In the course of developing this appeal, it has been suggested that HUD staff are prohibited from providing technical assistance to applicants once the Notice of Fund Availability (NOFA) has been published. Clearly, HUD cannot write applications for agencies. However, advising that an incorrect form is being utilized would seem to fall into a category of ''general information''. Moreover, there has been a practice by the HUD Columbus staff to assist applicants in clarifying application related questions.

It has been the experience of this community that HUD staff are dedicated professionals, who see their role as facilitating community planning efforts. Regardless of the outcome of this appeal, we will continue to build a partnership with HUD to promote this objective.

We look forward to hearing from you at your earliest convenience.

Sincerely,

TIM MCCORMACK, *President*,
JANE L. CAMPBELL,
JIMMY DIMORA,
Cuyahoga County Board of Commissioners.

WHAT AETNA ISN'T TELLING YOU ABOUT THE GOODRICH CASE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 10, 1999

Mr. STARK. Mr. Speaker, in recent weeks, Aetna has sent Members' offices criticisms of a recent California court case in which a jury has awarded $120 million to a widow for the economic loss and pain and suffering caused by the Aetna HMO's treatment of her husband, David Goodrich. Aetna is saying the facts do not support—and argue against—allowing HMO members to sue their HMO.

Ex parte communications about a lawsuit—and Aetna says it is appealing—are always questionable.

Aetna, of course, has a ton of money to lobby Congress. The Goodrich family has no Washington lobbyist. Therefore, I asked the Goodrich attorney to comment on Aetna's mailing to us.

Guess what? There is another side to the story.

Following is a side-by-side prepared by the plaintiffs. Also, I am including in the RECORD a press release from California's Consumers for Quality Care, which makes the excellent point that the CEO of Aetna, who loves to write long editorials about quality, has thrown a temper tantrum, blaming the ''not intelligent enough'' jurors. It would be far better for him to look within to the quality of his operations. Is this really the kind of CEO we would want as head of the nation's largest health insurance company?

AETNA MISLED CONGRESS ABOUT FACTS OF GOODRICH CASE: INVESTIGATIONS, WITHDRAWAL OF FEDERAL CONTRACTS CALLED FOR

BOARD OF AETNA ALSO ASKED TO FIRE C.E.O. HUBER OVER REMARKS

Consumers For Quality Care, the national health care watchdog group, today called upon Congress to convene hearings and suspend Aetna's government contracts over the HMO's attempts to mislead Congress about the facts of the landmark *Goodrich vs. Aetna* case in order to prevent HMO reform.

Aetna recently sent a statement to Congress distorting the facts of the case, in which a San Bernardino jury issued a $120 million rebuke of the HMO's conduct toward District Attorney David Goodrich. Goodrich died of stomach cancer after a two and one half year ordeal trying to get Aetna to approve cancer treatment recommended by his Aetna doctors.

In a letter to members of the United States House of Representatives and Senate today, Consumers For Quality Care urged action against Aetna because ''Aetna's conduct . . . shows a contempt both for the Court, the American justice system and for Congress.'' A point-by-point refutation of Aetna's statement to Congress about the case, based on the court record, was also released. (Available upon request)

''We intend to make a federal case out of Aetna's misrepresentations and remorseless defiance of the civil jury and their authority,'' said Jamie Court, director of Consumers For Quality Care, a health care project of the Foundation for Taxpayer and Consumer Rights. ''It should be federal case when the nation's largest HMO misleads Congress and thumbs its nose at the civil justice system. Aetna's defiance of civil society's dictates should bolster the case for giving to all patients the right to sue that Mrs. Goodrich has.''

The Goodrich case exposed the disparity in federal law between government workers, like the Goodrich family, who can sue their HMO and private sector workers, who are prevented from suing for damages unless Congress changes the Employee Retirement Income Security Act of 1974 or ERISA.

HUBER SHOULD BE FIRED

Consumers For Quality Care also wrote Aetna's Board of Directors asking it to fire Chief Executive Officer Richard Huber over his remarks attacking Goodrich's widow.

Huber responded in the Hartford Court to the verdict. ''This is a travesty of justice. You had a skillful ambulance-chasing lawyer, a politically motivated judge and a weeping widow.'' Later, a Los Angeles Times columnist reported, ''he [Huber] expanded his complaints, telling me that juries are customarily not intelligent enough to consider complicated contractual issues and that this one in particular was too ill-informed, as a result of the judge's evidentiary rulings, to render a sound verdict.''

''We have been astounded at your Chief Executive Officer's lack of remorse over the handling of David Goodrich's care and ask you to act immediately to remove him,'' wrote Court. ''If Aetna is dedicated to making things better for patients, Mr. Huber does not belong as your C.E.O. The true travesty of justice would be if Mr. Huber remains at the helm of Aetna and company policy continues to be indifference to its dying patients and to juries that condemn such policies.''

The Foundation for Taxpayer and Consumer Rights is a tax-exempt, nonprofit, nonpartisan organization dedicated to advancing and protecting the interests of consumers and taxpayers.

THE FOUNDATION FOR TAXPAYER
AND CONSUMER RIGHTS,
Santa Monica, CA, February 9, 1999.

The True Travesty of Justice.
AETNA INC.,
Hartford, CT.

DEAR MEMBERS OF THE BOARD OF DIRECTORS: The origin of change is regret. We have been astounded at your Chief Executive Officer's lack of remorse over the handling of David Goodrich's care and ask you to act immediately to remove him.

As you may know, Goodrich, a district attorney who risked his life by prosecuting gang violence, died of stomach cancer after a two and one-half year ordeal trying to get Aetna to approve cancer treatment recommended by his Aetna doctors. A San Bernardino County jury issued a $120 million rebuke of your company's handling of Goodrich's treatment.

Unfortunately, your C.E.O., Richard Huber, responded to the verdict without remorse: ''This is a travesty of justice. You had a skillful ambulance-chasing lawyer, a politically motivated judge and a weeping widow.'' (The Hartford Courant, January 22, 1999)

Does Mr. Huber really deny the right of a widow to weep for her husband?

Later, a Los Angeles Times columnist reported, ''he [Huber] expanded his complaints, telling me that juries are customarily not intelligent enough to consider complicated contractual issues and that this one in particular was too ill-informed, as a result of the judge's evidentiary rulings, to render a sound verdict.'' (Kenneth Reich, ''Verdict Against Aetna Is An Omen Of Clash Over HMOs,'' Los Angeles Times, Thursday, January 28, 1999, p. B5.)

Is Aetna really this contempful of the civil justice system and its ethic of responsibility, or are these Mr. Huber's own views?

We had hoped that $116 million in punitive damages might be enough to cause Aetna to reconsider how it deals with patients like David Goodrich. The message from the jury was that Aetna must do better. But Mr. Huber's remarks suggests that in the future Aetna's patients will get no better treatment at Aetna than David did.

The Goodrich jury felt that Aetna did not respond quickly when a patient's life hung in the balance and that Aetna ignored its own doctors' recommendations for Mr. Goodrich's care. In one instance, it took Aetna four months to approve high-dose chemotherapy and Goodrich could no longer benefit. Company and industry standards claim a 24 to 48 hour turn-around time.

Is this the appropriate standard of care at Aetna?

When it was clear Mr. Goodrich could wait no longer, Goodrich's doctors ultimately acted without approval. The public servant died believing he had left his wife with $750,000 in medical bills. While Aetna claimed, in a letter to Congress, that the treatment was paid for by ''another insurance company,'' in fact the taxpayers picked up the bill. Mrs. Goodrich was a Yucaipa school teacher and the school district paid $500,000 of David's bills, only under the threat of litigation and with the understanding the cost would be repaid out of any Aetna verdict.

If Aetna is dedicated to making things better for its patients, Mr. Huber does not belong as your C.E.O. The true travesty of justice would be if Mr. Huber remains at the helm of Aetna and company policy continues to be indifference to its dying patients and to juries that condemn such policies.

We urge you to remove Mr. Huber as a signal that pro-patient reforms at Aetna will be forthcoming and that no other family will have to endure what the Goodrich family has.

Sincerely,

JAMIE COURT.

THE FOUNDATION FOR TAXPAYER
AND CONSUMER RIGHTS,
Santa Monica, CA, February 9, 1999.

AETNA HAS MISLEAD CONGRESS & THE PUBLIC

DEAR MEMBER OF CONGRESS: Attempting to stymie HMO reform, Aetna, the nation's largest HMO, has misled you in a recent communique defending its treatment of cancer patient David Goodrich. The San Bernardino County district attorney died after a two and one half year ordeal trying to get Aetna to approve cancer treatment recommended by his Aetna doctors. Goodrich died believing he had left his wife with $750,000 in medical bills. A San Bernardino County jury awarded $120 million in the case—including $116 million in punitive damages for malice and oppression—to the widow.

Attached is a detailed refutation, based on court records, of Aetna's false and misleading statements to you. We urge you to immediately convene hearings regarding Aetna's conduct in this matter, which shows a clear contempt both for the Court, the American justice system and for Congress.

As you know, 125 million Americans with private sector, employer-paid health care cannot sue their HMOs for damages due to the Employee Retirement Income Security Act of 1974 or ERISA. Aetna's remorseless conduct bolsters the case for reforming ERISA and allowing all patients the same right to sue that government workers, like the Goodrich family, now have. Aetna has yet to accept the message that the Goodrich jury sent—that it must respond more quickly to its patients and defer to its doctors' recommendations. Civil remedies for all patients are clearly needed to force Aetna to behave more responsibly.

In his remarks in the Hartford Courant, Aetna's C.E.O. Richard Huber responded to the verdict: "This is a travesty of justice. You had a skillful ambulance-chasing lawyer, a politically motivated judge and a weeping widow." In fact, the judge was a former insurance defense attorney. Aetna's own lawyers' questioning caused Mrs. Goodrich to cry on the stand. The family's attorney was also a long-time friend of Mr. Goodrich who only took the case at the behest of the head San Bernardino District Attorney, who himself could not compel Aetna to pay for Goodrich's treatment.

Later, a Los Angeles Times columnist reported, "he [Huber] expanded his complaints, telling me that juries are customarily not intelligent enough to consider complicated contractual issues and that this one in particular was too ill-formed, as a result of the judge's evidentiary rulings, to render a sound verdict."

Aetna's lack of remorse and the unwillingness to accept responsibility in this case is a symptom of the company's larger defiance of civil society's mandates. Such a company should not be entitled to federal contracts. We urge you to investigate Aetna's handling of this matter and are ready to assist.

Sincerely,

JAMIE COURT.

THE GOODRICH CASE: THE TRUE FACTS THAT AETNA DIDN'T TELL YOU[1]

Aetna's false and misleading statement:	The truth (court records show):
The statements attributed to the plaintiff's attorney in press coverage give an incorrect impression of the facts in the Goodrich case. The pertinent facts are.	The facts given by the plaintiff's attorney in the press coverage were the same facts that the jury heard, the same facts that the judge—who was formerly a partner in an insurance defense firm—allowed the jury to hear after repeated consideration of Aetna's motions regarding the evidence, and the same facts that led the jury to believe that Aetna would not listen unless the punitive damages imposed on it were sufficiently high.
In June 1992, Mr. Goodrich sought emergency medical treatment after collapsing at work. He was admitted to the hospital and treated. Although the hospital was not in his Aetna HMO network, Aetna paid the bills due to the emergency nature of the treatment.	Aetna's statement that it "paid the bills" for David's emergency treatment despite the fact that "the hospital was not in his Aetna HMO network" is a clumsy attempt to make it sound as though Aetna was doing David a favor by paying for his emergency care and, to that extent, is patently misleading: Under both federal and California law, Aetna was required to pay for all emergency treatment received by a member, including David, whether the treatment was provided at a network facility or not. And, notably, Aetna did not approve that payment until September 4, 1992—three months after the charges were incurred.
Mr. Goodrich's primary care physician, Dr. Richard Brown, referred him to a specialist, Dr. Joseph Dotan, who performed surgery on June 25, 1992 to remove a mass from Mr. Goodrich's stomach. This procedure was covered by Aetna. A biopsy revealed Mr. Goodrich had a rare form of stomach cancer.	Again, Aetna's statement implies that it did David a favor by paying for Dr. Dotan's surgery bills. In fact, Dr. Dotan was an in-plan, network provider under contract to Aetna. Aetna was required under Aetna's contract with Primecare Medical Group of Redlands, the medical group David was assigned to to pay for that treatment.
On July 28, Dr. Dotan referred Mr. Goodrich to an out-of-network hospital, City of Hope, for a consultation regarding his cancer. Aetna approved the out-of-network referral, and Mr. Goodrich scheduled an appointment at City of Hope for Sept. 3, 1992.	There are many problems with Aetna's statement on this issue: Dr. Dotan, David's in-plan surgical oncologist told David and his wife, Teresa, that David's form of cancer was very rare and he did not have "vast experience" with it. Dr. Dotan submitted David's case to the Redlands Community Hospital Tumor Board, the Chairman of which was also an Aetna in-plan oncologist. The Chairman of the Tumor Board also concurred that David's cancer was very rare and expressed the opinion that there was not a single doctor in the Redlands medical community who was qualified to treat it. Dr. Dotan and the Tumor Board recommended that David be sent to City of Hope for consultation about how to treat the tumor. But Dr. Dotan could not simply authorize David's referral to City of Hope. Instead he was required to obtain authorization for the referral from Aetna, through the medical group, Primecare. To that end, on July 28, 1992, Dr. Dotan requested a referral for David to see a doctor at the City of Hope. The referral for a consultation was approved on August 5, 1992. David was not told that the consultation had been approved until August 11. At this point, David was more than two months post-collapse and nearly one month post-diagnosis.
On Sept. 3 at City of Hope, Dr. James Raschko met with Mr. Goodrich and told him he might be a candidate for a treatment program combining highdose chemotherapy with a bone marrow transplant that, for his condition, was considered experimental. City of Hope scheduled him to be evaluated on Oct. 2, with the first stages of the bone marrow transplant procedure to begin on Oct. 28.	Dr. Raschko did not tell David that he "might be a candidate" for a bone marrow transplant. As reflected in Dr. Raschko's medical records, Dr. Raschko considered David a "perfect candidate" for the proposed treatment. Whether the bone marrow transplant was considered "experimental" or not is irrelevant. Under California law, every HMO is required to issue an "Evidence of Coverage and Disclosure Form" to each of its members. The "EOC," as it is commonly called, is required to set forth all the benefits provided and must disclose all of the exclusions from coverage and limitations on coverage. Aetna's EOC did not contain an exclusion for experimental procedures. Thus, even if the treatment were considered "experimental," Aetna was required to cover it. If Aetna, Primecare and the plan doctors had sent David to City of Hope earlier, he obviously would have been able to begin the treatment process before the cancer metasticized.
On Oct. 6, 1992, Dr. Raschko informed Mr. Goodrich that a CT scan performed on October 2 showed he was not a candidate for the proposed treatment as his cancer had metastasized to his liver. By the time Aetna received the request for experimental treatment two days later, on Oct. 8, the request for coverage was moot because plans for the treatment had been canceled. Dr. Raschko testified that no time delay had any negative effect on Mr. Goodrich's ability to qualify for the high-dose chemotherapy. Unfortunately, at no time did Mr. Goodrich ever become a candidate for this treatment.	Aetna did not "first" receive the request for the bone marrow transplant on October 8. Under its contract with Aetna, Primecare was obligated to process treatment requests and was therefore Aetna's agent for that purpose. Primecare—and thus Aetna—first received the request for authorization of the treatment no later than September 29. At that point, David's request for treatment was forced through a nightmarish consideration process that would be subsequently repeated later with regard to other treatment requests: David's primary care physician ("PCP") had to refer David to an in-plan oncologist for assessment of whether the treatment was appropriate. The in-plan oncologist supported the use of the bone marrow transplant for David's condition, believed that it made "good therapeutic sense," noted that there was no "standard" therapy available and that bone marrow transplants had been utilized for years and were not experimental. The in-plan oncologist had to refer David back to the PCP. The PCP then had to submit an authorization request to Primecare. Primecare's utilization review nurse was not authorized to approve treatment at an out-of-plan facility and so had to refer the treatment request to Primecare's medical director. Primecare's medical director also was not authorized to approve this treatment at an out-of-plan facility and so was required to refer the request to Aetna's local medical director. Aetna's local medical director was uncertain about approving the treatment request and referred the request to Aetna's home-office medical director in Hartford, Connecticut. Aetna's home-office medical director considered the procedure "experimental"—even though there was no experimental exclusion in David's plan and even though the in-plan oncologist did not consider it experimental. Under Aetna's own internal policies, the home-office medical director was required to send any treatment requests to Aetna's home-office Technology Assessment Department before denying a treatment request on the basis that it was experimental. The treatment request was, therefore, sent to the Technology Assessment Department. The head of Aetna's home-office Technology Assessment Department reviewed the request and, because of his uncertainty as to whether the treatment would provide a medical benefit to David, referred it to the Technology Department's consultant. The consultant opined that the treatment was experimental and not covered—even though there was no experimental exclusion in the EOC. The head of the Technology Assessment Department then sent the treatment request to an outside medical consultant group, Medical Care Ombudsman Program ("MCOP"). The MCOP then sent the treatment request to three oncology consultants for review. The three oncology consultants concluded that the treatment was experimental and sent their recommendation that it not be approved to MCOP. MCOP sent its recommendation that the treatment be denied to Aetna's Technology Assessment Department. The Technology Assessment Department issued a memorandum that it would deny the treatment as being experimental, and then requested that the coverage language of the plan be provided. The Technology Assessment Department sent its denial of the treatment to the Aetna home office medical director. The home office medical director sent the denial to the Aetna local medical director. The local Aetna medical director sent the denial to the Primecare medical director. The Primecare medical director sent the denial to the Primecare utilization review nurse.

THE GOODRICH CASE: THE TRUE FACTS THAT AETNA DIDN'T TELL YOU[1]—Continued

Aetna's false and misleading statement:	The truth (court records show):
	The Primecare utilization review nurse sent the denial to David Goodrich—on November 18, 1992. This was two and one-half months after David's original consultation at the City of Hope, nearly a month after he was to have started the bone-marrow transplant procedure, and four months after his diagnosis. The denial was based on the fact that the treatment was deemed "experimental"—even though there was no exclusion in the plan precluding coverage for experimental treatments. During this entire period of time, Aetna/Primecare's own standards required a 48-hour turn-around time for these determinations, as did the National Commission for Quality Assurance (NCQA).
Nevertheless, Aetna went forward with the original request and had it reviewed by independent medical experts selected by Grace Powers Monaco, a well-known patient advocate. They found that there was no hope of the experimental procedure benefiting Mr. Goodrich.	It is nonsensical for Aetna to say that despite the fact that David's cancer had metastasized and he could no longer qualify for City of Hope's bone marrow transplantation protocol, it decided to "nevertheless" go forward with the original request for treatment. As evidenced by the above outline of the process, the process had been started before the metastasis was discovered and the cumbersome and snail-like procedure merely lumbered its way along its pre-determined path. Aetna's communications with its own doctors were simply so lacking that it did not know that the proposed treatment was no longer viable.
Between October 1992 and January 1993, Mr. Goodrich chose to pursue conventional chemotherapy treatment with City of Hope—the out-of-network facility—without authorization. City of Hope never charged Mr. Goodrich for this treatment. The same courses of treatment were approved by Aetna for coverage at in-network facilities, but Mr. Goodrich declined to avail himself of that treatment.	It is false to say that David simply "chose" to pursue standard chemotherapy to treat his metastatic cancer. In fact, Aetna broke its specific promises to David by failing to discover any other potential treatments for him. In its marketing materials and in its EOC, Aetna specifically promised David, as well as other plan members, that it was dedicated to keeping David healthy, and helping to cure him when he got sick; Aetna promised "to do more;" it promised that it would provide David with "comprehensive health services" "designed with [his] personal health in mind;" that Aetna and its physicians would "coordinate all necessary medical services. . . . "that they would be "directing and arranging [his] health care services;" that they would "coordinate all [his] health care needs." Even more significantly, Aetna represented to its members in the EOC that the "Primary Care Physician listed on each member's card has accepted the responsibility for that member's health care." Similarly, in defining "Primary Physician," the disclosure form states that the Primary Physician "has overall charge of medical rendered to Members . . . and . . . directs the majority of health care services provided to such Members." Although there was another option for treating David's liver metastasis—cryoablation (freezing) of the liver lesions—neither Aetna nor its doctors ever did anything to find out about that, or any other, alternative. Despite its promises, Aetna did not "direct and arrange" David's care or "coordinate" his health care needs. Aetna abdicated its responsibility for David's care. David's treating doctor, Leland Foshag, M.D., who is a nationally renowned specialist in treating cancers that have metastasized to the liver and who eventually performed the cryoablation surgery on David, testified that if David had received the cryoablation surgery six to nine months sooner, David would have lived 15 to 20 months longer than he did. But Aetna stripped him of that chance by not even bothering to find out how to treat David's condition. Aetna's own in-plan oncologist recommended that David receive the standard chemotherapy treatment at City of Hope—in order to assure the continuity of David's care. And under California law, Aetna was required to do just that. But Aetna ignored its own doctor's recommendation and ignored its duty to assure that David had continuity of care and, instead, refused to authorize or pay for that treatment. Since City of Hope—charitably—provided the treatment to David and did not charge David for the treatment, Aetna insisted that the cost of that treatment not be included as any part of the damages in the lawsuit. Thus, the City of Hope could not be reimbursed for the services it provided to David and its good deed was punished by Aetna—and Aetna escaped payment for treatment it actually owed under its contract.
On August 5, 1993, Mr. Goodrich consulted with his primary care physician, Dr. Wang, regarding an experimental procedure called cryosurgery. Dr. Wang referred Mr. Goodrich to an in-plan oncologist, Dr. Jack Schwartz, who recommended approval for the procedure at an out-of-network facility, St. John's Hospital, with Dr. Leland Foshag. A request for approval also was sent to Mr. Goodrich's other insurance company, which indicated it would pay for the procedure. Mr. Goodrich underwent the cryosurgery at St. John's on Sept. 21, 1993. Aetna again had this request for experimental treatment reviewed by independent medical experts selected by Grace Powers Monaco. This time, one specialist thought the cryosurgery might help Mr. Goodrich, so Aetna approved the treatment and paid for it..	Cryoablation was not an experimental treatment, even in 1993. The request for the cryoablation had to go through the nightmarish approval process and took months to do so. "Mr. Goodrich's other insurance company" was a self-funded benefit plan operated by his wife's employer—the Yucaipa-Calimesa Unified School District, under which he was covered as his wife's dependent. In other words, the taxpayer's program. But Aetna was the primary insurer and whether the school district would be willing to cover the procedure was totally irrelevant to Aetna's duty to provide coverage to David in the first instance. Primecare, on behalf of Aetna, actually denied the treatment request for the cryoablation after David had already had the surgery. Aetna finally paid some, but not all, of the bills from the cryoablation six months after the surgery. Aetna never paid for the original consultation with Dr. Foshag.
In October 1993, Mr. Goodrich again began receiving conventional chemotherapy treatment without authorization at an out-of-network facility, this time at St. John's. Mr. Goodrich was notified by Aetna that self-referred, out-of-network treatment that was available in-plan could not be covered. He was offered a nurse case manager whose job would have been to assist him in coordinating his care with the appropriate providers to get the maximum coverage available under his health plan, but he did not respond..	Aetna's primary defense at trial—and its argument to the jury centered on—Aetna's claim that it should not be liable for either the bills or David's premature death because they resulted from David's failure to follow Aetna's "rules." Aetna even insisted that the jury be instructed that it could allocate some or all of the fault to David. On the verdict from, the jury allocated 0% of the fault to David and 100% of the fault to Aetna. Much of the chemotherapy treatment received by David after the cryoablation was not standard chemotherapy. In fact, there were only two places in California that were equipped to provide some of the chemotherapy treatments—USC and UCLA. Since David could not obtain that treatment from "in-plan" facilities, Aetna was required under California law to pay for it at out-of-plan facilities. Requiring David to receive even the standard chemotherapy or to obtain even the lab tests or x-rays through in-plan facilities despite the fact that the treatment was being coordinated by Dr. Foshag and the medical oncologist working with him, Dr. Chawla, breached Aetna's obligation to assure that David had continuity of care as required under California law. Even when David tried to comply with Aetna's demands, Aetna rejected his treatment requests. Many, many times David asked his PCP to submit an authorization request to Primecare and Aetna for approval of a CT scan, blood test or chemotherapy treatment that Dr. Foshag or Dr. Chawla needed to have done and requested that those services be provided at in-plan facilities. The PCP signed those authorization requests and submitted them to Aetna. Aetna routinely denied those requests because they had been requested at the behest of the "out-of-plan" doctors, even though the requests were signed by the plan doctor assigned to David. At one point, Teresa asked David's PCP why Aetna was denying even the requests for treatment to be provided in-plan and the doctor's only response was "HMOs are fine as long as you don't get sick." David did utilize the services of a nurse case manager. Sharon Hopkins, R.N., Primecare's utilization review nurse assigned to David's case, actually spoke with David "for hours" during this time period. She looked forward to David's calls because he was "such a nice man" and was "so interesting" and "so easy to talk to." Even though she had to keep denying his claims, she liked talking to him because he never made their relationship seem adversarial. He explained to her that he simply had to do whatever was necessary to try to stay alive as long as possible. Ms. Hopkins even visited David when he was in the hospital.
This pattern continued throughout 1994, as Mr. Goodrich received out-of-network, unauthorized conventional treatment at St. John's, and he ignored repeated warnings that out-of-network treatment could not be covered. Mr. Goodrich's out-of-network treatment was covered by his wife's health insurance—a fact that was withheld from the jury by a court ruling. Suggestions that he died without knowing these bills would be taken care of are not true. At no time did he take any action to question, protest or appeal any coverage denials by Aetna..	Since David did, in fact, request that the CT scans, x-rays, blood tests and chemotherapy treatments that could be done in-plan be approved, and since Aetna routinely denied those requests, what else was David supposed to do? The trial judge ruled that Aetna could not introduce evidence of the existence of coverage, if any, under the school district's plan because, as the judge put it, whether anyone else agreed to pay the bills was irrelevant to Aetna's responsibility to pay the bills. It is revolting and repugnant that Aetna would try to defend its own wrongful conduct by trying to foist its legal obligations onto a small school district. Aetna delivered its final denial letter to David when he was in intensive care the day after a final surgery in January, 1995. At that point, David did not know whether the school district would pay the bills. He died, still in the hospital, on March 15, 1995—knowing that there were more than a half million dollars in bills still outstanding and that neither, Aetna nor the school district would agree to pay them. Although the school district eventually paid the bills—over a year after David died—the payment of the bills depleted the school district's benefit fund so much that the school district's teachers were not able to receive their full raises the following year—evidence that the jury would have heard if Aetna had been allowed to tell the jury that the school district had paid the bills. The school district has a lien on any recovery by Teresa in the case and will be paid back out of the judgment for all the bills it paid. About the assertion that David never appealed Aetna's denial. The hospital itself repeatedly initiated appeals in response to Aetna's denials. All the appeals were rejected and the denials reaffirmed. The school district even appealed Aetna's denials of the bills. Aetna also rejected that appeal and reaffirmed the denials. After David's death, Teresa, through the PCP, also initiated an appeal. That appeal, too, was rejected and the denials reaffirmed. Aetna demanded that Teresa mediate her claims against Aetna immediately after she filed her complaint in this action. She did so. Aetna never tendered any payment for the bills at issue in the lawsuit. Aetna litigated the lawsuit for three years and never once offered to pay any of the bills. So, what difference would an appeal by David before he died have made?

THE GOODRICH CASE: THE TRUE FACTS THAT AETNA DIDN'T TELL YOU [1]—Continued

Aetna's false and misleading statement:	The truth (court records show):
In January 1995, Mr. Goodrich entered St. John's for surgery that had been precertified and approved by his other insurance company. This was conventional surgery that could have been conducted in-plan, so coverage by Aetna was denied. Mr. Goodrich remained hospitalized until his death on March 15, 1995.	Requiring the surgery to be conducted in-plan would have violated Aetna's obligation under California law to assure the continuity of David's medical care. The surgery was not precertifed and approved by the school district plan. In fact, the hospital did not call the right administrator and the school district's administrator later refused to cover the bills because of that mistake. Aetna had no right to rely on the school district's coverage since Aetna was the primary carrier. Aetna did not deny coverage for the surgery until after it was completed, in violation of the time standards Aetna was supposed to follow.
All of Mr. Goodrich's medical bills were covered by Aetna—when treatment was provided in-plan or authorized in accordance with plan requirements—or by Mr. Goodrich's wife's health insurance, although the jury was not permitted to hear about the secondary coverage. During the course of his treatment, the total out-of-pocket cost to the Goodriches was less than $2,000.	The abject falsity of this statement is evidenced by the facts, set forth above, demonstrating that even when David requested, through his in-plan PCP, that he be provided with in-plan treatment at in-plan facilities, the requests were denied by Aetna. Aetna had no right to foist its contractual obligations off onto the school district, or to force the school district's teachers to forgo their raises in order to provide Aetna with an even greater cost savings and profit margin. Teresa Goodrich—a kindergarten teacher—was faced with over $500,000 in bills for over a year after David died because both Aetna and the school district refused to pay the bills.
At no time did Mr. Goodrich fail to receive any treatment recommended by in-plan or out-of-plan doctors, and all treatment was obtained without delay due to the timing of coverage approvals or denials.	As testified to by Dr. Foshag, Aetna should have discovered and provided David with the cryoablation at least six months earlier and, if it had, David would have lived longer.

[1] Statements are from Aetna's response of January 29, 1999 to Congress. Attorneys for the Goodrich family, Sharon Arkin and Michael Bidart, prepared the factual response (909–621–4935).

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, February 11, 1999 may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

FEBRUARY 12

9:30 a.m.
Budget
To hold hearings on national defense budget issues.
SD–608

FEBRUARY 22

1 p.m.
Aging
To hold hearings to examine the impact of certain individual accounts contained in Social Security reform proposals on women's current Social Security benefits.
SD–628

FEBRUARY 23

9:30 a.m.
Health, Education, Labor, and Pensions
To hold hearings on Department of Education reform issues.
SD–430

10 a.m.
Foreign Relations
To hold hearings on the President's proposed budget request for fiscal year 2000 for foreign assistance programs.
SD–419

FEBRUARY 24

9 a.m.
Environment and Public Works
To hold hearings to examine the President's proposed budget request for fiscal year 2000 for the Environmental Protection Agency.
SD–406

9:30 a.m.
Armed Services
Readiness Subcommittee
To hold hearings on the National Security ramifications of the Year 2000 computer problem.
SH–216

Health, Education, Labor, and Pensions
Public Health and Safety Subcommittee
To hold hearings on.
SD–430

Health, Education, Labor, and Pensions
Public Health and Safety Subcommittee
To hold hearings on antimicrobial resistance.
SD–430

2 p.m.
Armed Services
Personnel Subcommittee
To hold hearings on proposed legislation authorizing funds for fiscal year 2000 for the Department of Defense and for the future years defense program, focusing on recruiting and retention policies within DOD and the Military Services.
SR–222

Energy and Natural Resources
National Parks, Historic Preservation, and Recreation Subcommittee
To hold oversight hearings on the President's proposed budget request for fiscal year 2000 for National Park Service programs and operations.
SD–366

FEBRUARY 25

9 a.m.
Energy and Natural Resources
To hold oversight hearings on the President's proposed budget request for fiscal year 2000 for the Department of Energy and the Federal Energy Regulatory Commission.
SD–366

9:30 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the Military Order of the Purple Heart, the Fleet Reserve, the Retired Enlisted Association, the Gold Star Wives of America, and the Air Force Sergeants Association.
345 Cannon Building

Health, Education, Labor, and Pensions
To hold hearings on protecting medical records privacy issues.
SD–430

10 a.m.
Foreign Relations
East Asian and Pacific Affairs Subcommittee
To hold hearings to examine Asian trade barriers to United States soda ash exports.
SD–419

2 p.m.
Judiciary
Antitrust, Business Rights, and Competition Subcommittee
To hold hearings to review competition and antitrust issues relating to the Telecommunications Act.
SD–226

Energy and Natural Resources
To hold oversight hearings on the President's proposed budget request for fiscal year 2000 for the Forest Service, Department of Agriculture.
SD–366

MARCH 2

9:30 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the Veterans of Foreign Wars.
345 Cannon Building

Energy and Natural Resources
To hold oversight hearings on the President's proposed budget request for fiscal year 2000 for the Department of the Interior.
SD–366

MARCH 4

9:30 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the Veterans of World War I of the USA, Non-Commissioned Officers Association, Paralyzed Veterans of America, Jewish War Veterans, and the Blinded Veterans Association.
345 Cannon Building

MARCH 10

9:30 a.m.
Armed Services
Readiness Subcommittee
To hold hearings on the condition of the service's infrastructure and real property maintenance programs for fiscal year 2000.
SR–236

MARCH 17

10 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the Disabled American Veterans.
345 Cannon Building

MARCH 24

10 a.m.
Veterans' Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the American Ex-Prisoners of War, AMVETS, Vietnam Veterans of America, and the Retired Officers Association.
345 Cannon Building

SEPTEMBER 28

9:30 a.m.
Veteran's Affairs
To hold joint hearings with the House Committee on Veterans' Affairs to review the legislative recommendations of the American Legion.
345 Cannon Building