

HMO Reform Needed to Protect Citizen Rights

On September 10, 2008, 71-year-old Alynne Griffiths filed a lawsuit against her HMO, PacifiCare of Nevada, for sending her in 2006 to an Endoscopy center that was experiencing a known Hepatitis outbreak. Griffiths contracted the Hepatitis C during her procedure and required treatment for the liver-afflicting virus that can lead to organ complications and cancer. At least 85 cases of both the chronic and acute versions of the virus were linked to the center.

Griffiths' case provides added credence for the need for HMO and healthcare reform. While many lawsuits have been filed against various parties involved in the Hepatitis C outbreak, Griffiths' claim is the only one directed toward an insurance provider. She believes that the real culprit wasn't the center – which officials say had repeatedly used “unsafe” medical practices during the time of the outbreak – but the HMO that “strongly encouraged” her to go there for her procedure.

Since the rising reports of Hepatitis C have surfaced, the Shadow Lane Clinic where Griffiths received her treatment has been under investigation by the Center for Disease Control and Prevention. They discovered that the clinic had been improperly reusing syringes and vials of medication that led to contamination, and encouraged the 60,000 patients treated there to seek testing for Hepatitis B, C, and HIV.

Griffiths commented, "I would like to see a broader referral system where people can get access to different doctors and not be so restricted to these doctors who were involved...Unless you're independently wealthy, you have to go where your insurance company sends you." She is still feeling the effects of a restrictive HMO as she tries to treat her Hepatitis C: many of the specialists she has been referred to for treatment are not included in her HMO network, and are therefore inaccessible on her budget.

Griffiths' lawyer, Gerald Gillock, sees the contracts between HMOs and the medical centers as also being a crucial issue in the case. “We have a limited number of Health Maintenance Organizations that control the medical care available to all of the lives in Clark County...these insurance companies have to maintain a quality control program. They have to inspect and ensure these health care providers are furnishing quality health care to their insured.”

Gillock is currently representing over 50 other patients of the Shadow Lane facility who have suffered due to their unsanitary medical practices, yet does not want to compromise the individuality of each case by forming a class action suit. This has not deterred him from preparing for a large-scale attack on HMOs, as he has begun to organize with other lawyers from around the country who are dealing with similar cases. He said, “We're ready to roll up our sleeves and get into the trenches...We're quite confident that we're going to establish that these organizations have totally neglected their insured.”

Yet compared to many of her peers, one could consider Alynne Griffiths lucky she is receiving coverage for any of the procedures – flawed or no – that she has endured in the past few years. Over 30% of all insurance claims filed by customers of PacifiCare, Griffiths' provider, are denied without any reason. A recent investigation of the HMO by the California Department of Insurance has brought this staggering statistic to light, leaving the company no option but to play dumb to such accusations as they volunteer to internally investigate the matter.

The most disturbing fact: PacifiCare and their record of denials is the norm...not the exception. In North Carolina, which prides itself on its healthcare record, the average statewide denial rate is 20% accordingly to a recent state study.

This policy of unqualified denial is a well-known tactic used by HMOs to line their pockets at the expense of their clients, and has unfortunately filtered in and out of public awareness for the past decade. In arguably the grossest example of this attitude, Teri Goodrich sued Aetna HMO in 1998 for not paying for her husband's treatment for stomach cancer. One of her not-so-subtle implications in testimony was that the HMO deliberately postponed reviewing his claim for treatment until the cancer had metastasized to a fatal stage, thus relieving the amount of treatment they would need to pay for. By the time his initial claim was denied five and a half months after the Goodrich's filed it, the cancer had spread to David Goodrich's stomach; he was on his deathbed.

While it is shocking to think instances of such heinous and malicious inaction such as this is lawful, it is even more shocking to know that it is actually sanctioned by the government who offers a law that basically amounts to immunity from legal action against HMOs in most states. Former Senate Minority leader Tim Daschle said, "I think they see themselves in a permanent legal immunity situation that allows them to make these callous decisions without having to pay the price."

Yet patients in need of care are not the only ones who suffer at the hands of the business-oriented HMOS; doctors have long felt undermined and challenged by the fact that at the end of the day, it is the HMO administrators and claims officials that have the final word on treatment. Dr. Anthony Tonzola, president of the Physician's Union, said on the issue, "HMOs have been practicing medicine without a license for years through their interference with medical decisions made by doctors." Even in the event that the HMO doesn't deny a claim made by a patient, they still in essence make the ultimate decision on the care a patient receives through what they *will* cover. Alynne Griffiths experienced their control over her medical destiny when PacifiCare did not cover the doctors she was referred to for her Hepatitis C.

HMOs are able to continue place the people that are to provide care the people at undue and immoral risk because for most that can't afford the out of network costs there is no other option. Alternatives for non-HMO plans for companies and individuals is not an option as HMO plans are the only real source of accessible health insurance available in the United States, and because

of this simple fact, HMOs have essentially been given a US Government sanctioned monopoly on the public that they can exploit at their convenience.

A question of motives and ethics needs to be raised in the discussion of healthcare and HMO reform: why aren't HMOs non-profit organizations versus for profit companies abiding to shareholders over patients, or at least government monitored institutions?

Alynn Griffiths' case provides an opportunity for the state of Nevada to set a precedent for what American's should expect from their HMO: honesty, functionality, support, respect for Physician and Provider care plans and a partner in personal health management. Yet real action must occur in Washington, such as government monitoring of claim denials, limits on denials to a maximum of ten percent of claims, and pressure on insurance providers to expand networks and treatment options for patients. Changes must force HMO focus from *their* bottom line and to patient care.