# Managed Care's Destruction of American Health Services

by Linda Everett

Much of the impetus for the 1946 Hill-Burton Act came from the shocking finding, in 1941, that nearly one-third of the males ages 18 to 37 called up for the draft, were physically or mentally unfit for military duty. Hill-Burton became one of several turning points in which the United States committed its resources to providing for and advancing the fundamental needs of all of its people, including assuring medical care of older and disabled Americans (through the Federal Medicare program) and assuring health care for impoverished families (through the Federal/state-financed Medicaid plans). But, just about every one of those fundamental health care advances, mandated by Federal or state laws, has been buried under the financial oligarchy's managed-care health plan to divert the $1 trillion which the nation spends annually on health care into the insurance industry coffers.

The two timelines below show a few key Federal programs established to provide for health care infrastructure and public health, along with a brief history of managed care's rise and the carnage its policy has caused. Not only are the nation's hospitals crumbling, incapable of meeting the medical needs of their communities, but managed care has actually reversed many advances in medical treatment.

## The HMO Takeover

### 1967

The campaign begins to make medical cost increases an issue. The American Hospital Association, for example, announces that hospital expenses per patient day in 1967 were $57.93, or 30% more than in September 1965.

### 1971

President Nixon's special message on national health care outlines three basic proposals: 1) require employers to provide basic health insurance coverage; 2) replace Medicaid; 3) encourage the establishment of health maintenance organizations (HMOs).

### 1972

Congress passes legislation that guts the original Hill-Burton mandate that hospitals built with Hill-Burton funds must provide care to indigent patients. Instead, Hill-Burton hospitals, 20 years after being built, no longer have to set aside a certain number of beds for patients who cannot pay.

### 1973

The Health Maintenance Organization and Resources Development Act of 1973 passes, for the first time providing $375 million in Federal aid to HMOs, to cut medical costs and to give access to health services to medically under-served. Congress requires that HMOs offer: a set fee for basic health services; 24-hour service to its enrollees; charge uniform fees, regardless of an individual enrollee's medical history; and prohibit HMOs from expelling or denying coverage to anyone because of health conditions.

Over the next 20 years, managed care companies scuttle every one of these requirements, by "cherry picking"—enrolling only healthy patients or, after open enrollment, denying access to needed specialists, tests, or treatment for enrollees who are chronically ill, mentally or physically disabled, who are often indigent.

### 1974

The Employee Retirement Income Security Act (ERISA) is passed to provide uniform Federal protections of employee group health, pension, and welfare plans. Under ERISA, such plans are preempted from state insurance oversight. Should an ERISA-protected health plan wrongfully deny or delay treatment, resulting in a patient death or injury, the plan may be sued only for the actual costs of the treatment denied—not for the worsened medical crisis, death, or permanent disability that resulted.

By the 1990s, instead of protecting employees, ERISA is used by group managed care plans as a shield to escape liability and prosecution under state insurance and other laws, when they intentionally and systematically deny needed treatment. Managed care companies are protected in

# The Beginning of Health Maintenance Organizations

Health Maintenance Organizations (HMOs) were first formally authorized by Congress in the Health Maintenance Organization and Resources Development Act of 1973, a bill to amend the Public Health Service Act "to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, health care resources, and the establishment of a Quality Health Care Commission, and for other purposes." This was the final result of lengthy debate in both Houses of the 93rd Congress over H.R. 4871 and S. 14.

The legislation is a classical example of the kind of "fascism with a Democratic face," about which Lyndon LaRouche had been warning in the early 1970s, with liberal Democrats and Republicans, either wittingly or unwittingly, passing legislation to impose vicious austerity on the population in the name of cost-cutting. In this legislation, health care was to be increasingly turned over to nurses and paramedics, and doctors' ability to competently treat patients was to be curtailed. As Sen. Hubert Humphrey (D-Minn.) put it, the bill "provides a strong incentive for a long-overdue emphasis upon preventive services to avoid the need for costly, intensive care."

The chief Senate sponsor for the bill was Edward M. Kennedy (D-Mass.), who today opposes the worst aspects of managed care. The final bill was passed with overwhelming majorities in both Houses.

The bill authorized $375 million in fiscal years 1974-78, to create a limited experimental Federal health care program over a trial period, to develop money-saving alternatives to existing fee-for-service forms of health care, and specifically to encourage development of HMOs. President Richard Nixon signed it into law on Dec. 29, 1973.

At the time of passage, HMOs such as California's Kaiser system, which came into existence in the early 1900s, had enrolled an estimated 7 million Americans, or approximately 3% of the population. The legislation enlarged this to about 6%, while it was in existence.

court from malpractice and liability suits after causing tens of thousands of catastrophic injuries, deaths, and life-long disabilities.

**1975**

U.S. Healthcare, Inc. is formed.

**1976**

Congress alters the 1973 HMO legislation, after HMOs complain that Congressional requirements saddle them with costs that make them more expensive and less able to compete with other medical services. The changes, for example, allow HMOs to deny enrollment to persons institutionalized with a chronic illness or permanent injury.

**1977**

The Health Care Financing Administration is formed to oversee Medicare and Medicaid programs. HCFA's first administrator, Robert Derzon, calls for expanding HMO capitation rate for Medicare, so that the government would pay one flat rate per person for a specified time period—regardless of the patient's medical needs—to reduce "overutilization" of services and save billions. Derzon encourages the use of living wills to cut cost-inducing activities.

**1978**

168 HMOs are operating, with 7.8 million enrollees.

Federal aid to HMOs is provided on a continuing, rather than experimental, basis. HMO outpatient facilities get extra funding, as part of an effort to reduce costly hospitalizations. While requiring HMOs to reimburse members for emergency medical services provided by someone other than the HMO, the laws also permit HMOs to refuse to pay for unusual or infrequently provided services and procedures.

**1981**

The last year that Federal assistance is given to HMOs.

**1983**

Medicare starts prospective payment system in which hospitals are paid a pre-set rate based on a patient's diagnosis (Diagnosis Related Groups), not on the actual cost, thereby penalizing hospitals for giving needed care that exceeds the DRG payment.

Within three years, the length of hospital stays for elderly and disabled Medicare patients drops dramatically, as hospitals send still-sick patients home.

**1986**

25.7 million people are enrolled in HMOs.

In the first lawsuit of its kind, a Michigan woman sues her Blue Cross Blue Shield HMO, charging that its profit-making mechanism, enforced through her "gatekeeper" doctor, led to denial of diagnostic tests and treatment for two years, during which she suffered from undiagnosed invasive cervical cancer.

**1987**

The Budget Reconciliation Act includes a provision prohibiting HMOs and competitive medical plans (CMPs) from

paying incentives to physicians, designed to withhold needed care from patients.

## 1988

Following the October 1987 stock market crash, Congress passes legislation allowing insurance companies to directly sponsor HMOs, without having to establish a separate legal entity.

## 1990

Congress repeals the 1987 prohibition, replacing it with supposed protections for both physicians and patients.

HMO financial incentives give rise to scores of lawsuits, after HMO doctors who benefitted financially, delayed or denied medical care to patients who later sustained injuries or died.

## 1991

The Bush FY 1991 budget includes a plan to encourage the use of managed care in Medicare and Medicaid, to contain health costs. But, Medicare was established precisely because private insurers refused to provide health insurance for older patients and chronically ill or disabled patients. Within eight years, it is shown that poor people with health problems do worse in managed care/HMO plans.

## 1994

An estimated 17 million children are enrolled in managed care.

Columbia/HCA, Inc. is formed, establishing the largest for-profit hospital cartel in the world, with its own HMO. Columbia rips into the community hospital system, eventually buying up, merging with, and selling off hundreds of hospitals, according to their profitability standard.

## 1995

A 16-year-old commits suicide after Physicians Health Services, a Connecticut HMO, refuses to pay for his continued hospital care, despite his two earlier suicide attempts. A Federal court upholds the suit, because the HMO failed to provide a proper standard of care.

Anesthesiologists from several New York hospitals sue Aetna, charging the HMO with violations of the Sherman Anti-Trust Act: unreasonable restraint of trade, wrongful, fraudulent, and malicious interference with the physicians' hospital contracts and use of economic duress in dealing with doctors (*Ambose v. Aetna*). Aetna threatens to remove all Aetna patients—up to 30% of the hospitals' patient base—if the hospitals do not force their anesthesiologists to sign an Aetna contract that includes a 25% wage cut.

## 1996

The new Welfare Reform Act eliminates the 60-year-old Federal Aid to Families with Dependent Children (AFDC) program, delinking it from Medicaid, leaving 675,000 low-income Americans uninsured by 1997, with more in 1998-99.

Pennsylvania cuts 220,000 medically indigent people from medical assistance, resulting in several deaths; a study finds that similar cuts in care will result in 3,500 needless deaths in California.

States mandate that 42 million low-income Americans, 16% of whom are disabled, shall enroll in some form of managed care, which have no expertise in the complex needs of the disabled.

The Welfare Reform Act specifies that immigrant families who arrived after August 1996 can receive no health care coverage for five years. California Sen. Diane Feinstein (D) warns Congress of the danger of "mass contagion" because immigrants are fearful that their resident status will be revoked, and therefore they don't seek help when ill. California has 1.7 million uninsured children; 37,000 of them in Orange County have no immunization at all.

67.5 million people are enrolled in HMOs.

Managed care plans open campaigns to enroll Medicare patients for lucrative Federal HMO premiums.

Aetna purchases U.S. Healthcare, an HMO with 2.8 million members, for $9 billion.

## 1997

The Balanced Budget Act of 1997 gouges $433 billion from Medicare and Medicaid programs over ten years. The Act uses financial inducements to get Medicare patients to enroll in managed-care plans.

57% of all managed-care plans claim they're losing money; in fact, they can't bleed any more from medical facilities and doctors, whom they've stopped paying.

A Federal review of Montana's new Medicaid program for the mentally ill found that, once managed care took over, inpatient days dropped by 96%; residential services dropped 85%; partial hospitalizations dropped 45%; intensive outpatient sevices dropped 25%; and outpatient visits dropped 76%.

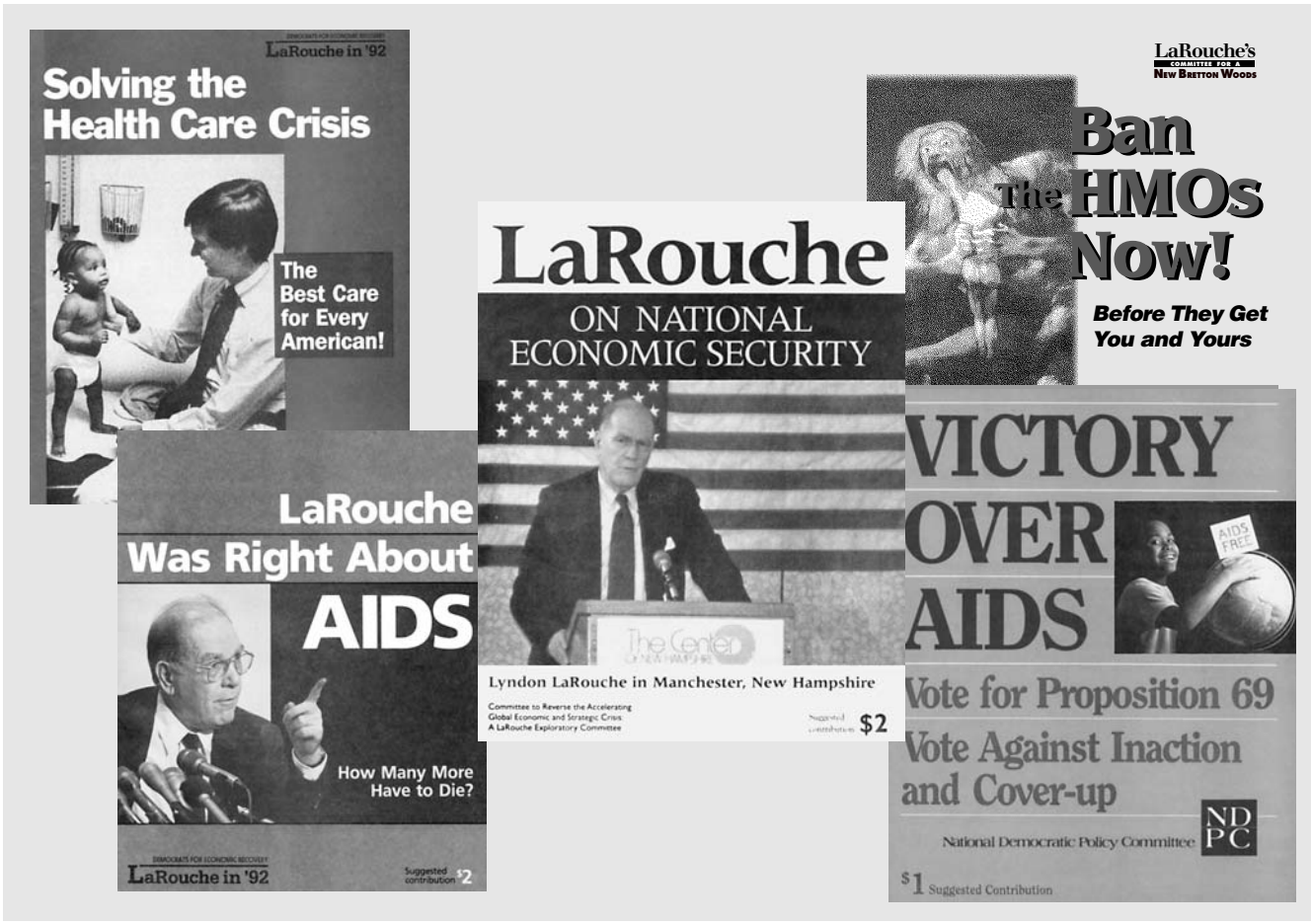
## 1998

49 states enroll Medicaid recipients in managed-care plans to slash state costs. Half of Medicaid's 32 million recipients are enrolled in 355 managed-care plans.

Aetna purchases NYLCare (1.5 million members) from New York Life Insurance for $1.5 billion. A class-action suit is filed in California against Aetna, Cigna, and Prudential, for aggressively enrolling older and disabled Americans in their Medicare managed-care plans, knowing that the plans would, within months, proceed to dump these patients in more than 30 states.

New Jersey's largest and oldest HMO, HIP of New Jersey, goes bankrupt, leaving its facilities and medical professionals scrambling to buy their own medications, treatments, chemotherapy, and supplies for 200,000 patients.

Government exposes how managed-care plans intentionally overcharged Medicare for billions of dollars. Aetna, Pa-




*Pamphlets issued by the LaRouche movement over the years warned of the insanity of "managed-care" policies, and put forward a rational alternative, based on the Hill-Burton Act of 1946. If that program had been implemented, we would not face the national health care crisis that we do today.*

cifica, Blue Cross Blue Shield, and Kaiser Permanente managed-care plans exit Medicaid plans in 12 states.

## 1999

Managed-care plans dump more than 650,000 Medicare patients, in 19 states, leaving tens of thousands of patients without coverage and unable to afford supplemental insurance to cover prescription drugs and services promised by HMOs.

Studies find that Medicare HMOs are illegally tripling charges to Medicare patients for services offered as free in their contracts, or that HMOs break contracts with seriously ill Medicare beneficiaries, denying promised services.

35 states consider patients' rights legislation, with Georgia and California passing laws that allow patients to sue their managed-care provider for wrongful denial of treatment, similar to Texas's law (1997). Missouri (1997), New Mexico (1998), and Louisiana (1999) utilize other methods to hold HMOs liable.

24 states have banned the use of "hold harmless" clauses that the managed-care companies use in physician/hospital contracts. Finally, managed-care companies can be held responsible for their decisions in patient treatment.

80% of recent medical graduates take jobs with HMO clinics or hospitals.

In California, HMO facilities demand that doctors see as many as eight patients an hour, spending just 7.5 minutes with each.

Doctors join collective-bargaining units and unions to defend themselves against HMO policies. Aetna sends its nurses into hospitals to speed up release of HMO patients. Anthem managed-care plans force hospitals to accept on-site reviews in hospital contracts.

Aetna purchases Prudential Healthcare (2.7 million members) for $1 billion, and announces its objective is total control over every aspect of how 400,000 physicians give care to their 20 million members.

Five class-action suits are filed against Aetna Inc., Cigna Corp., Foundation Health Systems, Humana, Inc., Pacificare Health Systems, and Aetna's Prudential Insur-

ance, "for pursuing fraudulent and extortionate policies and practices." Federal racketeering charges are also brought against some of the plans, which together, cover some 32 million people.

U.S. District Court in Texas upholds the right of chronically disabled patients who suffered from heart or pulmonary disease, to sue their Humana Medicare HMO because its physician financial incentives caused doctors to limit or deny specialist referrals and the substantial treatment their disabilities required (*Zamora-Quezada v. HealthTexas et al.*).

### 2000

Aetna is now the largest U.S. managed-care company, with 22 million members. One in every ten Americans is in an Aetna plan.

Aetna files suit against New Jersey hospitals to force them to stay in Aetna contracts. The hospitals lost up to $17 million a year on Aetna's contracts; Aetna denies 20% of all claims as "medically unnecessary" and won't cover one out of five days hospitalizations.

Harvard Pilgrim Health Care, New England's largest and oldest non-profit managed-care plan, is placed under state receivership. The plan covered 1.5 million people in Massachusetts, Rhode Island, Maine, Vermont, and New Hampshire. Failures of managed-care plans and HMOs surged 78% between 1998 and 1999—from 9 to 16 failures, affecting more than 821,000 people.

Aetna plans to exit the managed-care business to move into "defined contributions," in which employers give out vouchers that employees can use to buy their own insurance coverage. Families with a chronically ill or disabled member will be forced to pay more for care.

Wellpoint Health Networks and ING, the Dutch banking conglomerate, bid $10 billion to take over Aetna-U.S. Healthcare. Aetna plans to sever its health care unit from its financial companies.

Washington State and Arizona pass laws to allow patients to sue managed-care plans whose negligence results in injury or death.

About 170 million American are enrolled in HMOs and other managed-care organizations.

Aetna reaches a "landmark" settlement in a 1998 lawsuit: The state of Texas charged Aetna with systemic and industry-wide illegal policies, fraud, false and deceptive advertising, and illegal contracts with doctors to limit patient treatments "to maximize profits." Aetna admits no wrongdoing, and agrees to adhere to existing state laws for two years. 40 other class-action and personal lawsuits are still outstanding. Aetna is restructuring "to realize maximum shareholder value." Aetna plans to eliminate all Medicare coverage in its managed-care plans, affecting a "substantial" number of its 670,000 HMO members.

---

# The Breakdown of U.S. Health Care

### 1946

Hill-Burton Hospital Survey and Construction Act is passed by Congress.

### 1946-60

The incidence of most notifiable diseases drops during this period, due to the government's emphasis on public health measures and infrastructure development. The 83rd Congress holds hearings on "The Causes, Control, and Remedies of the Principal Diseases of Mankind" in 1953, consistent with the Hill-Burton approach to hospital and public health, to determine what is required and provide it. Over the next decade, two diseases are successfully beaten back. Tuberculosis, a marker for general public health, declines from a peak of 137,000 new cases in 1948, to 55,500 cases in 1960; pertussis (whooping cough) declines from a peak of 156,500 cases in 1947, to 14,800 in 1960; and diphtheria declines from 18,700 cases in 1945, to 900 cases in 1960.

### 1960s

113.1 million people, 60% of the U.S. population, are covered for hospital care; 107.7 million for surgical costs; 86.0 million for regular medical costs; and 38.3 million for major medical expenses

Congress passes several initiatives to support training of physicians, dentists, professional nursing and other health personnel.

Rubeola measles, which had peaked at 683,000 new cases in 1952, and been in the hundreds of thousands of cases every year between 1945 and 1966, drops to 62,700 cases.

### 1965

Medicare is established, providing health care for the aged (and later, for the disabled and those with end-stage renal disease), financed under Social Security, paying for 90 days of hospital care; 100 days of nursing home care; and 100 home health care visits. Private insurers refused to offer health insurance to older, disabled Americans.

Medicaid is established as a medical safety net for the poorest, sickest, and most disabled, based on income or type of disability. The Federal- and state-funded program mandated that states provide children with Early Periodic Screening, Diagnostic and Treatment (EPSDT) to prevent disabilities and control transmissible illness.

Drawing on wartime experience of military physicians

from World War II, Korea, and Vietnam, plans are formed to established a nation-wide regionalized system of trauma care centers to ensure life-saving care to those who sustain massive critical injuries.

## 1970

The number of hospital beds (community and specialty) declines to 7.9 beds per 1,000 population, down from 10.2 beds per 1,000 in 1945. There are 7,156 hospitals with 1.62 million beds.

## 1975

Funding for health service programs is renewed by Congress, overriding President Ford's veto. The number of hospitals drops to 7,123, a decline of 33 since 1970; the number of hospital beds declines 150,000, to 1.47 million, or 6.8 beds per 1,000 population.

## 1978

The percentage of the population which has health insurance peaks, at 84%.

## 1979

11 cases of AIDS are identified.

## 1980s

Hospitals invest heavily in nurse educators, who train new registered nurse graduates for specialized areas, creating highly skilled staff within hospitals.

The number of hospitals drops to 6,965 (1980), a decline of 191 since 1975; the number of beds drops to 1.37 million, a decline of 101,000 during the same period, a rate of 6.0 beds per 1,000. The number of HMO plans rises to 236, with an enrollment of 9.1 million people.

## 1981

The Centers for Disease Control reports on a cluster of cases of Pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma, a rare form of cancer. By mid-1981, 116 such cases are reported to CDC, prompting the hunt for the AIDS virus by the U.S. medical establishment.

## 1985

Another 93 hospitals and 51,000 beds have been lost since 1980, dropping the beds per 1,000 rate to 5.5. AIDS cases to date reach 16,500; it is the leading cause of death among men aged 30-34 in New York City. There are 393 HMOs, covering 19 million people.

## 1986

Tuberculosis emerges as an AIDS marker, as the long, steady decline in TB cases is reversed, and a resurgence begins. There are 22,800 cases in 1986.

Patients receiving coronary-artery bypass graft (or CABG) under managed care or HMO show higher death rates than under traditional fee for service plans. Federal study of Medicare deaths finds a 10.4% increase in 30-day mortality rate at California hospital (1991-93) which offers assembly-line surgery at reduced rates to attract HMO contracts.

## 1987

New York City health authorities estimate that 500,000 residents are infected with the HIV virus.

## 1990

The number of hospitals drops to 6,649, a decline of 223 since 1985, and a decline of 474 since 1970. The number of hospital beds drops to 1.21 million, down 98,000 since 1985 and 405,000 since 1970, to 4.9 beds per 1,000 population. 652 HMO plans cover 34.7 million people. An estimated 50% of U.S. children under age five have not received needed vaccinations, reflecting the decline of public health measures.

## 1991

Rural areas experience medical care shortage. Between 1984 and 1991, 550 rural hospitals stopped providing acute care.

## 1992

26,700 tuberculosis cases are reported, a 20% increase over 1985. 95 hospitals are closed, and 23,000 beds disappear. Between 1992 and 1997, over 400 emergency departments close throughout the country, as managed-care companies deny payments for emeregency interventions, resulting in increased disabilities and deaths.

Congress passes the Americans with Disabilities Act to give disabled individuals protection against discrimination.

But, under managed care, it's proven that disabled children with complex health care needs, such as those with spina bifida, are denied basic tests that could save them from preventable death (State of Minnesota study).

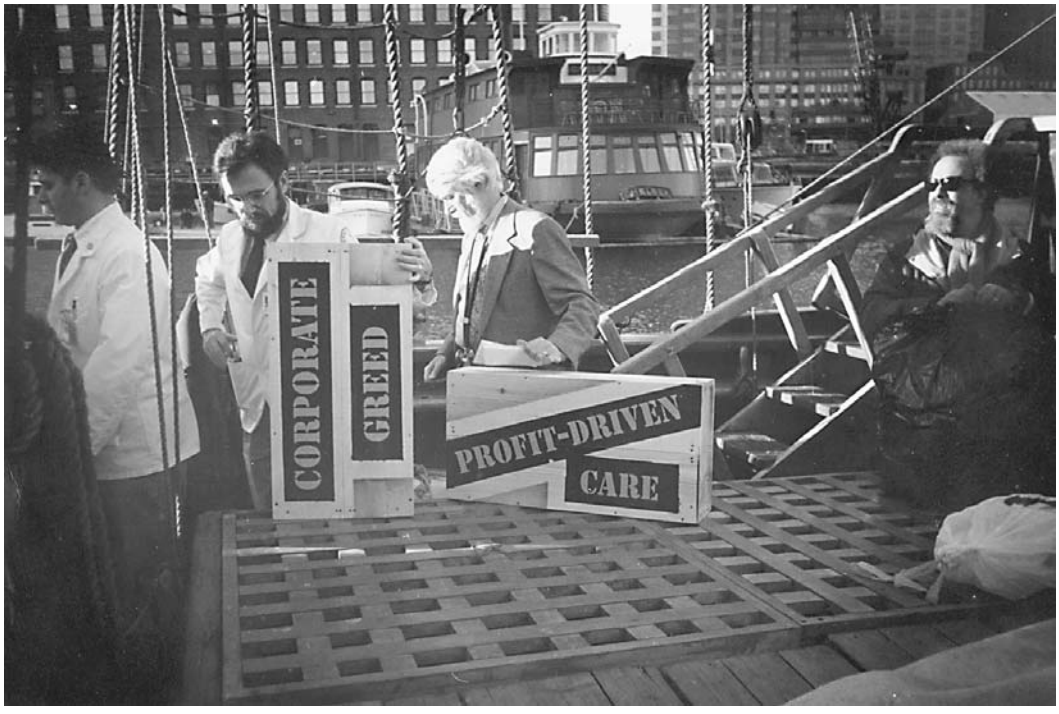
## 1993

The CDC reports 339,000 U.S. AIDS cases to date, with 204,000 deaths. The lethal rodent-borne hantavirus erupts in the Southwest; contaminated water causes an outbreak of cryptosporidiosis in Milwaukee; and a pertussis epidemic hits the U.S., due to failure to vaccinate.

The number of hospitals declines by 72, to 6,467, and the number of beds declines by 16,000, to 1.16 million, or 4.6 beds per 1,000 population. Between 1980 and 1993, 675 community hospitals are closed. In California, the number of hospitals declines 13% between 1983 and 1993. Hospital in-patient days drop 30-44%; in-patient procedures drop 35-46% (*Journal of American Medical Association*).

All 24 hospital regions are below the inadequate nation average of 3.4 RNs per 1,000 residents. Cuts of just 7.75% of hospital registered nursing staff increases morbidity rates by up to 400%.

Trauma care centers are found to save 64% of the 140,000




*Demonstrators against HMOs and managed care rally on the original Boston Tea Party ship in Boston Harbor, dumping crates labelled "Nursing Cutbacks," "Corporate Greed," etc., into the water.*

Americans who would otherwise die of injuries each year. Managed care often refuses to pay for trauma care that saves the patient's life. One-third of nation's trauma centers shut down. When proper rehabilitation follows trauma care, 85% of critically injured patients return to productive lives within one year of treatment.

## 1994

Necrotizing fasciitis, the so-called "flesh-eating" bacteria, erupts; cases of hantavirus, which had killed 53 in the Southwest, are reported in Florida.

The financier/HMO climate of cost-cutting on hospitals forces the "downsizing" of highly trained/paid registered nurses in hospitals, substituting untrained technicians or unlicensed aides, or, even hospital janitors (Ohio) to care for acutely ill patients, leading to increased patient deaths, hospital infections, medication errors, and injuries. Hospital nurses are forced into mandatory overtime, working as many as 16 hours straight or 60-80 hours weekly, while patient load increases.

## 1995

The United States nationally has a vaccination rate of only 75%, with many states much lower: Missouri (65%), Nevada (68%), Arkansas (69%), Illinois (69%).

70% of U.S. hospitals, under market-driven health care reforms, undergo massive restructuring, eliminate "excess" hospital beds, and cut 40% to 50% of registered nurses, resulting in increased patient morbidity and mortality. For-profit hospitals are closing emergency rooms to eliminate treatment of indigent, uninsured patients.

Over one-third of the U.S. population, an estimated 79 million Americans under age 65, are uninsured or underinsured, that is, they are unable to pay for out-of-pocket expenditures exceeding 10% of their income that their health insurance or managed-care plans don't cover.

## 1996

The level of uncompensated charity care that physicians provide to the nation's medically indigent, uninsured population drops (from a high of $11 billion to less than one-third of that) due to proliferation of managed care.

The prevalence of tuberculosis in homeless persons is substantially higher than that in the general population; shelters are identified as sourcs of TB outbreaks.

Ratio of registered nurses at community hospitals falls to 2.65 per 1,000 population.

High death rates among black, Hispanic men ages 15 to 24, from 1990 to 1996, are linked to poverty and lack of access to health care. The suicide rate for older black teens has tripled since 1980. One out of every 1,500 African-Americans will die of homicide or suicide every year.

Patients are permitted only half the amount of time today in hospitals as they were in 1980. The average annual number of days of in-patient hospital care drops to 604 per 1,000 people—down from 1,217 per 1,000 people in 1980.

HMOs have 60 million enrollees. About one-half of full-time working poor and one-third of all poor people are uninsured. About 43.4 million American, or 16.1%, have no health insurance.

## 1997

California emergency room doctors are limited to 12 minutes of care per emergency room patient in HMO facilities. 42% of HMO enrollees surveyed in California had medical care denied or delayed; 31% lost time (up to ten days, or sometimes more) from work due to HMO delay of care.

State Children's Health Insurance Program (SCHIPS) is established to provide medical care to indigent children who don't qualify for Medicaid, but whose families do not earn enough for private insurance.

## 1998

Poor people are twice as likely to suffer deteriorating health if they are treated by HMOs as compared to traditional fee-for-services arrangement; low-income Americans are more likely to be in poor health, have more disabling conditions, and have higher mortality rates than those with higher incomes.

A Boston Public Health Commission study finds that poverty and lack of access to health care increases death rates dramatically. Suits over patient deaths due to understaffing of nurses at medical facilities increases. About 70% of the under-65 population has private health insurance, a drop from 80% in 1980.

Majority of HMOs in California do not pay emergency room doctors for care of their patients; state takes no action, even when it is impossible for hospitals to keep specialists on emergency stand-by. Three emergency-care patients die after a Kaiser Permanente HMO facility cut costs by shutting its emergency room in one California county, and merging three of its hospitals into one, leaving just 24 intensive care beds for its 350,000 members.

Managed-care plans systematically deny billions of dollars in payments for approved services, illegally delay payments to hospitals and doctors for over a year, and retrospectively deny approval for services. Physicians increasingly are forced to borrow to make payroll, keep their offices open, and hire extra staff to deal with HMO paperwork.

Increase in suicides of HMO patients forces the American Psychological Association to sue managed-care plans that arbitrarily slash the annual number of out-patient sessions cited in contracts (Aetna U.S. Healthcare); terminate psychologists (who advocate more care for patient) "without cause" (MCC Behavioral Care); and demand that mental health practitioners accept drastic cuts in reimbursement rates or resign (a violation of their contracts).

## 1999

Medical errors are the leading causes of death and injury in America. Between 44,000 and 98,000 people die in hospitals every year due to preventable medical errors—far more than the number of Americans dying from breast cancer, highway accidents, or AIDS. Preventable deaths, permanent injuries, and unnecessary suffering are also rampant in nursing homes, day-surgery and out-patient clinics, and retail pharmacies. Fatal medication errors alone ranked between the fourth and sixth leading cause of deaths in the United States in 1994-99.

Almost 1,000 state laws are passed in 48 states in attempts to protect patients, doctors, and hospitals from managed-care policies.

Despite basic medical capabilities, managed-care plans' denial or delay of diagnostic care or treatment, resulting in needless amputations, patient deaths, suicides, invasive cancers, and infections.

In some areas of California, only 30% of preschool children are immunized. In one *colona* in El Paso, Texas, 25% of all children under age seven have hepatitis A.

A California physician group cancels contracts with Aetna after citing a 47% rate drop in payments over the last four years.

## 2000

HMOs offer New York hospitals a "choice": Either take reimbursement rates that don't cover costs, or, drop out of the plan entirely. Other HMOs sign contracts to provide services for state prisons (where hepatitus C is prevalent and usually untreated), and "take the money (premiums) and run," leaving hospitals without payment of millions of dollars of care. Two-thirds of Massachusetts hospitals facing their 13th consecutive quarter in red ink (reimbursements do not cover the costs of care and HMOs refuse to pay for billions of dollars of services). Four out of five Pennsylvania hospitals surveyed cannot cover operating costs with patient revenues. 10,000 Michigan hospital jobs have been lost in 18 months, with an additional 7,000 jobs lost in related industries. Non-profit hospitals are forced to reduce/eliminate services and programs; some are closed.

Ignoring medical needs, Milliman & Robertson, the best known actuarial firm that publishes length of hospital stay guidelines used by the insurance industry as a basis to pay hospitals, sets target goals for length of hospital stay for children with bacterial meningitis of less than 4 days hospital care, when 13 days are usually needed; for complicated appendectomy (4 days, when 11 is the norm); for osteomyelitis (3 days when 11.7 is typical).

AIDS is officially declared by the U.S. government a national security threat.