Pennsylvania Association of Health Underwriters

TESTIMONY

HB 710

STATE HOUSE JUDICIARY COMMITTEE

JANUARY 20, 2000

GETTYSBURG, PA

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TESTIMONY - HB 710

PENNSYLVANIA ASSOCIATION OF HEALTH UNDERWRITERS

HEALTH INSURANCE LIABILITY - UNINTENDED CONSEQUENCES

My name is Ross Schriftman. I serve as legislative chair of the Pennsylvania Association of Health Underwriters. Our membership is primarily composed of health insurance agents who serve the needs of hundreds of thousands of our fellow citizens. The products we sell and service include health, dental, long term care and disability insurance as well as other group and individual benefits.

Our members are very concerned about the trend toward additional liability specifically in the area of health insurance. Although the popular stance today is to support the right of patients to sue their health insurers, we believe there are dire unintended consequences that you must consider.

Many say that the mere threat of law suits will make health insurers more accountable. However, what is the real goal that we are trying to achieve? Is it accountability or quality health care for all Americans? Is it blame or better treatment? We believe the ultimate goal is quality health care for all of us. We do not believe that expansion of liability works toward that end.

First, you need to understand human nature. People do not purposely put themselves at greater risk to be sued on a voluntary basis. Let me start with the impact on the business community which is the primary source of the dollars for health insurance in our nation.

Negative impact on the business community

According to a study done last year by the Louisiana business community to its members, 90% would not offer a health plan if the premiums would increase to cover the cost of employees being able to sue their health plan. Also, 94% of the respondents in the survey would not offer a health insurance plan if they could be sued by an employee for the actions of their health plan. The participating organizations in this survey were the Louisiana Association of Business and Industry, the National Federation of Independent Business, the Louisiana Health Care Alliance, the Louisiana Association of Health Underwriters and the Louisiana United Business Association. I have attached a summary of this survey to my testimony as well as several articles addressing the issue of health insurance liability.

Negative impact on the business community(continued)

The business community is very concerned about the expansion of liability. Even if business owners were not liable, they may be called upon to testify at a trial since they had input in the selection of the health insurance for their employees. Questions such as "Why did you select the plan you did?" and "Didn't you investigate whether this insurer had a history of denying care to the people they insure?" would certainly be raised to a business owner.

A small business owner would lose valuable time and business focus dealing with this matter. He or she would have to pay an attorney, review employee enrollment documents, plan summaries and other document to prepare for trial. Oddly enough, the business owner who provides no health insurance to his or her employees escapes all these problems. Those business owners, even today, have a tremendous advantage over their competitors who do provide health insurers. Not only can they sell their product for less because they do not expend money for health insurance, they also do not have to deal with regulatory issues raised by such laws as COBRA, HIPAA, and ERISA when it comes to group health insurance. Add liability to the mix and many will walk away from their social mission to help their employees insure their health care needs.

Without the business community providing health insurance, the system will collapse. We have already seen a rise in the number of Americans without health insurance. Studies have shown that most of these people are employed, but their employer cannot or will not provide health insurance. The reasons include the ones listed above. Now add another liability and see more stop participating.

Businesses have already taken the brunt of increasing health care costs demonstrated in the premiums. Add the added costs of liability and many will walk.

Negative impact on the medical community

We strongly support tort reform; not expansion of medical liability. If more law suits occur by adding health insurer liability, doctors will be spending more time in court and less time practicing medicine. After all, they have the medical records and they have been treating the patient. Again, just like any business, the doctor will have to focus time and effort and preparation for a case and less time seeing patients. Who suffers?

Negative impact on the medical community(continued)

We have also seen the collapse of several large HMO's; one just to our East in New Jersey. Insurers cannot continually raise premiums to cover questionable treatment requests and to defend themselves in court. If premiums are not raised, however, there will not be enough money to pay their bills and hospitals and other providers do not get reimbursed for the services they provided.

Insurers and providers are integrally untwined when it comes to financing health care. Providers cannot operate without the money provided by the insurers. The insurers must remain solvent and profitable to have the money to pay claims on a timely basis. Law suits disrupt this process and make health care worse; not better.

Furthermore, the recent report by the National Academy of Sciences contained valuable information this committee should review. The report estimated that 98,000 Americans die each year due to medical errors. One of the most disturbing findings of the report was that doctors and hospitals seek to hide these mistakes out of concern that they would be subject to litigation. The irony here is that by admitting a mistake an individual or organization can be sued. It is common sense that in order to fix a problem, you must first admit that you have one. We have become a nation of denial whenever an error is made. For example, it certainly would be refreshing for elected officials to go home to their constituents and say, "I admit I voted the wrong way on that bill and I am sorry for the harm it has caused." However, you and I now that the public will not be forgiving.

The Federal Agency for Health Care Policy and Research has funded a research project by Dr. Lucien Leape and others who have the responsibility for shifting the focus of ways to reduce errors from blaming individuals to addressing system problems that make errors likely to happen. We believe this is the kind of effort that needs to be made if we are to achieve better health care.

Will we ever eliminate all mistake? . Do we always know the best treatment? Liability may cause some to do the least and not the best for the patient for fear of being sued. Also, what happens if the health plan goes along with the doctor on a decision and the doctor is wrong and the patient is harmed? Who becomes liable? It is always easy to second-guess a decision after harm is done.

Negative impact on the medical community(continued)

We now are beginning to see real potential patient harm directly related to the increase in law suits. I have included with my testimony, a statement concerning the AMA's fear that the pap test will no longer be performed because an increase in the number of law suits. Again we have an irony. Will women die in the future, because providers fear law suits? On the other hand, are there any studies proving that liability improves the quality of health care? I have not seen one. A recent briefing by the Washington Legal Foundation is included in my testimony. Legal scholars believe lawsuits will hurt; not help.

Negative impact on patients

None of the protections the bill addresses extend to those who have no health insurance or lose their coverage because of the price for that protection. Ultimately, those that bear the cost of successful law suits are those that are insured by the plan.

When a tobacco company is successfully sued and the cost of cigarettes increases, some people may decide no longer to smoke. That is a good thing. However, when an insurance company is successfully sued and the premiums for coverage increase, some people are forced to drop coverage and that is a very bad thing.

One successful law suit in California will cost an HMO $113 million if their appeal to the decision is denied. Whether or not the case has merit, the success of this suit would cost every insured person $113 if the insurer has 1,000,000 people in their plan. Add to this just 50 law suits of the same size in Pennsylvania and we are talking about more than $5 billion out of the pockets of all of us.

Negative impact on taxpayers

The fewer Americans have private health insurance, the larger the number of people who become the responsibility of the government eventually through the Medicaid program. Expenditures for Medicaid in Pennsylvania are more than $5 billion per year when you include medical assistance for health care and long term care. If more people lose their private health insurance, will you be willing to raise taxes to cover these people under government programs, if you made a mistake by passing legislation that opens the floodgates for law suits?

Negative impact on taxpayers (continued)

Also, consider the cost to taxpayers for the judges, court staff and court time involved in hearing these cases. What other important legal matters will not be heard and how many additional judges will need to be added and new courtrooms built if the number of cases increases dramatically. If you do not think medical malpractice extending to health insurers will increase the number of cases, you need only look at the yellow pages in your local directly. I recently reviewed the Philadelphia Yellow Pages. There are 30 pages of listings of lawyers in Philadelphia. That sounds normal. However, there are just as many pages of ads for personal injury lawyers. The pitch in the ads is always the same. "You pay no fee unless we recover" and "You are entitled to the highest award possible." What they are saying is that you have nothing to lose by suing and you could receive substantial sums of money. It's even better than the lottery because you don't have to lay any money down. How many cases are settled prior to court just so the target of the suit can avoid a long and costly battle? For health insurers, how many questionable treatment decisions would be covered simply because the insurer is afraid to deny? We may never know this. We would only know how many cases were brought forth and how much money insurers would have to pay. The real cost of defensive treatment coverage approvals is ultimately paid for by policyholders.

Negative impact on health insurers

Health insurers get their money to run their business in two ways. First is from the premiums we all pay for our coverage. Second, if the insurer is for-profit, it receives capital through the faith of investors buying their stock and hoping they will turn a profit. If an HMO or other insurer is losing money or facing law suits or about to have additional regulations imposed on them by legislators, they are less attractive to investors. If you don't believe that this is happening, I suggest you review some of the financial reports from services such as Standard and Poors on the advisability of investing in health insurance companies. You may not want to put your money there while other segments of the economy are booming.

If an insurance company cannot attract investors, they must go back to policyholders and raise premiums. Again the public suffers

<u>Negative impact on health insurers</u> (continued)

There is a difference between a Health Maintenance Organization (HMO) and a health insurance company. In Pennsylvania, there is a law creating a State Guarantee Association. This may provide some protection for policy holders if a company's operations are suspended due to financial weakness or other causes. This law does not apply to non-insurance company plans such as HMOs. Recent action in Massachusetts forced that State's legislature to pass a law protecting a bankrupt HMO; one of the largest in that State. Just last year, the state of New Jersey had to take over the operation of a major HMO that had gone bankrupt. Although the reported reasons for these failures did not directly relate to health plan liability, the added cost of such legislation could bring other major giants down. Already, the attorneys who successfully argued against the tobacco companies have begun a class action suit against several large HMOs. They are using the Federal "Rico" racketeering law as the basis for their suit. Their claim is that the HMOs are breaking their pledge to provide quality health care. These attorneys who are flush with cash from the hundreds of millions in legal fees they received will not give up their efforts easily.

Insurance companies and HMOs are working on small profit margins in recent years. Many, in fact, lost money when comparing premiums collected and claims and administrative expenses. If not for investors, many more failures could have occurred.

Adding additional liability exacerbates the situation. It does not help. Insurers would need to hire more legal staff to defend themselves. Employees dealing with the public may be less inclined to answer technical questions of patients who call in. Instead, more routine questions will have to be referred to legal staff so that the wrong answer may not be given or the right answer mis-interpreted. This slows the whole process and makes the system less functional.

<u>Negative impact on Local and State Government</u>

The various municipal governments, counties, school districts, authorities and the Commonwealth itself provide health insurance to their employees. Those in the position of making health plan selections will also have to testify in court. Who will be handling the needs of employees while human resources managers are tied up with these legal matters? Will additional staff be hired to cover the absent employee's duties. Will some local governments decide not to provide health insurance to their workers as many small employers have done or are considering doing?

Negative impact on Insurance Agents and Representatives

Good health insurance agents work very hard to help their clients work through the health care system. We also try and find the most affordable and, yet, most comprehensive coverage for our clients. We are currently liable for errors and omissions concerning the insurance contracts we sell. We can be sued if the coverages were not appropriate for the client and we can be sued if the coverages were not properly explained, or an unwarranted delay occurred that was our fault or for a number of other causes. Until now, we could not be sued for a medical decision which we do not make. HB 710 now makes us liable for something we do not control; medical coverage decisions. Our malpractice insurance does not cover us for such actions.

As health insurance agents, many of us sell other products such as disability insurance and long term care insurance. Health insurance is the most service-oriented type of product we sell because their can be numerous claims of various types of a period of years involving just one patient. More and more of our members no longer sell health insurance. There is too much aggravation, too little resulting income and too many pitfalls. Business clients forget the COBRA rules or fail to add a new employee to the plan on a timely basis. Every time a new law mandating an additional benefit occurs, employees are not sure if it applies to them or not. Policy contracts have additional inserts that need to be explained and are quickly forgotten by those clients doing their other daily activities of working and taking care of their families.

Then a General Assembly makes us liable for decisions made by a health insurance about what they will or will not pay for. Our reward for providing a social mission of insuring more Americans becomes our downfall for ourselves and our families. We will sell other products and leave the social mission to the Commonwealth. This trend has already started and HB710 will certainly push it along. As I stated earlier, human nature will not go toward the danger (i.e. liability) but away from it. Ultimately, people who want and need health insurance will suffer.

Another fact that cannot be ignored is that, just like other segments of the business community and the medical profession, we will have to spend valuable time away from our work preparing and testifying. Our clients, who need and deserve our help, will not get it if we will be spending our days in court. We will also be forced to hire legal counsel. None of this is good for our clients; your constituents.

What do we recommend?

In 1998, the General Assembly worked very hard and passed good legislation that ultimately became Act 68. This law creates ways to improve the protections available to Pennsylvanians. We urge you to consider a moratorium on passing any liability legislation until Act 68 has had a chance to work. We ask that you allow us to continue to fight for the rights of our clients when they feel that their health insurer has not done right by them. Act 68 is an important tool and we can assist our clients through the processes established by this law.

We also urge you to consider various tax incentives to make health insurance more affordable for all Pennsylvanians. We ask you to join us in our efforts to insure as many people as possible. The most important patient right is the right to be able to afford the coverage they need.

CONCLUSION

We need to get back to the time when people were not afraid to say they made a mistake. After all, we are human. Let us try better. Fear does not make our health care better. It increases secrets and hiding.

This reminds me of the old fable about the wind and the sun. They argued one day about their ability to remove the coat of a man walking along the road. The wind blew very hard and instead of the coat being removed, the man drew the coat tighter around him. Then the sun shown bright and gradually the man took off his coat. For us, let the sun shine into our health care system. Let us allow the doctors to treat without fear. Let the health insurers be open about the way their plans work and to make the improvements necessary. Allow us to work without fear that fulfilling our mission to insure as many of our neighbors as possible does not put our own careers and the financial well being of our families in jeopardy.

Louisiana Employer Health Plan Survey

February 1999

The following organizations have distributed the survey to their membership:

Louisiana Association of Business and Industry

Louisiana Association of Health Underwriters

Louisiana Health Care Alliance

Louisiana United Businesses Association

National Federation of Independent Business

II. EXECUTIVE SUMMARY

Following are the principal findings from this study which seeks to identify the opinions of Louisiana employers with regard to health care coverage. The results are derived from 1,436 completed questionnaires.

- Fully 93.9% of respondents would not offer a health plan if they could be sued by an employee for the actions of their health plan.

- A vast majority (89.9%) would not offer a health plan if the premium would increase to cover the cost of the employee suing the health plan.

- Two-thirds (67.6%) of Louisiana's employers have a health insurance plan for their employees.

- Of the one-third (31.0%) of Louisiana employers who do not provide health care coverage, nearly one-quarter (23.4%) used to provide this benefit. When asked why they dropped the plan, three-in-four (77.9%) say that cost was the primary reason, followed by government regulations (26.9%) as the reason for terminating their plan.

- When queried about the impact of rising premiums, Louisiana employers say, on average, they will drop their health plan if the cost rises by 19.0% or more in 1999.

- From an enrollment perspective, business executives predict 41.4% of employees are likely to drop their coverage if premiums increase by 15% to 25% in 1999.

- A majority (62.9%) of employers feel that health plan benefits should be selected only by themselves and their employees.

- A majority (51.1%) would be likely to add additional optional benefits if there were a guaranteed maximum cost. Only 13.0% of employers feel they would not add additional benefits under this scenario.

Legal Scholars Cast Doubt On Managed Care Lawsuits

Updated 12:22 PM ET January 5, 2000

NEW YORK, Jan. 5 /PRNewswire/ -- A panel of prominent legal experts gathered last month to attack the legitimacy of the recent class action lawsuits against managed care companies.

The briefing, sponsored by the Washington Legal Foundation (WLF), featured well-known legal authorities who addressed the legal theories underlying the lawsuits.

The speakers took issue with plaintiffs' attorneys who are trying to shoehorn shaky fraud claims against HMOs into two federal statutes and one state law: RICO -- a law originally enacted to thwart organized crime; ERISA -- a regulatory standard established to govern pension plans; and California's Unfair Competition Law 17200.

"Like Toto in the Wizard of Oz, we've pulled back the curtain to reveal that, when it comes to these suits against the managed care industry, the all- powerful trial lawyers are relying on smoke and mirrors," said Glenn Lammi, chief counsel of WLF. "Plaintiffs' lawyers are trying to pressure the industry to settle quickly because they don't have a legal leg to stand on."

"I don't see how these lawsuits can proceed without harming the country," said Professor George Priest of Yale University Law School. "[I]f they're successful, the managed care industry basically will be eliminated. That will result, I think indisputably and unquestionably, in an increase in health care costs to all Americans."

Other speakers included William Lash, George Mason University Law School, who addressed RICO claims; Lonie Hassel, expert on ERISA and partner at the Groom Law Group in Washington, DC; and Barbara Wheeler of the Civil Justice Association of California, who concentrated on California's Unfair Competition Laws.

A transcript is available by contacting the Washington Legal Foundation at 202-588-0302.

Contact: Glenn Lammi of the Washington Legal Foundation, 202-588-0302

AP Business News

Dow Ends Up 130; Nasdaq Down 150
Technology Shares Fall Again
Home Sales Fall; Retail Sales Soar
Guyana Says AT&T Service Cut
Change Urged for Canada Broadcaster
Bonds Rise on Tech Stock Slump
Breast Implant Ruling Appealed
Dollar Continues Rise Against Yen
Platinum at 6-Week Low; Cocoa Falls
Money Funds Up by $15.96B
Thursday's Money Rates
Big Movers in the Stock Market
Accounting Firm Violations Found
Asia, Europe Stocks Continue Fall
Soybeans Fall on S. America News
Nazi Victims, Austria Banks Settle

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Life & Health

Massachusetts HMO Makes Massive Cuts
BOSTON, Dec. 9 (The Boston Globe/KRTBN) -- Tufts Health Plan will slash 430 jobs in a massive retrenchment meant to save the ailing health maintenance organization $30 million next year as it struggles to regain its financial footing. [Consumers, Demographics]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944757624.4453.1&alert=1

Missouri Supreme Court Examines Refusal of Blue Cross Settlement
JEFFERSON CITY, Mo., Dec. 9 (St. Louis Post-Dispatch/KRTBN) -- During the Missouri Supreme Court's arguments Wednesday on the Blue Cross case, some judges suggested that lower court approval was not needed to create a foundation to fund health care for the poor. [Consumers, Demographics]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944756269.24203.25&alert=1

PAP Test May Vanish Due to Lawsuits
Dec. 9 (UPI) -- The Pap test for cervical cancer could become history because of overzealous lawsuits, doctors predict. At the interim meeting of the American Medical Association House of Delegates, physicians asked for a study on the issues raised the use of the Pap smear as a screening tool, noting that some doctors are reluctant to perform the test due to increasing legal action. [Consumers, Demographics]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944755024.20248.10&alert=1

Jobless Claims Rise
WASHINGTON, Dec. 9 (UPI) -- The Labor Department said Thursday new claims for state unemployment insurance benefits during the week ended December 4 rose a smaller larger-than expected 1,000 to a seasonally adjusted 293,000. Most economists on Wall Street were expecting first time claims to rise by 4,000. Labor said the number of people seeking jobless benefits during the latest reporting week was the highest since the week ending Oct. [Consumers, Demographics]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944754956.20248.4&alert=1

Seniors Spend $2,430 on Health Care
DES MOINES, Iowa, Dec. 8 (UPI) -- Even with Medicare, senior citizens spend an average $2,430 a year on their health care needs, about 19 percent of their income, the American Association of Retired Persons reported Wednesday. [Consumers, Demographics]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944689203.3750.0&alert=1

DCR Reaffirms Penn Mutual Life Ratings
CHICAGO, Dec. 9 (PRNewswire via COMTEX) -- Duff & Phelps Credit Rating Co. (DCR) reaffirmed the claims paying ability ratings of Penn Mutual Life Insurance Company (Penn Mutual) and its wholly owned subsidiary, Penn Insurance and Annuity Company, at 'AA-' (Double-A-Minus). [Trends, Ratings]
http://www.kpmginsiders.com/cgi-bin/webinsiders/document?id=944756776.28769.2&alert=1

DCR Assigns Initial Rating to Scottish Annuity's U.S. Subsidiary
CHICAGO, Dec. 9 (PRNewswire via COMTEX) -- Duff & Phelps Credit Rating Co. (DCR) has assigned an initial claims paying

Business News in Brief

In the Region

Cigna, 4 other HMO operators named in national lawsuits

■ Cigna Corp., Philadelphia, and four other large HMO operators are the targets of national lawsuits charging them with violating U.S. antiracketeering laws. The suits, which seek class-action status, were filed in U.S. District Court in Mississippi by a group of lawyers led by antitobacco lawyer Richard Scruggs. The suits follow a similar class-action complaint filed last month against Aetna Inc., the nation's largest health insurer and owner of U.S. Healthcare, Blue Bell. The filings seek compensatory damages and an injunction preventing the defendants from "pursuing the fraudulent and extortionate policies and practices" cited in the complaints. Cigna said "this appears to be an orchestrated effort" by the lawyers "to create enormous fees for themselves while doing serious potential damage" to the nation's health system. The other defendants are Foundation Health Systems Inc., Humana Inc., PacifiCare Health Systems Inc., and Aetna Inc.'s Prudential Insurance Co. of America. Each company's shares fell yesterday — Cigna down $3.75 to $81.25, Foundation down 31.3 cents to $9.44, Humana down 12.5 cents to $8.13, Pacificare down $1.25 to $52, and Aetna down $1.13 to $55.

Judge gives initial approval to diet-drug settlement

■ American Home Products Corp.'s $3.75 billion settlement of lawsuits filed by users of its diet drugs won a Philadelphia federal judge's preliminary approval. U.S. District Judge Louis Bechtle's initial approval of the settlement, which sets aside $1 billion to provide medical examinations to users of American Home's Pondimin and Redux drugs and $2.35 billion to resolve individual claims, triggers time limits on decisions by users of the fen-phen diet combination on whether to accept the company's offer. After American Home advertises the settlement's terms, starting next month, former fen-phen users will have about two months to decide whether to opt out of the settlement, said Charlie Parker, a Texas attorney representing former fen-phen users.

DuPont is accused of defrauding carpeting distributor

■ DuPont Co.'s floor-covering units were sued by a distributor that contends it was defrauded in a franchising agreement with DuPont, Wilmington, to sell carpeting to commercial customers. In a suit filed in federal court in Wilmington, officials of Associated/ACC International Ltd. contend that DuPont executives lured them into selling the company's Antron-fibre carpets under a franchise agreement and then undercut Associated by opening company-owned franchises to sell the same product. Officials of DuPont said they had not received a copy of Associated's suit yet. "Based on what little we know about it, we will defend ourselves vigorously," Bill Brown, a DuPont spokesman, said

NYSE

For NYSE footnotes, see next page.

Note	52-wk. Hi	52-wk. Lo	Stock	Div.	Yld.	P-E ratio	Sales 100s	Hi	Lo	Last	Chg
			A								
	25½	14⅜	AAR	.24	2.0	11	801	17⅛	17	17¾	
	35⅛	21	ABM	.56	2.6	13	1293	21⅛	21⅛	21⅛	
	25⅝	18½	ABN Amro e	.62	2.4		323	25⅛	25⅛	25⅛	-⅛
d	26⅝	22¼	ABN pfA	1.88	8.4		640	22⅜	22	22⅜	-⅛
	25½	21¾	ABN pfB	1.78	8.4		1134	21⅜	21½	21⅜	-3/32
	35⅛	15½	ACE Ltd	.44	2.4	8	5673	19⅛	18⅝	18⅝	-⅜
	10	7⅝	ACM Ins a	.90	11.8	q	1434	7⅝	7⅝	7⅝	+⅛
	8⅜	6¾	ACM Opp a	.63	9.8	q	122	7⅛	7⅛	7⅛	-⅛
	9	6½	ACM Sc	.90	12.5	q	2774	6⅞	6⅞	6⅞	
	6⅛	5⅜	ACMSp	.54	9.6	q	1133	5½	5⅝	5⅝	-1/16
	11⅛	8⅝	ACMMD a	1.35	14.1	q	586	9⅝	9⅞	9⅞	-⅛
	9⅞	7	ACM Mf a	1.02	14.1	q	346	7⅛	7⅛	7⅛	-⅛
d	14⅝	11¼	ACMMu	.87	7.7	q	286	11⅜	11⅜	11¼	-⅛
	32⅜	19⅞	ACNiels			20	4274	24⅝	23¼	23⅝	-¼
	16¹⁵/₁₆	7½	ACX Tech			6	342	10¼	9⅜	9⅜	-⅛
	66¹⁵/₁₆	32⅛	AES Cp			55	5398	60⅛	58⅞	58⅞	-1⅜
	56¾	36⅛	AFLAC	.30	.6	24	5496	51⅜	49¾	49⅜	-⅞
	14	6	AGCO	.04	.3	dd	3959	12¼	11⅜	12⅜	-⅛
	23⅜	15⅞	AGL Res	1.08	5.8	14	1375	18⅛	18⅛	18⅝	+⅛
d	25½	12⅝	AICI pfT	2.25	17.7		279	12¹³/₁₆	12¼	12¼	-⅛
	29⅝	13¾	AK Steel	.50	3.0	13	4578	17½	16	16⅝	-⅜
	23½	19¾	AMB Pr	1.40	7.0	12	1765	20⅜	19⅞	20	-⅛
	25½	20⅜	AMB pfA	2.13	9.8		92	21⅝	21⅜	21⅝	+⅜
	8¼	3⅛	AMF Bowl			dd	437	3⅞	3¾	3⅞	-⅛
	76⅝	39½	AMFM			dd	6087	73⅛	71⅝	73⅛	-1⅝
	23⅝	18⅞	AMLI Rs	1.80	8.6	12	403	21⅜	21	21	-⅛
	75⅞	52⅝	AMR			10	15326	62⅜	58⅝	61⅞	+2⅛
	24⅛	22¾	AMR Cp 39	1.97	8.8		177	23⅞	22⅜	22¾	-⅜
	25⅜	22⅝	ANZ Ex pf	2.00	8.7		217	23⅛	23	23	
	26⅛	23¾	ANZEx2 pf	2.02	8.6		364	23⅝	23¼	23¼	-⅛
	7⅛	2⅜	APT Sat				614	4⅜	4⅛	4⅝	-⅛
	24	14⅜	ASA Ltd	.60	3.0	q	1105	20⅜	19⅞	20⅛	+1
	64⅛	41⅛	AT&T s	.88	1.7	24	164443	53	50⅜	50⅝	-1¾
	26⅝	24	ATT N28 n	2.06	8.4		249	24⅝	24⅛	24⅝	-⅜
	26⅜	23⅜	ATT D28 n	2.03	8.2		695	24⅝	24⅛	24⅝	+⅛
	44⅞	12⅞	AVX Cp	.26	.6	66	641	44⅜	43⅛	43⅛	+⅜
	80¼	53⅜	AXA e	.90	1.3		212	70¼	69⅛	69⅜	-⅜
	38⅜	23⅝	AXA Fns	.10	.3	16	6974	35¼	33¹⁵/₁₆	34⅛	+⅛
	5	1⅛	Aames			dd	2670	1⅜	1⅛	1⅛	-⅛
	22¼	12⅜	AaronRnt	.04	.2	15	229	18⅜	17⅜	17⅜	-⅜
	24¹⁵/₁₆	21	AbbeyN pf	1.75	8.2		304	21⅞	21⅛	21⅜	-⅛
	23⅜	21⅛	Abbey per p	1.88	8.5		533	22¼	22¼	22⅜	-⅛
	53⅛	36⅛	AbtLab	.68	1.8	24	40234	38⅛	37⅜	38	-⅜
	50⅜	21	AberFlic s			23	13275	27⅞	26⅜	27¼	+¼
	13¹⁵/₁₆	7⅝	Abilibi g	.40			566	11⅜	11⅛	11⅝	-⅜
	6⅛	4⅝	AcadiaRlt	.48	9.8	30	100	4⅞	4⅝	4⅝	
d	20½	7⅛	Acetlns			38	2794	7⅜	6⅜	6⅞	-⅛
	20	11⅛	AckGrp	.02	.1	26	243	16½	16⅛	16⅜	
	18⅛	9¼	Acuson			16	642	12¹³/₁₆	11⅜	11⅞	-⅛
	33¼	24⅜	AdaEx e	2.45	8.0	q	373	31⅝	30½	30⅝	-⅛
	34½	17⅛	Adminstf			31	410	17½	17¼	17⅜	+⅛
	24⅞	12⅜	AFPProv e	1.20	5.8		300	20¾	20⅛	20⅛	+⅛
	13⅜	3⅝	AdvCmG			dd	647	8⅞	7⅝	8¼	-⅛
	33	14⅞	AMD			dd	24136	27	25¾	26¼	-⅛
	26	17⅜	Advest	.20	1.1	12	90	18½	18⅛	18⅝	-⅜
	27⅝	14⅝	Advolnc			11	1271	19⅞	18⅝	19⅛	+1⅜
	100⅛	69⅝	Aegon e	1.16	1.3	35	483	91⅝	90½	90⅝	-⅛
	22⅜	5⅛	Aeroflex			16	3788	8⅞	8⅛	8⅝	-⅛
	26⅛	25	Aetna pfcld	2.37			105	25⅛	25⅛	25⅛	-⅜
	99⅜	46½	Aetna Inc	.80	1.5	11	6377	56¾	54¾	55⅛	-1⅛
	53	31¾	AffCmpSv			21	1602	38¾	37⅜	37½	-⅞
	33⅝	22	AffMgrs			18	1243	31⅝	31⅛	31⅝	-⅛
	9⅛	3⅛	Agnico g	.02	.3		1126	7⅜	7⅛	7⅜	+⅜
	53⅝	26⅝	Agrilbrd			11	233	47½	46⅝	46⅝	-⅝
	10⅝	7¾	Agrium g	.11	1.3		997	8⅜	8⅛	8⅜	+⅛
d	25⅛	19⅝	Agrium pf	2.00	10.2		165	19¹³/₁₆	19⅛	19⅛	-⅛
	41⅞	29⅝	Ahold e	.71	2.3		669	31¼	30⅜	30⅝	+⅜
	49¼	25⅛	AirProd	.76	2.4	15	7532	32⅛	31⅛	32⅛	+½
	15⅜	5⅜	AirNetS			23	1293	6½	5⅜	5⅜	-⅛
	42⅝	19½	AirbFrt	.16	.7	10	6835	23¼	21⅝	22⅛	-1⅛
	14	7⅜	Airgas			11	879	9⅝	9⅜	9⅝	-⅛
	24¼	21⅜	AlaPw39 n	1.69	7.8		175	22	21⅜	21⅝	-⅛
	25⅜	21⅞	AlaPw47	1.78	8.2		188	21⅜	21⅛	21⅜	-1/32
	25⅜	21⅛	AlaPw 47B	1.75	8.2		131	21⅜	21⅜	21⅜	-1/32
d	25⅜	21¼	AlaPw48	1.75	8.2		98	21⅜	21¼	21¼	-⅜
	26⅜	22⅜	AlaPC pfR	1.90	8.2		127	23⅛	23⅛	23⅛	-⅛
	13¼	6⅜	AlamoGp	.24	2.5	58	106	10	9⅜	9⅜	-⅛
	54¹⁵/₁₆	36¼	AlskAir			7	2986	39	37½	38⅜	+1⅛
	25	13¾	Albnyln b	.42	2.5	16	399	16⅝	16½	16⅝	
	25⅝	16	Albemar	.40	2.2	10	273	18¹⁵/₁₆	18⅜	18½	-⅞
	32¹⁵/₁₆	20⅝	AlbrtE g				283	30¼	29¼	29⅝	-⅜
d	25⅛	24⅛	AlbrtE pf	2.28			241	24⅝	24⅜	24⅜	-⅛

Marketpl

NYSE Winners

Stock	Close	Chg
Pentacn	2¹³/₁₆	+⅝
AMCOL	17½	+3¾
JAlexandr	2¹³/₁₆	+½
Carson	3¼	+½
RoylGp g	20½	+3⅛

NYSE Losers

Stock	Close	Chg
AuroraF	7¹⁵/₁₆	-2¾
NavigCons	11	-3¼
ProlclOne	2	-5/16
BWAY	5⅝	-⅞
CaremkRx	4¹/₁₆	-5⅛

NYSE Most Active

Stock	Volume	Close
AmOnline s	43,426,100	83⅞ +
Compaq	22,119,400	24¹³/₁₆
AT&T s	16,444,300	50¹³/₁₆
Pfizer s	14,976,700	35⅝
PhilMor	10,948,500	25¾

NYSE Diary

	Yesterday	Mon	Wk
Advanced	912	943	1,
Declined	2,207	2,189	1,
Unchanged	449	445	
New Highs	39	62	
New Lows	301	247	
AdvVol(mils)	333.13	391.31	763
DecVol(mils)	745.10	646.65	332.
ConsVol(mils)	1,115.24	1,074,951,148	
Block Trades	19,189	18,320	19,8

AMEX Winners

Stock	Close	Chg	%Ch
Arhyth	2	+½	+33
StavElec n	2⅝	+⅜	+16
AirSys	2½	+5/16	+14

AMEX Losers

Stock	Close	Chg	%Ch
Dryclean n	2	-⅜	-15.
ImpSugar	3¹³/₁₆	-⅝	-14.
AQnlCyc n	2	-¼	-11.

Foreign Exchange

Nov. 23, 1999	Foreign currency in dollars		fo
	Tue.	Mon	T
f-Argent	1.0001	1.0005	.9
Australia	.6357	.6373	1.5
Austria	.0750	.0749	13.
c-Belgium	.0254	.0256	3
Brazil	.5176	.5172	1.9
Britain	1.6244	1.6200	

.companies' expertise in marketing, brand management, and the use of echnology for product delivery and servicing.

Those few insurers that possess sustainable competitive advantages in franchise and efficiency are the ones likely to maintain a stable credit profile in spite of this threat. Moody's said it sees consolidation, as well as reorganization through demutualization or the mutual holding company (MHC) structure, as major patterns shaping the industry.

Moody's believes mergers and acquisitions have been a particularly fruitful means of achieving economies of scale for many life insurers. Many company managements view consolidation as a quick way to acquire new product lines and distribution networks, which can become new sources of long term profitability.

"We anticipate further consolidation in the life insurance industry," says Patrick Finnegan, a Moody's senior vice president for life insurance. "Our rating actions will continue to reflect this trend, with lower rated companies remaining the likely beneficiaries of rating upgrades because of their being purchased by more highly rated entities."

Moody's believes that mutual life insurers who change their legal structure will benefit from their access to new sources of capital, but will inevitably become more focused on improving shareholder returns. This focus may lead to increased risks for policyholders and creditors, which may in turn factor into some companies' ratings. Companies who skillfully manage restructurings could experience rating upgrades; companies who are unable to respond to new mpetitive forces may come under increased ratings pressure.

Finnegan also expects that the trends toward demutualization and MHC conversions will continue, but believes the MHC structure will exist as a halfway point on the road to full demutualization for most companies who adopt it.

AETNA HIT AGAIN WITH HMO CLASS ACTION:

On October 28, 1999, Fred Furth, the senior partner in the San Francisco law firm of Furth, Fahrner & Mason, announced that the REPAIR team, consisting of law firms across the country, had filed a class action suit against Aetna, its healthcare subsidiary, and its California HMO plan.

The suit, brought on behalf of enrollees in that plan over the last four years who pay (or have their employers pay) premiums, alleges unfair business practices and false and deceptive advertising. Furth quoted Aetna CEO Richard Huber's statement that Aetna's "in a con game. We sell a promise..."

"This lawsuit alleges that Aetna fails to deliver on that promise in order to enhance its own corporate profits," said Furth. As he further pointed out, "many doctors are fed up with the HMO system, which interferes with their ability to deliver quality healthcare. We believe they will fully support this lawsuit."

IN OTHER AETNA NEWS:

On October 28 Aetna announced that the Office of Thrift Supervision (OTS) had

Lawsuits Targeting HMOs Proliferate

By Allison Bell

Plaintiffs' attorneys have been putting more pressure on managed care companies this fall.

Columbus, Ohio, attorney Elizabeth Burkett drew national attention in September, by winning a $51.3 million jury verdict in a Newark, Ohio, state court against Anthem Inc., Indianapolis. Her client, Robert Dardinger, says Anthem aggravated the brain cancer that killed his wife by withdrawing preauthorization in the middle of what appeared to be a successful course of chemotherapy.

Boies & Schiller L.L.P., Armonk, N.Y., and Cohen, Milstein, Hausfeld & Toll, Washington, made a splash Oct. 4, by filing what they hope will be certified as a class-action suit against Humana Inc., Louisville, Ky., in the U.S. District Court in Miami. The suit alleges Humana misled patients by failing to disclose the financial incentives it offered to doctors to keep medical costs down.

Meanwhile, lawyers from Berger & Montague P.C., Philadelphia, were heading to the U.S. District Court in Philadelphia to file a similar suit against Aetna Inc.'s Hartford-based Aetna U.S. Healthcare subsidiary.

Other law firms said they were preparing HMO suits of their own.

Investors have panicked: Humana, Aetna and three other large managed care companies watched the prices of their shares fall 30 percent or more between Sept. 6 and Oct. 6. At least four other companies experienced drops of 15 percent or more.

But experts interviewed questioned the assumption that suits will kill the industry. Even Dr. Herbert Loveless, consultant with ExpeTeam Inc., an Irvine, Calif., think tank who expects half of all HMOs to disappear by 2010, doubts the suits will be the cause. Although HMOs sometimes make tragic mistakes, "most people have figured out ways of getting around the restrictions," Dr. Loveless said. "People get what they need."

Anthem declined to comment on the Ohio case, but Aetna responded to the Philadelphia suit by accusing the plaintiffs' lawyers of thinking mainly about their own profits.

Humana emphasized its commitment to independent arbitration programs and quality improvement initiatives. "More than 85 percent of our members routinely tell us they are satisfied," Humana reported.

Dr. William Mahood, an Abington, Pa., gastroenterologist who serves on the American Medical Association board, said the AMA believes health plans should be held liable for the results of utilization review decisions. The tragedies that result from the worst decisions "really do panic the public," he said.

But Dr. Mahood and American Association of Health Plans spokesman Donald B. White both agreed that the kinds of tragic UR errors that make the news are rare.

Dr. Loveless believes the real problem with utilization review programs is not the occasional error, but the inability of the programs to cut medical expenses enough to justify their cost.

Proving the kinds of market conduct allegations spelled out in the Humana and Aetna suits will be difficult, according to Judy Chin, an analyst at Standard & Poor's Rating Services, New York.

"Certainly, the suits are a concern," but S&P is not sure when, or if, the suits will affect plan ratings, she said.

Mary Chase, a health care consultant in PricewaterhouseCooper's New York office, rejected the idea that suits could wipe out the managed care companies. "We can't afford for them to be doomed," she said.

AAHP argues that the United States will have to manage care, one way or another, to cope with the aging of the baby boomers. "Managed care is here to stay, and in fact will grow exponentially," Mr. White predicted.

Reproduced from National Underwriter Life & Health/Financial Services Edition, October 11, 1999.

No[illegible]h Suburbs Edition | Owls win; S[illegible]chez sprains ankle – Sports Extra

The Philadelphia Inquirer

c MONDAY, NOVEMBER 22, 1999 www.philly.com 75 cents in some locations outside the metropolitan area 50 C

In mass litigation, the serious cases can get los

Second of two installments.
By L. Stuart Ditzen
INQUIRER STAFF WRITER

By the spring of this year, the diet-drug litigation had been going for 1½ years and more than 800 federal lawsuits had been consolidated before U.S. District Judge Louis C. Bechtle in Philadelphia.

If those cases were stacked on top of each other, the pile would rise more than 60 feet in the air, as tall as a six-story building. Additional lawsuits in state courts would reach two or three times higher.

A Deluge of Claims

And those stacks, claiming heart-valve damage and other injuries tied to the use of the diet pills Pondimin and Redux, would grow taller in proceeding months.

In February, Bechtle put a question to the lead lawyers in the diet-drug litigation: Of all the suits before him, how many plaintiffs were claiming serious injuries — *diagnosed* injuries as opposed to *alleged* ones?

The answer the judge received, after the lawyers reviewed their files, was this:

Eleven.

That was barely more than 1 percent of the federal cases.

The number was so small that it surprised even defense lawyers, who had been arguing all along that the mass diet-drug litigation was long on mass and short on substance.

It did not mean that all other diet-drug claims were spurious. It did mean that only 11 cases were deemed serious enough to merit expedited attention in the federa

Bechtle did not want people wit claims to get lost in the crowd. That he asked for their cases to be pinp

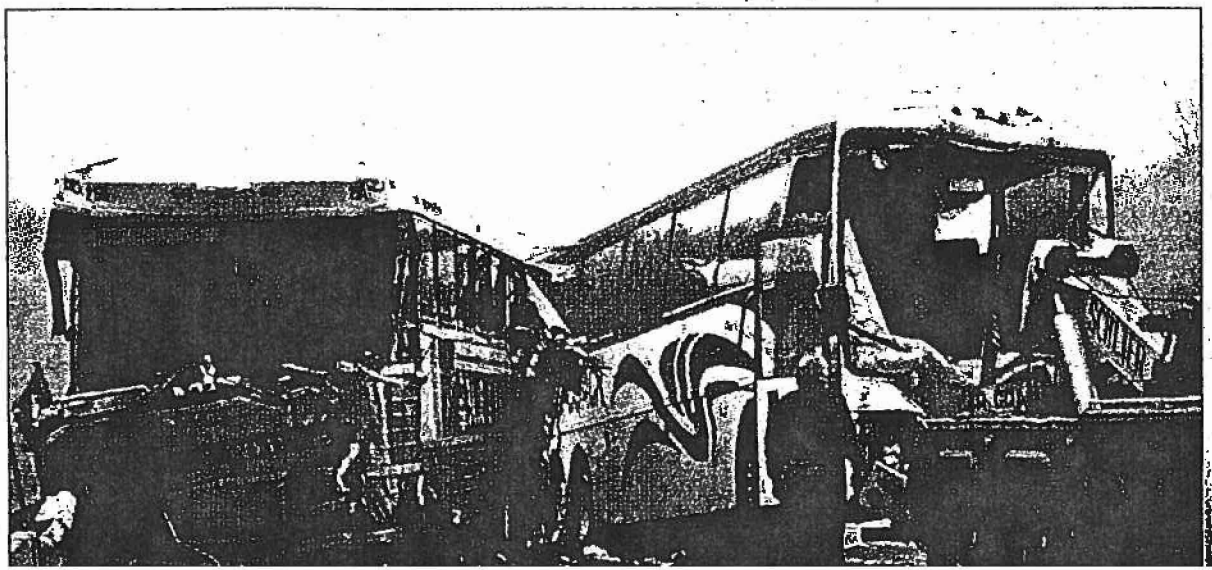
There are two large inequities tha cur in mass litigation, in the view lawyers and judges. One is that pe are not seriously injured can clog th

See SUITS on A12

■ The maker of Redux and Pondim submits settlement for court approv

Pileup of buses kills student and driver

106 others were hurt on the Penn State excursion. Police blamed thick fog and



High-te aid urg for poo nation

Clinton said prosper countries should he

time

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The Philadelphia Inquirer

Business

THURSDAY, OCTOBER 14, 1999

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214.43 100 = Sept. 30, 1994

Court reserves a special place for business lawsuits

Starting in January, two Philadelphia Common Pleas Court judges will hear only these cases, in the first program of its kind in Pennsylvania.

By L. Stuart Ditzen
INQUIRER STAFF WRITER

In a program designed to resolve legal disputes between businesses efficiently, the Philadelphia Common Pleas Court will assign two judges exclusively to hear business cases beginning in January.

President Judge Alex Bonavitacola announced the program yesterday with Edward F. Chacker, chancellor of the Philadelphia Bar Association, and Charles Pizzi, president of the Greater Philadelphia Chamber of Commerce.

Bonavitacola said the program, which business leaders and corporate lawyers have wanted for several years, is aimed at serving the "specialized needs" of businesses engaged in litigation.

State court systems in Delaware, New Jersey and New York all have business courts or judges assigned to hear only business-related cases. This is the first program of its kind in Pennsylvania.

Philadelphia's "commerce case program," as it is to be called, will handle lawsuits involving contract disputes, partnership breakups, business dissolutions, unfair-competition claims, intellectual-property disputes, some types of securities cases and class actions, and an array of other business cases.

Two ranking judges who developed the program will preside over it. They are Administrative Judge John W. Herron and Judge Albert W. Sheppard Jr., both of whom have been leaders in reducing a massive civil-case backlog, from more than 28,000 cases in 1992 to 7,000 currently.

Court officials said yesterday that it would have been impossible to create the com-

See COURT on C2

Tobacco money could aid hospitals

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Family May Owe More to Sued HMO

Judge Calls Case Of Post-Crash Care 'Depressing Parable'

By David S. Hilzenrath
Washington Post Staff Writer
Tuesday, November 16, 1999; Page E01

After battling their HMO in court for five years, trying to recoup millions of dollars of rehabilitation expenses and other damages, the family of a Maryland student recovering from a 1992 brain injury could end up owing the health maintenance organization money.

A decision by U.S. District Judge Thomas Penfield Jackson shows how difficult it can be to collect damages from a health plan, an issue at the heart of the national debate over patients' rights.

Even though Jackson found that the CapitalCare HMO shirked its responsibility, he said the law shields the HMO from most of the damages sought by the parents of Alistaire Moore. What's more, the HMO is entitled to be reimbursed for its medical costs from money Alistaire gained in separate litigation over the car crash that caused her injury, Jackson ruled last Wednesday.

"This depressing parable of modern American medical care . . . ends, for the moment, in a disposition that pleases no one, including the Court," Jackson wrote.

Alistaire's parents, William and Judith Moore, had alleged that CapitalCare abandoned them during Alistaire's rehabilitation, leaving them to pay a mountain of bills and devote much of their time to Alistaire's care while their family business suffered.

Jackson essentially agreed, saying, "No one at CapitalCare . . . ever undertook to develop and coordinate any rehabilitative care for Alistaire Moore." He faulted the HMO for rejecting claims for home tutoring and the like, which the HMO asserted were not its responsibility.

The Moores had hoped Jackson would spare them additional battles by ordering the HMO to pay for Alistaire's future medical expenses, which are expected to exceed half a million dollars. Instead, Jackson

which are expected to exceed half a million dollars. Instead, Jackson ruled that Alistaire must repay the health plan the more than $200,000 it has already spent on her treatment.

Under its contract, the health plan is entitled to be reimbursed for Alistaire's care out of the $900,0000 to $1 million she received through lawsuits over liability for the accident, Jackson wrote. He was agreeing with a counterclaim the health plan had filed against the Moores.

"They won, but they lost," said Mary M. Glidden, a rehabilitation consultant and expert witness for the Moores.

The decision suggests that Alistaire, rather than the health plan, could be required to bear the financial burden of her ongoing care, at least until she has exhausted the money from the earlier settlements. That money didn't come close to making Alistaire whole, an attorney for the Moores maintained.

CapitalCare argued that the Moores chose to go outside the HMO and arrange Alistaire's care themselves, which their policy allowed them to do under a different set of benefits. "I don't think we ignored Mr. and Mrs. Moore," said Charles J. Steele, a lawyer for the health plan.

The damages the judge rejected included reimbursement for two years at Phillips Exeter Academy, a New Hampshire prep school, which the Moores claimed was important to Alistaire's recovery; thousands of hours the Moores spent attending to their daughter, which they valued at $291,003; and the business profits they claimed to have lost while filling the breach left by the HMO, estimated at almost $1.8 million as of 1996.

The saga began in September 1992, when Alistaire, then 15, was returning to Exeter. Her father was busy at work, so the Moores, partners in an audio-video engineering firm, hired a driver to make the trip.

The driver, Dolores Seiger, recalled in interviews that she left home in the middle of the night, got lost on the way to the Moores' house, had to spend more than an hour helping load the car, and set out with Alistaire before dawn. By the time the car was passing through New York, Seiger had gotten a speeding ticket and had stopped for coffee to help keep herself awake, she said. With Alistaire napping in the passenger seat while lulling music from "The Phantom of the Opera" played, the driver said her eyes closed and the car left the road.

"My heart goes out to the Moores. . . . It haunts me that I was involved in a such a serious thing," Seiger said.

When Alistaire emerged from a coma, the student who had been on

track to graduate high school two years early was completely incapacitated, unable to speak.

The Moores brought Alistaire home from the hospital in December 1992 and launched an intensive rehabilitation regimen in which fitness training, karate lessons, and tutoring in physics, math and French supplemented other forms of therapy. The Moores claimed they had the approval of the HMO, which would have had to spend much more money to keep Alistaire hospitalized. But getting the HMO to pay many of the bills became a maddening ordeal, as the Moores tell it.

The judge declared that Alistaire's primary-care physician and a CapitalCare case manager had given at least "tacit approval" to the Moores' home therapy program. Moreover, he said it was "arbitrary and unreasonable" for the HMO to refuse to cover bills for tutoring and the like simply because the people providing the services were not licensed therapists.

The judge did not spell out his ruling's bottom line in dollars and cents, and he said further court proceedings may be needed to sort out the details.

The Moores' attorney, Martin H. Freeman, said the ruling in favor of the HMO's counterclaim "is clearly in error" and "essentially takes the bottom out of the case."

In suing CapitalCare, the Moores have incurred "several hundred thousand dollars" in legal costs, their attorney said. Moreover, although Alistaire has recovered enough to attend Towson University, she has limited potential to support herself, Glidden said.

Greater Philadephia AHU

"And God Said . . ."
The Case Against Health Plan Liability

By Ross Schriftman, RHU, LUTCF

Chapter One

In the beginning, lawyers were in despair. They wandered the earth looking for billable hours. Their sorrow was great and they cried mightily.

Then the lawyers discovered "discovery" and they said it was very good. Now they could bill the people each time they sent each other words on long sheets of parchment.

Then it was declared by those in power to let the lawyers go forth with law suits. Therefore, there came a time when law suits multiplied exceedingly. And there were law suits of every kind; both large and small. Each with its own purpose.

And when it came to pass that those who practice medicine were afflicted with these law suits, they cried out for relief. And the doctors, the healers of the people, arose and went to the high place they called "Capitol Hill."

And they said to the makers of the law, "See, we are being set upon by the lawyers. They force us into hard labor and make us pay high malpractice premiums. It is not fair in our eyes." But, instead of asking the law makers to limit their torment, they asked that the health plans also be set upon by the attorneys. And they said, "It is not fair that we are set upon and they are not."

And the law makers headed the plea of the healers and they set cruel penalties upon the health plans and they blamed the health plans for all forms of evil upon the earth. Yeah, they even claimed that the health plans brought upon death to the people for not doing the doctor's bidding.

The health plans pleaded for mercy saying that the multitudes would go without coverage because of the cost of the premiums. But the law makers believed not their plight and took favorable judgement with the doctors and lawyers. And the law makers passed strong laws to deal with the health plans and make them pay through the law suits to the lawyers. And the doctors were quite happy. But, the lawyers were exceedingly happy. For they had found a land of milk and honey in the deep pockets of the health plans.

As time passed, the people began to grumble. There were bad tidings as their cost for the health plans rose beyond the peoples' means. And the businesses both large and small, to the very smallest of them pleaded and cried. But the lawmakers would not change and the people without coverage became impoverished, but the lawyers were not concerned.

Chapter Two

And many of the health plans, even the HMOs among them were swallowed up by other health plans or disappeared from the face of the earth altogether. As a fish is swallowed, they were no more.

Among the people, sickness increased. The doctors saw less people, since few had coverage. And the doctors became concerned and envious of the lawyers. And those health plans that remained on the earth became as poor as the people with much debt. They could no longer pay as much to the doctors. And they doctors were very unhappy. But the health plans were at the mercy of the lawyers and feared the law suits.

Then the law makers, concerned about the sick and showing care for the poor, passed more laws declaring that death be no more.

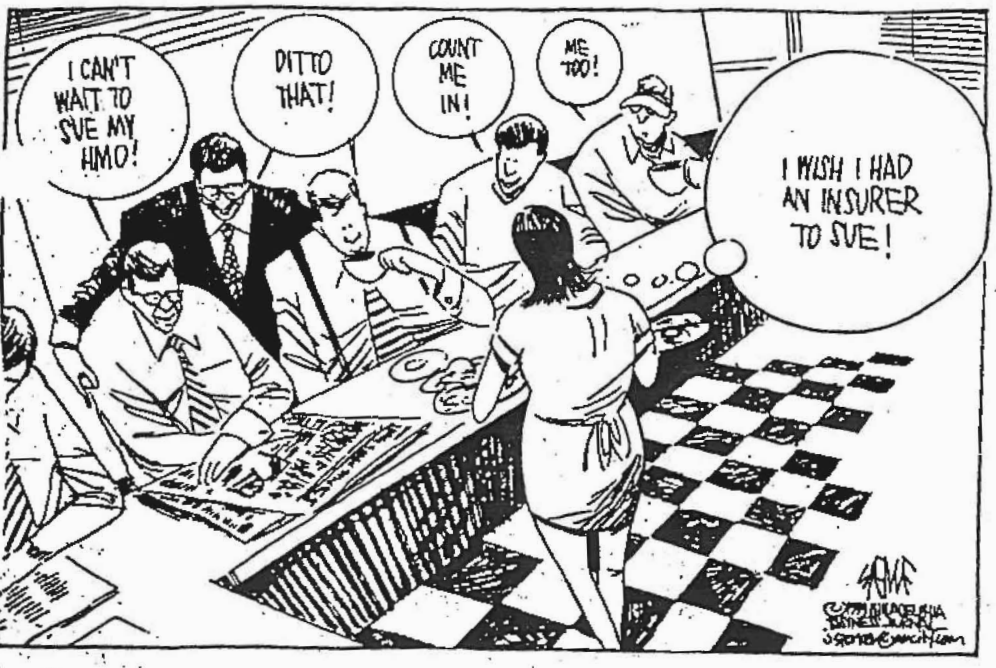
Then God become exceedingly angry and God said, "It is I who must remind man and woman kind that you are mortal. You shall all perish from the face of this earth. There is no healer, lawyer or health plan that can stop my decree. From this day forward, you shall treat each other with kindness while I give you the good grace to live. Though shalt not afflict each other with blame or with the waving of fingers. You shall all repent for I gave you this world and you shall repair it."

Alas and it came to pass that the people arose and removed many law makers.

And there arose new law makers who knew not law suits. And they heard their people's plea, but it was a difficult journey to repair the errors of the passed. And the healers of the people were allowed once more to heal and the health plans to cover and the lawyers to defend justice.

The lawyers repented and put on sackcloth and sat in ashes and did more pro bono work for the poor and the defenseless. The health plans took mercy and changed their ways and worked with the doctors to make people well and happy. And the people heard God and remembered that they are mortal and no longer demanded immortality from the doctors or the health plans. And the people showed kindness and consideration one to the other.

And God saw that it was good.



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