medicaid programs paid the HMOs to provide, ended up on the streets, in prison, or dead.

A survey of the Massachusetts Department of Mental Health Medicaid program found that, after the state contracted with a for-profit managed care company, Massachusetts Behavioral Health Partnership (MBHP), for its acute care Medicaid mental health patients, 52% of the clinicians said that at least one of their clients was put in life-threatening danger (suicide) due to premature hospital discharge by MBHP. That adds up to at least 2,600 of the 30,000 acute care patients whom MBHP is charged with caring for. Some 64% of the clinicians said that several thousand patients were sent to different hospitals each time they were hospitalized; 55% said that several thousand patients were bounced from one hospital to another in the middle of their hospital stay; and 51% said that thousands more patients were sent to hospitals so far away that their families could not visit. The state contract allowed MBHP—which has since been purchased by Columbia HCA, the largest for-profit hospital cartel in the country (and now under investigation by the Federal government)—to make $8 million in bonuses if it produced "efficiencies" in care.

ERISA-protected employee managed care plans promise mental health services, but systematically block access to care. The result: distraught HMO patients who are repeatedly

denied treatment, and who frequently commit suicide. Among known HMO suicides are Richard Clarke of Haverhill, Massachusetts, and Nitai Moscovitch, 16, of Brookfield, Connecticut. The pattern of denied treatment is so systemic, that the American Psychological Association has initiated several lawsuits nationally against scores of managed care organizations.

Target: the physically disabled

Individuals in Medicaid's mandatory managed care plans face continual life-threatening crises, since they are being denied the basic, yet complex, specialized medical care and medications that their lives depend upon to control chronic conditions. Meanwhile, others cannot even get basic medical examinations, because none of the HMO doctors have offices that are accessible by wheelchair. The crisis is no less serious for those 17.6 million Americans with disabilities who are in the workplace.

Case study: Michelle Leasure, 37, mother of three, has significant disabilities because of an auto accident and systemic lupus. She is employed by a Baltimore-based, nonprofit agency that switched to Prudential HMO. Leasure has no control over her bowels, and wears a colostomy bag to contain her waste. Maryland's law requires that insurers cover 100% of all supplies used for an ostomy (the surgical opening into the abdomen that allows waste to pass through into a disposable pouch), but Prudential denied the supplies. The HMO told the patient to reuse each disposable ostomy bag for five days: "When at work, wash the bags out in the public restrooms and walk [she uses a wheelchair!] to the sink [with her ostomy exposed], and finish washing the feces out into the sink, then reattach it to your flange." For the three months that Prudential denied her ostomy supplies, she couldn't work, and was forced to live in her bathtub. Leasure told *EIR,* "The HMO realizes that I am an expense. If they deny care long enough, I will die."

In the year with Prudential, Leasure suffered two strokes and three nursing home stays. Despite excruciating pain for six months, the HMO denied surgery to readjust Leasure's neural implant, which releases medication into her spine to relieve chronic pain. Then it agreed to surgery, but refused to let doctors test the device. So, her stabilized implant is now useless. The day after surgery, the HMO approved fixing it—but not the $10,000 surgery needed to do so, nor the morphine pump that doctors ordered to ease her constant pain. The HMO took a year to approve bone graft surgery to save Leasure's foot. Now, it is too late, and physicians say they will have to amputate.

The HMO is protected by ERISA.

Target: children

Approximately one-third of all U.S. children are in managed care plans. Yet the National Association of Children's Hospitals found that HMO and MCO financial disincentives and cost-cutting policies are associated with a decline in the pediatric specialty care that children need: "Children with complex health care needs face special problems. . . . Preventive care, such as urological testing for children with *spina bifida,* can prevent one of the leading causes of death for children with this condition." Yet, health policy experts found that plans do not routinely cover urological tests "that could save these children from death."

According to the State of Minnesota's Service Delivery Standards for its Project for People with Disabilities, "Children require comprehensive services to promote physical, emotional, and intellectual growth and development. Unlike adults, for whom the goal of treatment is to return the patient to his/her pre-disorder condition, children need uninterrupted progress in their development. . . . At the end of treatment, children should not return to 'normal' but, rather, arrive at a more advanced level of development. Disruption of developmental patterns during childhood may result in long-term consequences that can present themselves in adulthood."

In New York, 40% of pediatricians in a major Medicaid HMO could not even give an appointment for an 18-month-old child needing an immunization. Children's hospitals nationally, which treat the most severely ill and disabled children, provide almost all of the care for Medicaid children in managed care. But, these hospitals must fight HMOs' denial of treatment—while trying to collect the near $1 billion HMOs owe them for services the hospitals and doctors do provide. There are hundreds of cases, like that of Madison Scott of California, who was born with a correctable eye condition, retinopathy, but because his HMO failed to authorize care when she needed it, the child is now blind.

Case study: Ethan Bedrick, born with severe cerebral palsy, required physical therapy to prevent muscle contractions. In 1993, when he was 14 months old, his insurer cut off his physical therapy. The plan's doctor, with no knowledge of the disease, and with no exam or consultation with Ethan's physicians, concluded that the therapy would not result in "significant progress" for him. A 1996 ruling found that the decision had been arbitrary and capricious. The judge noted that "the implication that walking by age five . . . would not be 'significant progress' for this unfortunate child is simply revolting." The suit was eliminated under ERISA. (*Bedrick v. Travelers Insurance Company.*)

Target: heart disease patients

This disease is the major cause of death in the United States (900,000 deaths yearly), and the pattern of HMO managed care treatment shows higher death rates than under traditional care. These plans consign enrollees who require coronary-artery bypass graft or CABG (pronounced "cabbage"), to "discount" hospitals that compete for HMO business by

stripping down services. When Good Samaritan Hospital in Los Angeles set about in 1986 to offer cut-rate, assembly-line open-heart surgery in order to attract HMO and Medicare/Medicaid business, mortality rates increased. Good Samaritan's heart cases soared from 250 in 1985 to 1,300 in 1989 and 1990, the peak years when the hospital offered big discounts to managed care firms, in exchange for volume referrals of patients. But, data from the Health Care Financing Administration, the Federal monitoring agency, found that the mortality rate went up as well during that period. In fiscal 1989, the HCFA found 6.7% of the hospital's Medicare CABG patients died on-site or within 30 days of discharge. So, as business grew, the mortality rate climbed even higher. In fiscal 1990, it was 8.2%—one percentage point above what HCFA says is the expected range for the hospital's patient profile. Between 1991 and 1993, Good Samaritan's 30-day mortality rate for Medicare cases jumped up to 10.4%. Under scrutiny, the rate has since been lowered. But, court papers filed in a class action suit against Kaiser Permanente, one of the nation's largest HMOs, show the HMO plotting equally ruthless policies to achieve its fiscal goals of "a drastic reduction in total costs" of care.

The Regional Resources Management Director instructed Kaiser managers in a 1995 seminar: "We need to get from 300 [hospital days per 1,000 patients] to 180 days and do it in less than two years. . . . We're basically on-line to getting 180 days by 1996." How do you cut hospital days in half in one year? The manager spelled it out: Kaiser was dumping its chest pain protocols—which saved lives by early identification of heart attacks—because it "tripled our hospital days."

Target: the elderly

HMOs have been bilking enrollees in Medicare, the Federal health insurance plan for 40 million older and disabled Americans, for decades (see Linda Everett, "Plan to Privatize Medicare Is Defeated," *EIR,* April 9, 1999), using it as their personal cash cow, and then dumping 1 million enrollees when they couldn't milk it any longer. In 1993, five Medicare patients filed a class action lawsuit against the Federal agency that oversees Medicare, because their Medicare HMO, Family Health Plan (FHP), had denied services that resulted in their sustaining several serious impairments, including the loss of a leg by a 71-year-old woman, Grigoria Grijalva (*Grijalva v. Shalala*). The U.S. Circuit Court of Appeals (Arizona) ruled in August 1998 that Medicare HMOs which deny patients treatment and their right to a timely appeals process, are violating patients' due process rights as guaranteed by the Fifth Amendment of the U.S. Constitution.

The Medicare Rights Center, a national not-for-profit organization in New York, fields about 50,000 calls from Medicare patients each year. Nearly one-half of the cases involve instances in which HMOs willfully deny medically necessary services, medical equipment, emergency care, specialist care, surgical procedures, and home health care that are all clearly covered by Medicare.

The crisis is compounded for disabled older Americans. In December 1998, the U.S. District Court for Western Texas upheld efforts by patients of Humana Gold Plus, the Medicare HMO plan of Humana Health Plan of Texas, and Pacificare of Texas's Secure Horizons, among others, to sue the plans for limiting or withholding their care in order to reduce costs. The patients, all of whom suffer chronic disabilities, such as heart disease and pulmonary disease, said their disabilities required substantial time, treatment, and expense—but that the HMOs' doctors were motivated by the plans' financial incentives to stay below a set number of referrals to specialists, hospitalizations, and tests. The court found that the HMOs' financial controls had served to motivate discrimina-

Physicians relate HMO gallery of horrors

A July 1999 Kaiser Family Foundation-Harvard University survey randomly selected verbatim accounts from doctors of the most recent event in which managed care plans denied their patients care. Here are a few:

- HMO had no vascular surgeon available, delaying care for diabetic patient, leading to leg amputation.
- HMO doctor denied patient with bowel obstruction a colonoscopy because it was too expensive; patient died.
- Plan refused breast biopsy; patient had breast cancer.
- Plan refused chemotherapy for a patient with recurrent cancer.
- Medicaid HMO plan refused colonoscopy, missed cancer.
- HMO's clinic and emergency room ignored a 35-year-old man's back pain and neurological symptoms for six months; HMO denied him a referral to a neurosurgeon. Patient became paralyzed from chest down due to spinal tumor.
- Patient in septic shock, needed ventilator support in intensive care unit. HMO denied ICU care.
- Alcoholic HMO patient requiring detox stabilization was kicked out of hospital, killed himself on the same day.
- Patient did not meet HMO's hospital admission criteria; when finally admitted, her pulseless leg had to be amputated.

tion against patients with disabilities, a violation of the Americans With Disabilities Act (*Zamora-Quezada v. HealthTexas, et al.*).

The ERISA incentive to deny care

Enacted in 1974 to provide uniform Federal regulation of employee pension and welfare plans, ERISA preempts all state laws that relate to employee benefit plans, including health benefit plans. When wrongfully denied care, individuals in ERISA-protected HMOs or managed care plans can only sue for the actual costs of the benefit denied, which is why it is "economically rational for insurers" to wittingly plan and enforce policies that deny treatment—no matter what their consequence. You may be permanently injured because your HMO wrongfully denied a diagnostic test of your spine; but, under ERISA, all you can sue for in court, is the cost of the test—not your lifelong medical costs due to the disability, and not your lost earnings from decades of unemployability that resulted from the HMO's action!

ERISA-protected group plans are completely immune to state regulations concerning medical negligence, breach of contract, wrongful death, etc. No other industry in the nation has such immunities. Congress, when it passed ERISA to protect employees, never intended the law to be used as a weapon against those employees at the very time they or their families needed protection the most.

The Democrats' Patients' Bill of Rights, Rep. Charles Norwood's (R-Ga.) original plan, and Rep. Greg Ganske's (R-Iowa) proposal would, under various conditions, remove the ERISA shield, and would put HMOs and managed care plans back under state venue, making them liable, like any health insurance company, under existing state laws, thereby providing a state with cause of action. Sen. John Chaffee's (R-R.I.) proposal allows patients to sue HMOs in Federal court, thereby creating a Federal cause of action; but this measure failed in the Senate.

The states of Texas, Georgia, Louisiana, and Missouri have also passed specific laws that apply to suing HMOs and other plans, providing protections in a variety of ways. Also, according to the National Conference of State Legislatures, a dozen states have passed another aspect of patient protection legislation over the last three years, dealing with what is known as "hold harmless" clauses. It works this way: The most egregious HMO and managed care plan contracts with physicians state that the plan has the right to override a physician's medical treatment decision, and that the plan holds the right to define what is "medically necessary" care, which they can change at any time, according to their profit margins; but, the contract explicitly states that the *physicians* hold full risk of liability for the plan's health care decisions—i.e., the plans are "held harmless" against suits! Now, states are banning such clauses, declaring, in effect, that managed care plans are indeed responsible and liable for the effects of their treatment decisions, although the states do not always explicitly spell out what legal remedies patients have in these cases.

The American Association of Health Plans, the managed care trade group, spent over $1 million to defeat the Patients' Bill of Rights. They, and the Republican majority, claim falsely that allowing suits against HMOs would drive up health costs, causing employers to cut insurance benefits, and causing more families to be uninsured. But, HMOs were *already* raising premiums up to 58% in 1998—*before* the issue became politically hot—and they're still raising rates in 1999, even though no legislation has yet been enacted.

In Texas, home to two of the most vociferous opponents to letting patients sue HMOs, Sen. Phil Gramm and Rep. Dick Armey, only three cases against health plans have been filed since that state passed legislation—over Gov. George W. Bush's opposition—that allowed such suits in 1997. As these few cases show, employers and their workers who are denied care are already paying a high human price for managed care.

Case study: A woman died after her HMO refused to authorize cancer treatment. Her husband sued the HMO, claiming it caused her death by refusing to authorize treatment. The court found that his claim was preempted by ERISA (*Turner v. Fallon Community Health Plan*).

Case study: A woman's deterioration of her facial bones due to osteoporosis, prevented her from eating. Her doctors needed to replace her facial bone with bones from her hip. Her medical plan, which fully covers all medical conditions but dental-related ones, denied the surgery, claiming that the problem was "dental." She had no claim under ERISA (*Udom v. Department Store Division of Dayton Hudson Corp.*).

Case study: A woman, injured in an auto accident, was transferred to four different hospitals in three days by her HMO, which based its action on the availability of providers participating in her plan at those facilities. As a result of transfers and delays in treatment, she sustained irreversible nerve damage. The court found that ERISA preempted her negligence claims (*Dearmas v. Av-Med, Inc.*).

Case study: A physician ordered a pregnant woman hospitalized because of her history of problems during pregnancy. Her employer's health plan denied it, but authorized home nursing care during the day, but no monitoring at night. While she slept, the fetus went into distress and died. The judge, although disturbed by the insurer's focus on cost, had to eliminate the claim for damages, because of ERISA (*Corcoran v. United Healthcare Inc.*).

Case study: A heart patient treated for angina was assured by an HMO that he could continue treatment with his cardiologist. But, once enrolled, the HMO's primary doctor refused to refer him to his former cardiologist. The patient died six weeks later, the day before the HMO authorized a visit (*Nealy v. U.S. Healthcare*).