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BETWEEN YOU AND YOUR DOCTOR: THE BUREAUCRACY OF PRIVATE HEALTH INSURANCE—DAY 1

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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BETWEEN YOU AND YOUR DOCTOR: THE BUREAUCRACY OF PRIVATE HEALTH INSURANCE—DAY 1

WEDNESDAY, SEPTEMBER 16, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Tierney, Watson, and Jordan.

Staff present: Jaron R. Bourke, staff director; Yonatan Zamir, counsel; Jean Gosa, clerk; Charisma Williams, staff assistant; Leneal Scott, information systems manager, full committee; Adam Hodge, deputy press secretary, full committee; Dan Blankenburg, minority director of outreach and senior adviser; Adam Fromm, minority chief clerk and Member liaison; Ashley Callen, minority senior counsel; and Molly Boyl, minority professional staff member.

Mr. KUCINICH. Good morning. The Domestic Policy Subcommittee of the Oversight and Government Reform Committee will now come to order.

Today's hearing will examine how the bureaucracy of the private health insurance industry influences the relationship between physicians and their patients. This hearing is divided into two parts. Today the subcommittee will hear testimony from patients and health care providers with personal experiences. The subcommittee will also hear from a former health insurance executive who will testify about internal practices of the industry, and two individuals whose focus is on health policy. Tomorrow the subcommittee will hear testimony from top executives of the six largest health insurance companies in the United States.

Now, without objection, the Chair and ranking minority member will have 5 minutes to make opening statements followed by opening statements not to exceed 3 minutes by any other Member who seeks recognition.

And without objection, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials for the record.

An observer of the public debate on reform of the health insurance industry would draw three conclusions, all of which are false. The first is that Government does not play a role in insuring

health care today in America. The truth is that tens of millions of Americans get their health insurance right now through government-run health insurance: Medicare, Medicaid, VA and TRICARE.

The second myth is that government-run health care is inefficient and wasteful compared to private insurance. The truth is that government-run health care has lower prices and much lower administrative costs than private insurance. Government-run insurance negotiates harder bargains with pharmaceutical companies to get lower prices; it has no multimillion-dollar executives, no corporate jets, no dividends to pay, no lobbying expenses, no campaign contributions, no front groups to pay for, and no television advertising. Private insurers pay for all of these expensive things out of the premium dollars they collect, and these things have nothing to do with improving health care outcomes.

The third myth is that bureaucracy is solely a governmental problem. The truth is that for millions of Americans, there are layers of corporate bureaucrats standing between them and their doctors, often on matters of life and death, and those bureaucrats work for the private health insurance industry. The hearing we will hold today and tomorrow will examine the nature, costs, techniques and consequences of the bureaucracy of the private health insurance industry.

Wall Street considers paying for your cancer treatment as a loss, and they want to see health insurers keep those losses to a minimum. They have a statistic known as the medical loss ratio [MLR], that keeps track of how effectively private health insurance bureaucrats achieve that financial objective of keeping losses at a minimum. To please Wall Street, private health insurers have to deny medical claims, raise premiums, or both. Even as the rate of inflation of medical prices has increased, the share of premium dollars spent on medical care has come down to around 83 percent, from over 90 percent in the early 1990's.

The State regulatory record and civil litigation dockets are replete with recent findings of wrongful denial and delay of health care by private insurance bureaucrats. For instance, in 2008, PacifiCare, a subsidiary of United HealthCare, paid a $3½ million fine, $25 million in waived premiums and reimbursements of medical expenses, and restoration of health care to nearly 1,000 patients to resolve violations of California law including wrongful denial of 130,000 claims, incorrect payment of claims, failure to acknowledge receipt of claims in a timely manner, and for imposing the hassle of multiple requests for documentation already provided. Similar regulatory actions exist for nearly every private insurer.

Private health insurance bureaucrats play with the lives of people, our constituents, when they are at their most vulnerable, when they have a life-threatening injury, when their children develop severe diseases, when their parents are battling cancer. This is when the pressure that insurance companies can bring is the greatest.

From the insurer's perspective, people who really need their health insurance to cover life-saving medical treatment threaten the company with medical losses, and investors want medical losses to be minimized in order to maximize profits, pure and simple. The fact is that in America today, you don't know if your health insurance will take care of your serious medical bills until

you become seriously ill or injured. By then it is too late to shop around.

You buy health insurance on blind faith that coverage will be afforded to you when you really need it, but you receive no guarantees from private health insurers, especially if you get very sick. And that contradicts the purpose of health insurance in the first place, to spread the cost of illness, especially serious illness requiring expensive care.

We will hear today how the private health insurance bureaucrats have become more sophisticated at denying expensive treatment and more effective at wearing down doctors and patients, conditioning them to choose to pay for the treatment themselves or to go without, rather than insist that their insurer pay.

In the business of private health insurance, corporate bureaucrats may put profits before people, thereby becoming as noxious as disease itself. Such was the conclusion of the Ohio Supreme Court when it upheld the largest jury award in Ohio's history against Anthem for denying life-saving treatment to Esther Dardinger. From the court decision, "Then came the bureaucracy. Anthem had worn"—talking about the Dardingers—"Anthem had worn the Dardingers down as surely as the cancer had. Like the cancer, Anthem relentlessly followed its own course, uncaring, oblivious to what it destroyed, seeking only to have its way," from the Ohio Supreme Court in the case involving Anthem.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement of
Dennis J. Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee

Hearing entitled: "Between You and Your Doctor: the Private Health Insurance Bureaucracy" Part I

September 16, 2009

An observer of the public debate on reform of the health insurance industry would draw three conclusions, all of which are false.

The first is that government does not play a role in insuring health care today in America. The truth is that tens of millions of Americans get their health insurance right now through government-run health insurance: Medicare, Medicaid, VA and Tricare.

The second myth is that government-run health care is inefficient and wasteful, compared to private insurance. The truth is that government-run health care has lower prices and much lower administrative costs than private insurance. Government-run insurance negotiates harder bargains with pharmaceutical companies to get lower prices; it has no multi-million dollar executives, no corporate jets, no dividends to pay, no lobbying expenses, no campaign contributions, no front groups to pay for,

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Wall Street considers paying for your cancer treatment as a "loss", and they want to see health insurers keep those "losses" to a minimum. They have a statistic known as the "medical loss ratio," or MLR, that keeps track of how effectively private health insurance bureaucrats achieve that financial objective. To please Wall Street, private health insurers have to deny medical claims, raise premiums, or both. Even as the rate of inflation of medical prices has increased, the share of premium dollars spent on medical care has come down to around 83 percent, from over 90 percent in the early 1990's.

The state regulatory record and civil litigation dockets are replete with recent findings of wrongful denial and delay of health care by private health insurance bureaucrats. For instance, in 2008, PacifiCare, a subsidiary of United HealthCare, paid a $3.5 million fine, $25 million in waived premiums and reimbursements of medical expenses, and restoration of health care to nearly 1,000 patients, to resolve violations of California law including:

- wrongful denial of 130,000 claims,
- incorrect payment of claims,
- failure to acknowledge receipt of claims in a timely manner, and for
- imposing the hassle of multiple requests for documentation already provided.

Similar regulatory actions exist for nearly every private insurer.

Private health insurance bureaucrats play with the lives of people – our constituents -- when they are at their most vulnerable: when they have a life-threatening injury, when their children develop severe diseases, when their parents are battling cancer.

From the insurer's perspective, people who really need their health insurance to cover life-saving medical treatment

threaten the company with medical losses, and investors want medical losses to be minimized, in order to maximize profits. The fact is that in America today you don't know if your health insurance will take care of your serious medical bills until you become seriously ill or injured. By then it is too late to shop around. You buy health insurance on blind faith that coverage will be afforded to you when you really need it. But you receive no guarantees from private health insurers, especially if you get very sick. And that contradicts the purpose of health insurance in the first place – to spread the cost of illness, especially serious illness requiring expensive care.

We will hear today how the private health insurance bureaucrats have become more sophisticated at denying expensive treatment, and more effective at wearing down doctors and patients, conditioning them to choose to pay for the treatment themselves or to go without, rather than insist that their insurer pay. In the business of private health insurance, corporate bureaucrats may put profits before people, thereby becoming as noxious as disease itself. Such was the conclusion of the Ohio Supreme Court, when it upheld the largest jury award in Ohio's history against Anthem for denying life-saving treatment to Esther Dardinger: *"[T]hen came the bureaucracy...Anthem had worn [the Dardingers] down*

as surely as the cancer had. Like the cancer, Anthem relentlessly followed its own course, uncaring, oblivious to what it destroyed, seeking only to have its way."

Mr. KUCINICH. At this time I recognize the ranking member from Ohio, the Honorable Mr. Jordan. You may proceed.

Mr. JORDAN. Thank you, Mr. Chairman. I appreciate you having this hearing, and I want to thank our witnesses for participating. I look forward to hearing their unique perspectives on this important topic. I know many of them have tragic stories to share with us, and you certainly have our sympathy.

The ongoing health care debate is extraordinary. Americans who were not previously engaged in politics are now attending town halls, rallies, tea parties. During August and September, I had the opportunity to meet with many of our constituents in Ohio. Each and every person I talked to expressed grave concern about a government-run health care system, but no one denied that our current system needs reform, and that's what I hope we can gather from the next 2 days, the kind of reforms that are actually going to make sense and help families, help small business owners, help Americans.

Health care spending is out of control, and we're not covering many of the most vulnerable. Medicare alone accounts for 3½ percent of the gross domestic product. The Congressional Budget Office projects that by 2080, without intervention, it will be as high as 13½ percent. Total health care spending in 2007 exceeded $2.2 trillion, which represents over 16 percent of GDP.

In the debate there are areas of agreement between Republicans and the President. In fact, last week during the speech to the joint session of Congress, the President said, "let me set the record straight. My guiding principle is, and always has been, that consumers do better when there is choice and competition. That's how the market works."

Mr. Chairman, on this point I agree with the President. In fact, we have cosponsored a piece of legislation, H.R. 3400, that I believe relies on free-market approaches and tax credits to incentivize Americans to buy their own plans, instead of mandates and surtaxes which are part of the current House bill that passed out of committee.

Our bill allows individuals and businesses to purchase insurance across State lines, increasing their insurance choices from perhaps a dozen carriers to over 1,300. In contrast, the bill being discussed decreases competition by installing a government-subsidized public option into the marketplace to crowd out the private sector. Real competition in the private market helps reduce prices. A government-run monopoly will cost all of us, especially our children and grandchildren.

Rather than the Federal Government serving as an intermediary, my colleagues and Irealize that individuals and families are best served when there is a strong relationship between them as a patient and their primary and specialty health care providers. Our plan strengthens that relationship by reducing the practice of defensive medicine brought about by lawsuits. Enacting medical liability reform will help reduce the price of medical malpractice insurance in defensive medicine, both of which are passed on to consumers through increased costs and higher insurance premiums.

By establishing health courts, capping noneconomic, and creating best practice measures, we will eliminate frivolous lawsuits that

harm physicians, while also ensuring that justice is done to true victims.

Mr. Chairman, I hope that commonsense solutions are not ignored. I believe Americans trust their health care professionals more than they trust politicians and Federal Government bureaucrats. They want to keep what they like best about their current plan, while addressing some of the problems with cost, access and portability.

My trust rests in the ingenuity and compassion of the American people and with the professionalism and competence of our health care professionals.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman.

[The prepared statement of Hon. Jim Jordan follows:]

EDOLPHUS TOWNS, NEW YORK
CHAIRMAN

DARRELL E. ISSA, CALIFORNIA
RANKING MINORITY MEMBER

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Opening Statement of Ranking Member Jim Jordan
Oversight and Government Reform Committee, Domestic Policy Subcommittee
Hearing:
"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Wednesday, September 16, 2009

Mr. Chairman, thank you for holding this hearing today.

I would like to thank the witnesses for participating. I look forward to hearing their perspectives on this important topic. I know many of the witnesses today have tragic stories to share with us. Please know that you have my sincerest sympathy.

The ongoing health care debate is extraordinary. Americans who were not previously engaged in politics are now attending town halls, rallies, and tea parties. During August and September, I had the opportunity to meet with my constituents in Ohio. Each and every person I talked to expressed grave concern about a government-run health care system, but no one denied that our current system needs reform.

Health care spending is out of control and we are not covering many of the most vulnerable. Medicare alone accounts for 3.5% of the gross domestic product (GDP). The Congressional Budget Office (CBO) projects that by 2080, without intervention it will be as much as 13.5% of the GDP. Total health care spending in 2007 exceeded 2.2 trillion dollars which represented 16% of the GDP.

In the debate there are areas of agreement between Republicans and the President. Last week during his speech to the Joint Session of Congress, the President said:

> Let me set the record straight [here]. My guiding principle is, and always has been, that consumers do better when there is choice and competition. That's how the market works.

Mr. Chairman, on this point I agree with the President. H.R. 3400, a bill I co-sponsored, relies on free market approaches and tax credits to incentivize Americans to buy their own plans instead of mandates and surtaxes which are part of the current Democratic House bill.

Our bill allows individuals and businesses to purchase insurance across state lines, increasing their insurance choices from perhaps a dozen carriers to over 1,300. In contrast, the current bill being discussed decreases competition by installing a government-subsidized public option into the marketplace to crowd out the private sector. Real competition in the private market helps reduce prices. A government-run monopoly will cost all of us, especially our children and grandchildren.

Rather than a federal government bureaucrat serving as an intermediary, my colleagues and I realize that individuals and families are best served when a strong relationship exists between a patient, their primary and specialty health care providers. Our plan strengthens that relationship by reducing the practice of defensive medicine brought about by abusive lawsuits. Enacting medical liability reform will help reduce the price of medical malpractice insurance and defensive medicine, both of which are passed on to consumers through increased costs and higher insurance premiums. By establishing health courts, capping non-economic damages, and creating best-practices measures, we will eliminate frivolous lawsuits that harm physicians while also ensuring that justice is done to true victims.

Mr. Chairman, I hope the common-sense solutions delivered by Republicans are not ignored. I believe Americans trust their health care professionals more than they trust politicians and federal government bureaucrats. They want to keep what they like best about their current plan while addressing some of the problems with cost, access, and portability. My trust rests in the ingenuity and compassion of the American people and the professionalism and competence of our health care professionals.

Thank you Mr. Chairman.

Mr. KUCINICH. The Chair recognizes the gentleman from Maryland Mr. Cummings.

Mr. CUMMINGS. I want to thank the chairman for convening this hearing. It is a very important hearing.

One of the things that I want us to keep in mind is that insurance companies are making life-and-death decisions every single day. Folks talk about government, worrying about government coming in and making decisions. Insurance companies are making life-and-death decisions every day.

There's a gentleman in my neighborhood who had a swelling on his leg, I guess, maybe about 2 years ago. I see him almost every day. I live in Baltimore, 40 miles away from here. And he went in and he found out that it was cancerous. He had surgery, then he had radiation, and then he had chemo. And then the cancer apparently spread to other parts of his body.

And he had been a hardworking American, working for the city of Baltimore, and he had moved into a disability status. And he used to tell me about his problems in that the copay for the chemo left him in a position where he had to choose between eating and paying the copay. And I would see him almost every day, and I just think our society is better than that.

This is a point in time where we must leave politics at the door and address the problems of all Americans. We need to keep in mind, as the President said the other night, over the last 2 years, one out of every three Americans have had a gap in their insurance coverage. And what does that say? What that says is if you've got a gap in your insurance coverage, that means you've got to get some more insurance at some point.

Well, this is a bulletin coming over the wire. The older we get, the more likely it is that we're going to have a preexisting condition, and if you haven't gotten there yet, you just keep on living. And the fact is that we've got to deal with these preexisting conditions. We've got to deal with this rescission where a person gets sick, they've been doing everything they're supposed to do, working hard, paying their premiums, and when it comes time for the insurance company to help them, they suddenly find they have no insurance.

We've got to deal with the high cost of insurance going up. The President said it, and we have said it. We want people to keep what they have, but guess what? If it is too expensive, you won't be able to afford it anyway. That's a major problem.

And so I am glad that—and I had a town hall meeting, and it went well, and I have listened to—seen what has happened across the country with regard to town hall meetings. But I think we need to hear not only from the people who are opposed, we need to hear from everyday American citizens who have been placed in a position where they cannot get the coverage they need.

And so, Mr. Chairman, I applaud you for these two hearings, and I look forward to the testimony.

Mr. KUCINICH. I thank the gentleman.

Mr. KUCINICH. The Chair recognizes the gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman. I thank all the witnesses for being here today.

You know, this idea of competition is great, and it's interesting to hear people say they want these corporations to be able to go across States. I think many of them see that just as an opportunity to avoid State regulation, and we have to make sure that if that happens, and companies are allowed to go across States, that they do not get to avoid State regulation, just going to the lowest common denominator on this. They're seeking to avoid competition with any plan that essentially will do things other than their way. That's one of the reasons that they're so avidly fighting this public option. They're happy to compete with any other insurance company that does the things that they do: pay really excessive and exorbitant salaries to executives; pay a lot of money for underwriting to figure out ways not to cover people with health care; and give dividends that are just not reasonable, but that are extremely excessive to shareholders, who actually punish them when they spend too much of the premium dollar on health care delivery.

It's a little shocking to me as we watch what goes on around the country throughout these town meetings that so many people who consider themselves out there fighting for the people wittingly or unwittingly are out there shilling for insurance and prescription drug companies, that they're really for the status quo. And that's just a little bit amazing. If they were really populists, they would be out there saying there is a point in time where government ought to step between corporations that go to the excess, between corporations that use their power and their bureaucracy to deprive us of what we pay our premiums for, and you step in with a little regulation, and we're making sure that competition really does work.

That doesn't seem to be the message that's going around out there at all, and it's sort of surprising.

When you look at this medical loss ratio that the chairman mentioned earlier, essentially I think Mr. Potter you discussed this on interviews as well. Companies get punished when they show their medical loss ratio too high. In the 1990's, it was common for medical loss ratios to be 95 percent. Out of every $100 spent, $95 would go to health care, and $5 would go toward salaries and overhead and profits, and the companies were doing well; they were doing extremely well. Well, studies now show that in some instances that medical loss ratio is 57 percent, 57 percent of your premium dollar going for care and the rest of it going to them.

I'd be on the streets pounding away saying, why isn't my Government out there doing something to stop that? That's what's ridiculous. You want to go out and yell and scream and take a town hall meeting, go where the culprit is. They're the ones that are taking our premium dollars, and what do they give us in return? Rescission. You're in the middle of your care, and they go back and scrub your records to find out, ah, there's a reason we don't have to pay the claim; making sure that you have a preexisting condition where you don't get coverage at all, or putting a cap on it, a cap on it. Sixty percent of the bankruptcies in this country are directly or indirectly related to medical expenses families are experiencing, and 85 percent of those families have health insurance.

That's what we should be on the streets protesting about, and that's why this bill should directly look in there and say, look, we

need to put in some regulation. No more rescission, no more unreasonable caps, no more incredibly high deductibles and copays, no more telling people preexisting conditions are going to keep them off, and no more getting away with spending less than a reasonable amount of our premium dollars on actual health care services.

You can have a decent profit, you can have a decent salary, but $80,000 a day, as some executives were getting, and millions of dollars plus bonuses plus stock options is not a good way to spend our premium dollar, and that's why this health care reform package ought to be as much about health insurance reform as anything else.

We have to move in that direction. Yes, there should be an option out there where people say, I don't want to go to that private company that gives us that kind of bad coverage; I'll take another option, a public option, and that maybe will inspire these people to do the right thing. Maybe when they see that there's somebody not playing their game, that we're not just going to let people into the game who do it the way they do it, that they will have to behave a little better. And that's what this is about, and hopefully that's what the American people are going to understand this is about, and we'll move in that direction.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman.

We're now going to hear testimony from the witnesses, and the first two witnesses are sharing a personal narrative with us, which I think that when we in Congress tend to expound on these weighty matters, we're always much more informed when we hear what people have to say about their own experience. And so two of our witnesses will provide us with information about their personal experience. It is important that we pay careful attention.

Now, there are no additional opening statements, so we will receive testimony from our witnesses. I would like to introduce our first panel. Mr. Mark Gendernalik. Is that right?

Mr. GENDERNALIK. Gendernalik, hard G.

Mr. KUCINICH. OK. Mr. Gendernalik is a teacher from Los Angeles, CA, where he lives with his wife and three children. His daughter Sidney suffers from a rare neurological disorder known as infantile spasms.

Ms. Erinn Ackley is a resident of Montana where she lives with her husband and their daughter. In 2006, Ms. Ackley assisted her father William Ackley in his struggle to obtain approval from his private health insurer for prescribed medical treatment.

Dr. Melvin Stern, M.D., has been in solo practice as a private care pediatrician in Highland, MD, for the last 28 years. In addition to direct patient care, Dr. Stern has been continuously involved in teaching medical students, pediatric residents and physician extenders, such as physician assistants. Dr. Stern has served on the medical faculty of the Maryland chapter of the American Academy of Pediatrics, and has also previously served as the chairman of the Maryland State Medical Society's legislative committee.

Dr. Linda Peeno, M.D., is a physician and medical ethicist who consults and educates on issues related to health system operations, managed care and ethics. Dr. Peeno has worked in executive positions in a variety of health care organizations and as a

physician reviewing hospital requests for admission at the insurance company Humana. Dr. Peeno is now a nationally recognized expert on various issues related to health system operations and ethics, particularly managed care and insurance practices.

And finally, Mr. Wendell Potter. Mr. Potter has served since May 2009 as the Center for Media and Democracy's senior fellow on health care. Previously Mr. Potter spent 20 years in a variety of communications positions for private health insurance companies. Mr. Potter was the chief corporate spokesman for CIGNA insurance company.

I want to thank each and every one of the witnesses for appearing before the subcommittee today.

It's the policy of the Committee on Oversight and Government Reform to swear in all witnesses before they testify. I would ask that at this time if you could rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Thank you very much. Let the record reflect that each of the witnesses has answered in the affirmative.

I now want to ask each of the witnesses to give a brief summary of your testimony. I want you to keep in mind that it's helpful to have this summary no more than 5 minutes in duration. Your complete written statement will be included in the hearing record. So if you're worried about not getting in a certain word, just know it's going to be in the record of the hearing, and all Members will have access to that.

We're going to start with Mr. Gendernalik. You're going to be our first witness, and we'd like you to proceed at this time. And before you begin, I would like to recognize and welcome the distinguished gentlelady from California Congresswoman Watson. Thank you for being here. You may proceed.

STATEMENTS OF MARK GENDERNALIK, FATHER OF SIDNEY GENDERNALIK, LOS ANGELES, CA; ERINN ACKLEY, DAUGHTER OF WILLIAM ACKLEY, RED LODGE, MT; MEL STERN, PEDIATRICIAN, HIGHLAND, MD; LINDA PEENO, FORMER REVIEW PHYSICIAN FOR HUMANA, LOUISVILLE, KY; AND WENDELL POTTER, FORMER HEAD OF CORPORATE COMMUNICATIONS FOR CIGNA, PHILADELPHIA, PA

STATEMENT OF MARK GENDERNALIK

Mr. GENDERNALIK. Mr. Chairman, members of the committee, I want to thank you for inviting me here today to share my daughter's story with you. I hope it will inform you about the human side of the business of health care in America.

As an American, it is an honor to be a part of this democratic process at such an important time, and like many Americans, I'm unashamedly guilty of the swagger that comes with that heartfelt feeling that I live in the best country on Earth. Unfortunately, that swagger wears a little thin when we don't deliver, when we come up short, and health care is one such area where we are not the best in the world. Most will agree we are paying far too much for health care and getting far less than we are entitled to, far less than the American people deserve, far less than my daughter Sid-

ney deserves, and that less has consequences, real consequences, for people, especially my infant daughter Sidney.

Early one afternoon when Sidney was just 3 months old, as I walked down the steps of the living room in my home, Sidney's arm suddenly struck out at an awkward angle, her head cocked over to the side. Her eyes looked odd and distant. She was 3 months old. I was concerned and alarmed at that point. I thought, well, that's odd, and then we had a few more and a few more and went and saw a pediatrician, and we started what was going to be the beginning of what may be Sidney's lifelong struggle.

We're here today not only to help my little girl, but the families who have to fight beyond exhaustion just to receive the care that their hard-earned dollars were supposed to have provided them when they bought their insurance.

Since Sidney was sent to a pediatrician—or from the pediatrician to a neurologist, that neurologist ordered an MRI with contrast dye and an EEG. He conducted his own EEG in his office, sent out for the MRI to be done at UCLA Medical Center. The insurance company denied the medical center he wished to send her to, which was UCLA Children's Hospital.

She was then sent to an imaging center, which was pretty much a storefront operation that just does X-rays, MRIs, images. Their staff were incapable of injecting my small daughter with the dye necessary to create the contrast to give my neurologist the images he needed. The end result was my neurologist didn't get the images he needed to accurately diagnose my daughter, but the medical group got to save a little money.

In all of the struggle through, we made the best we could out of it. We reached a point where he was coming to the point we understood her diagnosis to be infantile spasms. It's a syndrome. It's diagnosed by an index of symptoms. We sent out for a second opinion just to be prudent. We ordered a second opinion. The insurance company authorized Children's Hospital L.A. to conduct a second opinion, and then refused to authorize the neurologist there to do any of the diagnostics to inform and form the second opinion.

My wife took the day off work. She went to the neurologist at Children's Hospital, waited, was seen. That neurologist went to order the standard panel of diagnostics, was denied. We were then sent to UCLA, where they didn't even have a room for us. We were sent there by the insurance company's telephone agent saying, hey, go there, they're ready for you, your authorization has been faxed. They weren't ready for us. My wife and my daughter spent the day, without food other than the hospital snacks, in the emergency room.

When I finally got off work, they were able to tell us—I joined them at the hospital. They were able to tell us that they weren't able to service my daughter that day; they had no beds; they didn't know we were coming. When they finally were able to admit us 2 days later, they immediately did their panel of diagnostics. Those diagnostics confirmed the diagnosis of infantile spasms. They set out the first course of treatment. The universally recommended course of treatment is a drug called ACTH.

The medical group would not return a phone call to the whole pediatric neurology department at UCLA, a prestigious medical

center. They would give them answers like, we'll call back today by 5, it's under review. After 6 days of being inpatient at UCLA, my wife and I were living with my daughter in the hospital room, the doctors came in and said, we're going to have to discharge you; we can't get any response from your insurance company—from your medical group.

After crying, I got angry. I tried calling the insurance company myself. I was hung up on twice for only asking for a supervisor in the tone of voice like I'm speaking to you today.

Finally, I called the State regulatory agency. They looked into it on my behalf, and we were able to mysteriously get an authorization over the telephone to UCLA and to my wife. No explanation, no written documentation, no anything. Clearly their plan was to exhaust us, to wear us out.

My time is coming to an end here. I have to just conclude with a final statement, if you will indulge me. Sidney's mom and I have spent so much time fighting to ensure her proper care that all too often I feel like her medical manager instead of her daddy. I need you people to let me be a daddy.

I understand there's a lot of talk and a lot of ideas. The Consumers Union is here today with their own ideas on ways we can put consumers back into this competition scheme I hear about because we're disenfranchised right now. All I want to do is go home and be a dad.

Thank you.

[The prepared statement of Mr. Gendernalik follows:]

Statement
Of
Mr. Mark Gendernalik
West Hills, California

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, September 16, 2009
2154 Rayburn HOB
10:00 a.m.

"Between You and Your Doctor: The Private Health Insurance Bureaucracy."

Mr. Chairman, Members of the Subcommittee:

Thank you for the invitation to testify today.

I am a schoolteacher with the Los Angeles Unified School District. A profession I chose in large part because it offered the benefits, especially health coverage, to allow me to provide for my family. About two and half years ago my wife, Bertha, and I welcomed twins into the world, a boy and a girl. Carter and Sidney arrived early, but thrived from the get go. They were soon home. All was well and they grew daily. Just before her three month "birthday", Sidney began experiencing weird episodes where her arm would jut out into full extension as she was falling asleep. The pediatrician advised us to watch the "seizures" closely, and I began to video tape their progression.

Soon we were referred to a pediatric neurologist, Dr. Roger Huf and the complicated cycle of referrals began. Dr. Huf started Sidney on an anti-seizure medication called Trileptal and ordered an MRI with contrast dye done at UCLA, with which he was affiliated. Regal Medical Group the agent for my HMO, Pacificare, denied the referral. In the meantime, Sidney returned to the Dr. Huf's office for an EEG. Regal Medical Group sent Sidney to the San Fernando Valley Interventional Radiology and Imaging Center, who could not administer the contrast dye into my infant daughter, because her veins were too small. I assume Regal saved some money, but Dr. Huf did not get the complete MRI he sought. Dr. Huf diagnosed Sidney with epilepsy.

Sidney continued to decline and become spacey and withdrawn. The seizures worsened. As a result Dr. Huf's diagnosis changed to a condition called Infantile Spasms. By November 8, 2008 we agreed with Dr. Huf to seek a second opinion, to confirm or refute this new diagnosis. Pacificare/Regal authorized us to take Sidney to Children's Hospital Los Angeles (CHLA) for a second opinion, but refused to allow CHLA to perform a new

EEG. Their stated reason was that CHLA was non-contracted. I have come to understand from the MRI experience non-contracted means too expensive. We called Children's Hospital Los Angeles immediately and thanks to my wife Bertha's persuasive speaking skills we managed to get an appointment for December 10, 2008. The new neurologist, Dr. Wendy Mitchell required us to bring an EEG. Dr. Huff had been authorized to conduct the new EEG but would be unable to accommodate us. Thanks again to Bertha's tenacity we were able to get sent to another neurologist, Dr. Raafart Saad Iskander, for the expressed purpose of having another EEG taken. Dr. Iskander told Bertha the EEG supported the diagnosis of infantile spasms.

At last, the misdiagnoses, the eleventh hour EEG, and time-consuming referral process were behind us. My wife took the day off work and made the trek into Children's Hospital Los Angeles. We were filled with hope that we might get an accurate diagnosis and help our daughter come back to us. The new (now third) neurologist, Dr. Mitchell, examined our daughter and the EEG report. She expressed dismay that it took approximately six months to get an accurate diagnosis and begin treatment for Sidney's degenerative condition. She immediately ordered Sidney to be admitted and commence a twenty-four hour EEG with video telemetry, as well a new MRI of Sidney's developing brain.

By this time I had begun doing my own research, and expected this, as it is the standard protocol recommended by the American Society of Pediatric Neurologists. Hopes were dashed again, when my wife called with the news that Pacificare/Regal had denied the request for the hospital monitoring and test. I immediately got on the phone with Regal and questioned them as to how THEY authorized the neurologist for us to see for an informed second opinion, and then refused to authorize the standard diagnostics necessary to create the informed second opinion we sought. They had no answer.

Soon however they claimed to have issued the referral for UCLA and provided an address for us to take Sidney to. They said the UCLA staff would be awaiting Sidney's arrival. I pressed them for an explanation. Their representative said their medical manager preferred UCLA. I countered that (A) They didn't like UCLA when the first neurologist requested the first MRI be done there and (B) Why then did they send us to Children's Hospital in the first place? I suggested this had more to do with dollars and cents, than what made good medical sense for my daughter. They told me I'd have to file a formal complaint to get my answers.

I called my wife, who was still waiting in Dr. Mitchell's office at Children's hospital. I relayed the address that the Regal Medical Group staffer had provided to me. She relocated to UCLA medical center, but found the address led to an administration building. Obviously at a wrong address, she again phoned me for assistance. I located an address for the UCLA Mattel Children's Hospital and guided her there over the phone. Upon arrival at the hospital, they put her and Sidney in the emergency ward. Bertha waited several hours as UCLA, struggling to make sense of the situation. They had not received a referral. Eventually, the final school bell rang and I drove to UCLA medical center to see my Sidney. Shortly after my arrival, Dr. Daniel Arndt came into the room

and told us we had to go home as they had no beds available for Sidney. We were told to expect a call in the next couple of days.

After a couple of long days of waiting, the call came to say that they had a bed for us. I took Sydney back to UCLA. The medical staff began to administer the twenty-four EEG. The following day the team of doctors reported that they concurred with the diagnosis of infantile spasms. Next they mentioned a drug I had read about, ACTH. They also mentioned it was an expensive drug and a course of treatment could cost over $100,000. No problem I've got insurance... right? Well, no.

Over the next seven days, Pacificare/Regal refused to authorize the drug. Our doctors had their telephone calls go unreturned, while Bertha and I fared no better. Pacificare/Regal was determined not to pay out this claim. Finally, after a week of watching my daughter continue to degrade in a hospital crib, and the doctors of the pediatric neurology team become demoralized, Dr. Arndt said they would have to discharge Sidney without the ACTH treatment. I implored him to give us one more day to get this resolved. Bertha and I worked the phones. I was hung up on by both Regal medical Group and Pacificare, for making the unreasonable request to speak to a supervisor. I eventually called the state capital in Sacramento, and found the Department of Managed Health Care. I was connected to a Nurse, I believe it was Anita Watson, who was able to listen to my concerns and take down the information and begin looking into the problem. She phoned me not long after and said her research confirmed the doctors' recommendation. She also said she would place a phone call to Pacificare. About an hour later both Bertha and the doctors at UCLA received the long-awaited phone call from Regal Medical Group with the authorization number for the needed drug, ACTH. We began the treatments soon after.

The toll it took upon my family will never be forgotten. The constant hassle of getting referrals for the correct services. The run-around to get the needed tests. The over-a-week recovery time lost to my daughter while we languished waiting for her meds. The months lost to an inaccurate diagnosis. The battle to get the medication approved. We did everything right. We worked hard and earned good medical coverage to protect us. Unfortunately, Sidney developed this rare and unexplained condition. Unfortunately she required extensive medical treatment. The one thing we can agree upon with the HMO is that we both wish Sidney had never gotten sick. We would have a completely healthy daughter and they could keep their money.

Consumers should not have to endure this kind of life-and-health threatening hassle. I hope Congress will find better ways to ensure that insurers deliver on the care they promise.

Continuing hassles

Unfortunately, the ACTH treatment was not successful. Sidney kept seizing, and kept losing ground on her developmental milestones. The treatment team at UCLA now recommended Vigabatrin. We expected this because that is what the research we had been reading suggested was the next line of defense. Vigabatrin came with its own perils. In particular it was known to be retina toxic and had the potential to damage the retina leaving the user with a reduced vision field.

Bertha and I were faced with a terrible decision. Do we risk our daughter's vision in order to grant her the best possible chance at a future complete with normal cognitive functioning, or do we maintain her sight and doom her to an almost certain future of severe mental retardation. We chose to proceed with the Vigabatrin treatment.

The doctors at UCLA had us complete a several page waiver explaining the risks of Vigabatrin and just as importantly the standard protocol designed to mitigate those risks. The protocol consisted of a series of specialized retina exams. First, there was an all-important initial, or baseline, exam to document the form and condition of her retinas before the drug had time to affect them. Then, there would be others to follow. Each subsequent exam would be compared to the first to evaluate the extent that any damage was occurring. This information would be weighed against any benefit the drug was offering, and we would make a decision to continue or not.

We began the treatment in late April of 2008. The referral for the retina exams was submitted to Regal Medical Group at that time. We were sent to Children's Hospital Los Angeles, where we received a June 23, 2008 authorization to see a Dr. Thomas Lee. Before the appointment to see Dr. Lee could be made, Bertha was informed by Children's Hospital that the appointment would be delayed because Regal Medical Group and Dr. Lee had not agreed upon a "rate sheet", or contract. Bertha called Regal Medical Group only to be assured that this would be resolved. It wasn't. After weeks of waiting the authorization was cancelled.

Next, Regal Medical group promised to make good on this situation and issued an authorization to Children's Retina Institute and a Dr. Khaled Tawansy. The Regal staff assured us that they had a contract with Dr. Tawansy and that he was approved to conduct the exam. Dr. Tawansy and his staff were the utmost in professionalism, received us for the initial consult and scheduled the retina exam for Huntington Hospital in Pasadena, California. On August 1, 2008 Regal Medical Group issued an authorization for the procedure to be conducted at Huntington Hospital. It was now three months after we were supposed to have the "baseline" exam conducted, but at least we were finally getting it done. More importantly we might get some idea if our baby girl's vision was still intact.

All was not as it seemed. Dr. Tawansy phoned on Saturday, August 2, 2008. Sidney was scheduled to go into surgery at Huntington Hospital the following Monday early in the

AM. The hospital had already called to take care of preadmission instructions. Dr. Tawansy seemed uneasy as he began to explain. He had received a phone call from Dr. Jeffrey Klein, Senior Medical Director at Regal Medical Group after 8:00 the night before. He asked if Dr. Klein had called us. We had not received any phone call from anyone at Regal Medical Group. He started by saying that Dr. Klein wanted him to move the surgery to a surgical center in Lynwood, California. I said, "No way." It soon became clear that Dr. Klein had cancelled the authorization, and if we went ahead as scheduled my family would have to cover the costs. Not a possible option. Dr. Tawansy in no way left me with the opinion that it was his first choice option. He remarked that he had already arranged for the equipment at Huntington Hospital. He also said that Dr. Klein suggested he tell us moving the procedure would save about seven thousand dollars towards Sidney's future care. I told him I have an unlimited policy and only Regal Medical Group would be saving money. Not only was Sidney going to face another delay, she was having her care downgraded to save the Medical Group some money.

I phoned the number Dr. Tawansy provided for Dr. Klein and left a message on his voicemail. I called all three numbers available on my Pacificare membership card. All three departments were closed, with no way to reach a live operator. I did receive a phone call from Joann at Regal Medical Group who informed me the authorization was no longer valid, but she would attempt to reach Dr. Klein.

Medical Group did authorize the procedure to be conducted by Dr. Tawansy at M/S Surgery Center in Lynwood, California. Worried about the traffic, I arrived especially early on the morning of November 21, 2008. As I drove up to the building, I was greeted by gang graffiti upon one of its walls. Not the kind of welcome I had hoped for. When the facility opened for business, I was greeted warmly by the staff and lead to a waiting area. The gentleman nearby was there for a worker's compensation injury. Others I saw as the day progressed appeared to be getting corrective laser eye surgery. As I waited for my daughter to be called in for Sidney's prep, I noticed a man who appeared to me to be a medical vendor of some sort. Unfortunately, Sidney and I spend a lot of time in doctor's offices and have seen far too many pharmaceutical sales representatives. This gentleman looked the type and asked for Dr. Tawansy at the receptionist counter. After he was lead back I confirmed with the receptionist that he was there to see Dr. Tawansy. Later, Dr. Tawansy would tell me that the surgical center didn't have the necessary equipment either he or his organization had to buy it. The vendor had been there to deliver it, as well as review its operation, just minutes before it was to be used on my daughter.

In the end, almost seven months after we were supposed to establish a baseline, Sidney did get the eye exam she needed. To the best of Dr. Tawansy's abilities she has maintained healthy retinas. Due to her cognitive deficits she is unable to report any problems with her vision. Ultimately the Vigabatrin did not produce good enough seizure control to warrant its risks. We discontinued treatment with it by March of 2009.

Consumers should not have to endure this kind of life-and-health threatening hassle. I hope Congress will find better ways to ensure that insurers deliver on the care they promise. The stress of constantly having to hold the HMO and their agents to their agreed

upon obligations has relegated me to the role of my daughter's care manager, and all to often robbed me of my role as Sidney's loving daddy.

Sidney Gendernalik
Relevant Chronology

Delay of Service: Withholding Authorization for ACTH

03-20-2007	Born as twin B at 32 weeks gestation spent 7 days in the Neonatal Intensive Care Unit (NICU) in order to make benchmarks for discharge. Unremarkable stay, breathing unassisted and feeding well.
06-29-2007	Approximate date parents first noticed unusual stiffening of right arm and head. Father, Mark Gendernalik, was holding her as it occurred.
07-02-2007	Sidney is taken to her pediatrician, Scott Calig, regarding unusual movements for the first time. Dr. Calig suggests it may be *hypnogogic Phenomena* as each occurrence is closely related to sleep. Advises the parents to watch carefully for any changes.
07-12-2007	Sidney's father returns to the pediatrician with a videotape of recent episodes Sidney has experienced. Dr. Calig suggests a referral to a neurologist.
07-25-2007	Sidney's first exam by neurologist, Roger Huf. Dr. Huf prescribes Trileptal (Oxcarbazepine). Dr. Huf requests MRI with contrast to be conducted at UCLA Medical Center and an EEG.
07-27-2007	Sidney undergoes an EEG at Dr. Huff's office; Begins treatment with Trileptal (ovcarbazepine).
07-28-2007	Regal Medical Group (agent for PaifiCare insurance company) denies authorization for UCLA Medical Center, and instead authorizes San Fernando Valley Interventional Radiology and Imaging Center to conduct the MRI. Dr. Huf's office is authorized to conduct the EEG.
08-09-2007	San Fernando Valley Interventional Radiology and Imaging Center conducts the MRI, but fails to successfully inject the contrast dye. The resulting MRI is adequate but not as thorough as hoped for. It does not however reveal any structural damage or defect to Sidney's brain.
10-26-2007	On or about this date Sidney is taken off the Trileptal due to a lack of progress and parental concerns.
11-08-2007	Due to inferential nature of the diagnosis of infantile spasms, Sidney's parents and Dr. Huf agree to seek a second opinion to potentially confirm diagnosis of Infantile Spasms. Dr. Huf recommends a new EEG and treatment with ACTH or Vigabatrin. On or about this date Dr. Calig

initiates referral to Children's Hospital Los Angeles for second opinion and new/updated EEG.

11-13-2007 Regal Medical Group denies a new EEG at Children's Hospital Los Angeles, but does authorize Dr. Huf to conduct a second EEG. Dr. Huf refused to do so citing scheduling concerns.

12-04-2007 Regal Medical Group cancels EEG authorization for Dr. Huf and issues a new authorization for a new neurologist, Dr. Raafart Saad Iskander.

12-07-2007 On or about this date, Dr. Raafart Saad Iskander conducts EEG.

12-10-2007 Sidney is seen by Dr. Wendy Mitchell, Children's Hospital Los Angeles. After Dr. Mitchell reviews case notes and examines Sidney she makes the following recommendations: a video EEG, organic workup, metabolic workup, lumbar puncture, and new medication, possibly ACTH. Regal Medical Group, via telephone, refuses to authorize Dr. Mitchell to conduct any of the above tests. Sidney's father telephones Regal Medical Group, while Sidney's mother, Bertha Valentine, awaits resolution in Dr. Mitchell's waiting room. Regal employee responds by issuing a new referral authorization for UCLA Medical Group. The Regal representative provides an address and assures Mr. Gendernalik the authorization will be faxed over. Ms. Valentine is relayed the address and departs for UCLA, only to find the address was incorrect and blocks away from the correct location. After getting the correct address from Mr. Gendernalik, she and Sidney arrive at UCLA Mattel Children's Hospital to find that no one there has any idea who they are or why they are there. The referral never arrives. Eventually Mr. Gendernalik is off work and joins Sidney and Bertha in the emergency room. UCLA fellow, Dr. Daniel Arndt reviews Sidney's case with the family, explains there are no beds available, and discharges the family with a plan to contact them once a bed is available.

12-12-2007 Sidney is admitted into the UCLA Mattel Children's Hospital. An EEG with video telemetry begin.

12-13-2007 The EEG with video telemetry concludes.

12-14-2007 UCLA treatment team confirms the diagnosis as Infantile Spasms. Dr. Daniel Arndt informs Mr. Gendernalik that the team recommends ACTH, but offers concern, as there has been a recent jump in the price of the drug. He states that the hospital is contacting the insurance company.

12-15-2007 Dr. Daniel Arndt states the hospital has not yet received any authorization from our medical group.

12-16-2007 No authorization or denial.

12-17-2007 No authorization or denial.

12-18-2007 No authorization or denial.

12-19-2007 No authorization or denial.

12-20-2007 No authorization or denial.

12-21-2007 Dr. Daniel Arndt informs Mr. Gendernalik that the medical group has not authorized the ACTH treatment, nor even returning calls or commitments to call with a decision. The hospital will be forced to discharge Sidney. Mr. Gendernalik pleads for one more day so that he and Ms. Valentine can make an attempt to resolve the matter. Ms. Valentine contacts Regal Medical Group repeatedly. Mr. Gendernalik does likewise and is hung up on when he asks for a supervisor. Mr. Gendernalik calls Pacificare. After more than a half hour on the phone, most of that time on hold, Mr. Gendernalik is hung up on after again trying to reach a supervisor. Mr. Gendernalik then calls the California Department of Managed Health Care. He is treated respectfully by the initial staff member then transferred to a registered nurse on duty, believed to be Anita Watson. Mr. Gendernalik explains Sidney's diagnosis, the recommended course of treatment, and the problem that Regal Medical Group/Pacificare have not responded for the past seven days. He further explains the impending eviction from the hospital without adequate treatment. After approximately one hour or more, Mr. Gendernalik received a follow-up call from the California Department of Managed Health Care nurse stating that she had researched the diagnosis and treatment options. She believes that ACTH is appropriate. Further she states that she has put a call into the Regal Medical Group on Sidney's behalf. In the coming hours, Ms. Valentine receives a phone call from a staff member at Regal Medical Group with an authorization code. The Pediatric Neurology team at UCLA receive a similar phone call. By 10:12 PM Dr. Arndt is finally able to order the ACTH Sidney requires. Sidney begins her ACTH treatments.

12-22-2007 Over the last two days nurses train Mr. Gendernalik and Ms. Valentine how to administer intramuscular injections of ACTH. Sidney is discharged.

Sidney Gendernalik
Relevant Chronology

Delay of Service: Withholding, Canceling, Discounting Surgical Eye Exam

04-21-2008 After several other drugs have been tried without success, Sidney's parents, Bertha Valentine and Mark Gendernalik, agree to her treatment with the drug Vigabatrin. The doctors of the UCLA pediatric neurology department counseled them about the drug. In particular that the drug is known to be retina toxic and may cause a reduction in Sidney's vision field. They are assured that this risk can be mitigated by the careful examination of her retina by a special test at the onset of treatment and then periodically throughout her treatment. An authorization for the test is requested from Regal Medical Group, and the Vigabatrin treatment begins.

06-23-2008 After weeks of trying to arrange for the retina exam, Regal Medical Group issues an authorization for Dr. Thomas Lee of Children's Hospital Los Angeles (CHLA) to conduct the surgical retina exam (electroretinography) Sidney requires. [This authorization was never honored as]

07-07-2008 Mr. Gendernalik attempts to contact both Pacificare and Regal Medical Group to complain about the delay of service. It is now more than two months since the baseline exam was to take place.

07-08-2008 Mary Miranda of CHLA confirms that Regal Medical Group could not agree upon a rate sheet (fees) with Dr. Lee. Mr. Gendernalik speaks with Ralph Brooks of Pacificare Dispute Resolution Department.

07-09-2008 Mr. Brooks of Pacificare Dispute Resolution Department states he is trying to speak with Mary Miranda of CHLA to resolve the matter. Robert Perez of Regal Medical Group calls to inform Mr. Gendernalik of a new authorization to see Dr. Khaled Tawansy. Mr. Perez confirms that Regal Medical Group does have a contract with Dr. Tawansy and the hospital needed to conduct the exam.

07-10-2008 Sidney is seen by Dr. Tawansy and an appointment is made to conduct the retina exam at Huntington Hospital in Pasadena, California on August 4, 2008, more than three months after the baseline exam was to supposed to occur.

08-01-2008 4:31 pm (as per fax date stamp) Regal Medical Group issues an authorization for the procedure to be conducted at Huntington Hospital. Huntington Hospital phones Mr. Gendernalik to conduct preadmission interview and provide preop instructions.

08-02-2008 Dr. Tawansy phones Mr. Gendernalik at home and states that Dr. Jeffrey Klein, Senior Medical Director at Regal Medical Group phoned him after 8:00 pm last night to cancel the authorization. Dr. Tawansy states that Dr. Klein is moving the authorization for the procedure to a surgical center in Lynwood, California. Mr. Gendernalik attempts to contact Dr. Klein without success and is told if he keeps the appointment for August 4th it will not be covered by insurance.

11-21-2008 Two days short of seven months after the baseline image was supposed to be taken, Sidney undergoes her retina exam at M/S Surgery Center in Lynwood, California. The facility is staffed by friendly professionals, but there are some nagging concerns. The facility was prominently marked up by gang graffiti on at least one side as Mr. Gendernalik drove up to it. The clientele consisted of a workers compensation claim, and others that seemed to be receiving corrective laser eye surgery. Dr. Tawansy had never done the procedure in a surgical center before, had to purchase the equipment just for Sidney's procedure and the equipment was delivered by the sales representative immediately before the procedure. At the conclusion of the surgical retina exam, Dr. Tawansy informed Mr. Gendernalik that the exam showed no signs of damage to Sidney's retina. While Mr. Gendernalik believes in Dr. Tawansy's professional abilities his concerns are not entirely laid to rest, as there never will be a baseline to compare with. This exam, in this location, under these circumstances was a case of too little, much too late.

Mr. KUCINICH. The Chair recognizes Ms. Ackley.

Thank you, Mr. Gendernalik.

STATEMENT OF ERINN ACKLEY

Ms. ACKLEY. Mr. Chairman, members of the committee, thank you for inviting me to participate in today's hearing on health reform. I am honored to have the opportunity to convey my family's struggle with the administrative measures and protocols used by my father's private health insurer and the lengths we went through to obtain his doctor-prescribed treatment in the form of a bone marrow transplant.

This is an abbreviated version of our emotional journey as my dad fought for his life when his insurance company set up one bureaucratic roadblock after another.

My father Bill Ackley dedicated 31 years of his life to the children of Montana as a public schoolteacher and administrator. In 2003, he retired to Florida, trusting his group health insurance, Blue Cross Blue Shield of Montana, would continue to pay, as they had for 16 years, for the medically necessary treatment of his chronic lymphocytic leukemia.

In 2005, my dad's doctor determined that he needed a bone marrow transplant because his chemotherapy regimen was no longer effectively managing his cancer. My father was accepted into a transplant program, and on December 11, 2005, an unrelated donor match was found.

In January 2006, my dad began two rounds of intensive chemo to suppress the disease in preparation for his transplant; 4½ months after finding a donor, we were euphoric on April 14th when my dad's transplant doctor gave him the news that his disease had responded well to the treatments, and he was ready to proceed with a mini transplant. However, we marked this as day 1 of our unexpected and emotional struggle with Blue Cross Blue Shield of Montana.

Because his insurance had paid for all of the treatments leading up to the transplant, including the donor search and testing, you can imagine how shocked and heartbroken we were a week later when his insurance notified the hospital, not my parents, that it was denying the mini transplant, claiming the procedure as investigational.

For the next 60 days, we continued to run around in circles with the insurance company, never actually speaking to a human who could discuss my dad's case, to obtain approval for my father's prescribed treatments while his body was still receptive to a transplant. On the surface this might not seem like a long time, but when a loved one is going through a life-or-death struggle, you can hear the clock ticking every minute.

My dad's doctor submitted a different request for a full transplant, which had been performed for nearly 20 years, but that, too, was denied on grounds that it was investigational. It is important to note that both transplant protocols were approved treatments under Medicare.

Neither of the two time-consuming approval processes my dad went through in an effort to overturn the denials were completed in the promised timeframe, and during this agonizing time we

reached out to the Montana Insurance Commissioner's Office, who persisted in keeping the insurance company in compliance. We enlisted the help of countless friends and families to hold the insurance company accountable on my father's behalf, and we then consulted an attorney who had experience litigating transplant denial cases.

On day 48, my Dad was readmitted for another round of intensive chemo as his cancer was growing rapidly again because we were waiting for transplant approval. We were emotionally exhausted, frustrated and devastated that we had to continue focusing our time and energy on holding this insurance company accountable instead of spending quality time with my father and concentrating our efforts on his care.

Due to his persistence and refusal to accept that unreasonable insurance company denials would be the deciding factor in his life-and-death struggle with the disease he had lived with for 20 years, my dad was finally transplanted with the stem cells of a selfless anonymous donor on August 17th, 126 days after the first transplant request.

What would have happened if the first transplant request had been approved? We will never know. We do know that he never returned home. We spent Christmas with him in his hospital room, and he did make it to the new year. My dad passed away on January 3, 2007, at the age of 59, leaving behind a grieving widow and daughter and missing the chance to share his joy of life with his only grandchild Eliza, born 17 months later.

My written testimony includes a very detailed timeline of our struggle with my father's insurance company, and I sincerely hope that you will read it and consider the implications of how an agonizing and bureaucratic denial and appeal process changed the course of my father's treatment and affected his chance for a successful life-saving transplant.

Thank you.

Mr. KUCINICH. Thank you for your testimony.

[The prepared statement of Ms. Ackley follows:]

Written Testimony
Of
Erinn Ackley
(Daughter of William Ackley, Red Lodge, MT.)

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, September 16, 2009
2154 Rayburn HOB
10:00 a.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy."

Mr. Chairman and Members of the Subcommittee,

Thank you for inviting me to participate in today's hearing on health reform. I am honored to be given the opportunity to convey my family's struggle with the administrative measures and protocols used by my father's private health insurer and the lengths we went through to obtain his doctor-prescribed treatment in the form of a bone marrow transplant.

In 1986, my father, William (Bill) Ackley, was diagnosed with Chronic Lymphocytic Leukemia (CLL) at the age of 39. CLL mainly affects people over 60 and is rare in people under the age of 40. Dad was an avid sportsman and maintained a healthy lifestyle. He was especially devoted to running, competing in numerous races, including marathons, even after his diagnosis. Until 2001, he and his oncologist were able to keep his disease from progressing and interfering with work or family and social obligations through intermittent cycles of oral chemo medication. In 2001, his disease reached a stage where more aggressive treatment was necessary, and he underwent IV chemotherapy treatments for approximately four months, which put the disease into remission. In 2003, at the age of 56, he retired from a 31-year career in elementary education as a teacher, principal, superintendent, and coach in the state of Montana. Upon his well-earned retirement, he and my mom, Marjory, moved to Ormond Beach, Florida. He retained his health insurance through the Troy Public School District group coverage plan through Blue Cross Blue Shield of Montana (BCBSMT), the same insurance coverage he had for all but the first year after his CLL diagnosis.

June-September 2005: In June of 2005, his CLL became active again, and he began IV chemo treatments as prescribed by his oncologist in Ormond Beach. By September 2005, it was evident that the chemotherapy was not effectively managing his cancer, and he was referred to Shands Hospital at the University of Florida in Gainesville. Shands has one of the top bone marrow transplant centers in the nation, and my father was accepted into their transplant program.

October-December 2005: The testing of my father's three siblings did not find a transplant match. A search for a non-related donor began in October 2005 through the National Marrow Donor Program. The best of four

suitable donor matches was selected on December 1, 2005—Shands had found the anonymous person who was willing to selflessly let the stem cells from his/her marrow be harvested for my dad's transplant.

January 4-February 14, 2006: On January 4, 2006, transplant evaluations at Shands Hospital were scheduled to begin. My father was admitted to a local hospital in Ormond Beach on January 30, 2006, for large doses of chemotherapy ("salvage chemo") to eradicate as much of his disease as possible in preparation for transplant. After 15 days, he was discharged on February 14, 2006.

February 28-March 28, 2006: After reviewing CT scans and other test results, his doctors at the Bone Marrow Transplant (BMT) Unit at Shands Hospital requested that my dad have another round of inpatient chemotherapy in Ormond Beach. He was readmitted to the Ormond Beach hospital on February 28, 2006, for his next round of intensive "salvage" chemotherapy. After nearly a month, on March 25, 2006, my father was discharged and then traveled to Shands Hospital on March 28, 2006, for pre-transplant tests.

April 13, 2006: On April 13, 2006, my dad met with his transplant doctor at Shands, Dr. Jan Moreb, and received the great news that the tests of the past couple weeks indicated his CLL had responded well enough to the two rounds of aggressive inpatient chemo that they were ready to proceed with the transplant. My dad signed his releases for treatments and trials. At this point, BCBSMT had covered my dad's expenses for his outpatient and inpatient pre-transplant treatments and tests, as well as the testing of donors identified through the National Marrow Donor database. On April 14, 2006, Dr. Moreb made a formal request for authorization from BCBSMT for a non-myeloablative transplant, also known as a "mini transplant." "Mini transplants" had been successfully used on CLL patients and are characterized by giving patients less intensive dosages of chemotherapy than standard transplants, resulting in fewer side effects.

April 18, 2006: BCBSMT informed the Bone Marrow Transplant Unit at Shands on April 18, 2006, that they had asked an outside "qualifier" to look over my father's case. The BMT coordinator at Shands stated to my parents that the hospital had never had any problems with approval for the mini transplant for CLL patients through Blue Cross Blue Shield of Florida and was optimistic that BCBSMT would also approve the procedure. Shands had submitted 46 pages of abstracts, studies, medical reviews, and statistics in support of the transplant protocol when it was submitted for approval. In an e-mail at this time, as he waited for word from BCBSMT, my dad stated "These guys are just playing with my life."

April 20, 2006: Two days later on April 20, 2006, the BMT coordinator at Shands was notified that the "mini transplant" procedure was denied by BCBSMT and immediately informed my parents of the denial. The doctor who made the determination for BCBSMT cited an outdated 2003 article as the justification for classifying the mini transplant as "investigational" for treating CLL patients. It is important to note that, at this time, CLL was one of the diseases listed as covered for transplant under federal funding guidelines, including those used for Medicare and Medicaid. It was not until four days later, on April 24, 2006, that my parents received notification by letter from BCBSMT.

April 26, 2006: On April 26, 2006, the consensus among the transplant doctors in the BMT Unit at Shands Hospital was that my dad should request an expedited appeal of the mini transplant, as that was the preferred treatment and my dad's "life or health would be seriously threatened by the delay of a standard 60 day reconsideration process." Dr. Moreb from Shands provided additional abstracts to BCBSMT to demonstrate response rates in more recent data refuting the statistics from the 2003 article that was used to justify the transplant denial. My mom began phoning and faxing back and forth between Shands Hospital and BCBSMT to set the expedited appeal in motion. On this day, my family contacted the Montana Insurance Commissioner's Office in an attempt to enlist their assistance with overturning the denial of my dad's bone marrow transplant.

April 27, 2006: The next day, on April 27, 2006, the Montana Insurance Commissioner's Office contacted BCBSMT requesting a copy of the Troy Public School's group coverage plan. Until the Insurance

Commissioner's office received written verification from BCBSMT that Troy Schools did not have a "self-funded" plan (they did not), the commission had no jurisdiction. On this day, the expedited appeal was in the hands of the Mountain Pacific Quality Health Foundation in Helena, Montana. The Montana Department of Public Health and Human Services had designated the Foundation as the organization that would perform the independent review. The Foundation was to have notified the member (my father), the provider (Shands Hospital), and BCBSMT of its decision within 48 hours (not including Sunday). As of May 2, 2006 (five days after the Foundation had received my dad's expedited appeal), neither my father nor Shands had received notification of the Foundation's decision.

April 28, 2006: By April 28, 2006, the BMT Coordinator at Shands had supplied information specific to the history of mini transplants at Shands to BCBSMT and the Insurance Commissioner's Office. Shands had begun performing mini transplants six years earlier in 2000. From 2003-2006, Shands performed mini transplants on 37 patients with various diagnoses. Three of those mini transplants were performed on patients with CLL. Two of the three people with CLL had Blue Cross Blue Shield coverage from states other than Montana.

May 1, 2006: On May 1, 2006, my family and a network of family and friends from across the country began a letter-writing and e-mail campaign to elected officials representing Montana in both state and national offices requesting any possible investigation or intervention to hold BCBSMT accountable for the transplant denial which was endangering the successful treatment of my father's disease and his life.

May 3, 2006: On May 3, 2006 (six days after the Foundation had received my dad's expedited appeal), the BMT Coordinator at Shands informed my dad that the expedited appeal did not reverse the original denial of the mini transplant. My parents did not hear directly from BCBSMT until a letter was received in the mail three days later, on May 6, 2006. The BMT Coordinator told my parents that Shands would submit another protocol for a "full transplant,", a procedure that had been performed at Shands for nearly 20 years. Shands is only one of the more than 70 transplant centers across the United States affiliated with the National Marrow Donor Program that performs bone marrow transplants on CLL patients. This is not an investigational or untried treatment for CLL.

May 7, 2006: In support of my dad, employees of Troy Public Schools contacted their insurance representative on May 7, 2006, in the hope that the insurance representative could personally contact BCBSMT and assist my father in receiving his prescribed treatment.

May 12, 2006: On May 12, 2006, Shands' BMT Coordinator informed my parents that the full transplant protocol was also denied on the terms that the transplant was an "investigational" treatment for CLL patients. At this point, the Montana Insurance Commissioner's Office still had not even been able to obtain a copy of my dad's insurance plan that was originally requested (and repeatedly requested thereafter) 16 days previously. The Bureau Chief of Policyholder Services from the Montana Insurance Commissioner's Office even volunteered to walk over to the BCBSMT office three blocks away to pick up the documents by hand.

May 15, 2006: Another letter-writing campaign to Montana's elected officials ensued on May 15, 2006. The staffs of some of these officials made inquiries to the Montana Insurance Commissioner's Office and BCBSMT trying to find a way to intercede within legal guidelines. If not before, BCBSMT was now aware of the interest its denial of my dad's transplant was generating.

May 23, 2006: As a last resort, my parents contacted the Blood & Marrow Transplant InfoNet Patient Advocacy group requesting a referral to an attorney who had experience with similar cases. In the following days, my family was referred to an attorney in Virginia with experience in litigating transplant denial cases. Pertinent documents were delivered to him on May 23, 2006, and subsequent consultation occurred soon thereafter. The attorney reviewed the denial letters, insurance policy, and letters from my dad, his doctor, and the National Marrow Donor Program Office of Patient Advocacy. The attorney said he was at a "loss" as far

as BCBSMT's denial on the grounds that the transplant procedure(s) are "investigational," since a transplant is standard protocol for a patient with CLL in the stage that my dad was experiencing.

May 26, 2006: After speaking with the attorney, it was decided that my dad would request an expedited appeal of the denial of the second proposed (full) bone marrow transplant protocol. Request for this expedited appeal was faxed to BCBSMT on May 26, 2006, accompanied by a letter from Dr. Moreb and a letter from the National Marrow Donor Program. The National Marrow Donor Program also provided nearly 40 pages of compelling documentation, including clinical studies and journal abstracts, to "Illustrate that allogeneic (non-related donor) transplant for the diagnosis of CLL is neither investigational nor experimental."

At this time, the Insurance Commissioner's Office finally had secured a copy of the BCBSMT contracts for the Troy School District health insurance plan and was proceeding with a review. The Insurance Commissioner's office called BCBSMT to inquire whether they had received my father's request for a second expedited review. The call ended up in voicemail, and they received no response. The Insurance Commissioner's office also contacted the BMT coordinator at Shands inquiring whether the medical director at BCBSMT had made an attempt to speak with Dr. Moreb. The BMT coordinator replied that no attempt had been made. Under Montana code 33-32-201(4), a "determination made on appeal or reconsideration, that health care services rendered or to be rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the health care provider." It seemed that BCBSMT was in non-compliance with this statute, and subsequent to the Insurance Commissioner's Office addressing this, the BCBSMT doctor did finally call and speak with Dr. Moreb the following week.

A nephew of my dad who lives in California and is an insurance company executive discovered that a doctor who was one of his colleagues knew a doctor in Montana with a personal connection to the President of BCBSMT. The Montana doctor volunteered to try to facilitate a direct conversation between BCBSMT's President and myself. This turned out not to be possible, but he did converse with me before talking with her himself, making her personally aware of my dad's treatment denials and appeals.

May 30, 2006: On the same day that this doctor spoke directly to the BCBSMT President, May 30, 2006, the Montana Insurance Commissioner's Office delivered a letter and several documents to BCBSMT asking for a response by noon the next day (May 31, 2006) regarding my dad's situation. Also on this day, the Troy Public School's insurance representative had a conference call with the Medical Director and the President of BCBSMT. All of these connections were aware of the fact that my parents had been in consultation with an attorney.

May 31, 2006: BCBSMT replied to the Montana Insurance Commissioner's Office on May 31, 2006, that my dad's expedited appeal had been delivered to the "Foundation" for *two* peer reviews on the morning of May 30 and that there was no way BCBSMT would have a response back from the Foundation by noon on May 31, as had been requested by the Insurance Commissioner's Office.

On May 31, due to the delay in obtaining authorization for the transplant first submitted by Shands a month and a half previously (on April 14, 2006), my dad's cancer was once again growing rapidly, and my dad had to be readmitted to the Ormond Beach hospital for another round of intensive "salvage" chemotherapy.

In an e-mail dated June 1, 2006, my mom wrote, "Dad is so counting on a reversal of the denial this time around and I think that is why his frame of mind (and even his physical energy level, appetite and mental focus) is so improved the past few days."

June 2, 2006: After weeks of trying for a face-to-face meeting, on June 2, 2006, the Bureau Chief of Policyholder Services from the Insurance Commissioner's Office was finally able to meet with someone from BCBSMT and express her concerns about the appeal process of my dad's transplant denial.

June 7-9, 2006: The insurance representative for Troy Public Schools informed my parents five days later, on June 7, 2006, that BCBSMT had reversed the denial and decided to cover my dad's transplant. Two days later, on June 9, 2006, my parents received a faxed copy from the Insurance Commissioner's Office of the letter from BCBSMT stating approval for my dad's transplant. The staffer at the Montana Insurance Commissioner's Office had been waiting all day to receive the official letter from BCBSMT. She stayed past her normal work hours to receive the document at 5:00 pm (MDT) and fax it to my parents in Florida. The peer review that BCBSMT decided to go with was a second one that leaned toward the non-myeloablative transplant (the mini transplant protocol originally submitted in April) over a myeloablative ("full") transplant.

June 10, 2006: The next day, June 10, 2006, my parents received a letter in the mail from the Foundation based on the opinion of the *first* peer review doctor (the doctor who denied my dad's first appeal) stating that he had not changed his mind and still believed that the transplant was "investigational" regardless of the different protocol submitted. If not for the staff at the Montana Insurance Commissioner's Office who had faxed the letter overturning the denial the night before, my parents would have believed the Foundation letter upholding the denial of full transplant was the final decision of BCBSMT, resulting in more emotional pain.

June 12-13, 2006: Two days later, on June 12, 2006 (13 days, not 48 hours, after the Foundation received the appeal), my parents finally received a letter from BCBSMT stating what the Troy Public School's insurance representative had told them five days earlier: The denial of the medical necessity of my dad's transplant had been overturned. The next day, on June 13, 2006, my parents received another letter from BCBSMT that had "CORRECTED LETTER" in bold type on the top and had inserted (also in bold type) into the original letter that my dad could have either the non-myeloablative (mini transplant) or myeloablative (full) transplant. In the end, both denials were reversed, *two months after* my dad's doctor requested approval for prescribed treatment.

At this point, it is important to once again remember that the bone marrow transplant that had been denied to my father as experimental and investigational by BCBSMT was a covered treatment under federal funding guidelines, including those used by Medicare and Medicaid for CLL patients. Had my dad been a few years older with Medicare coverage, his transplant would have been approved in April of 2006.

Because we had no central advocate to turn to during the agonizing process leading up to BCBSMT overturning its denial of my dad's transplant, we had to enlist the help of numerous others to fight on behalf of my father and persuade the insurance company to approve his prescribed treatment. Just how many people did it take?

- It took dozens of friends and family who wrote letters and sent e-mails to anyone in a position of authority they thought could help.
- It took the doctors and staff of the Bone Marrow Transplant Center at Shands in Gainesville, who spent countless hours documenting the necessity of my dad's transplant with a compilation of research documents and abstracts and devising a transplant treatment protocol that would be accepted.
- It took the support staff at the National Marrow Donor Program, who took the time to assemble more than 40 more pages of scientific data in support of the transplant.
- It took the dedicated staff in the office of the Montana Insurance Commissioner's Office, who persisted in keeping BCBSMT in compliance with the regulations of the appeals process and spending extra time to keep our family updated on events when the insurance company itself did not.
- It took the local representative of Troy School's BCBSMT health plan, who tried to personalize this case to the executives of BCBSMT.
- It took the connected individuals stretching from my cousin in California to the President of BCBSMT and the time they gave to help a person they had never met but whose cause they supported.
- It took the attorney in Virginia, whose reputation certainly signaled to BCBSMT the seriousness of my parents in pursuing all avenues to overturn the denials.

- And most of all, it took the unwavering persistence of my parents, who refused to accept that the unreasonable denial of my dad's transplant by an insurance company would be the deciding factor in my dad's life-and-death struggle with the disease he had lived with for 20 years.

At no time during this life-consuming denial and appeal process were my parents able to speak with a "real person" at BCBSMT. The only people my parents could get hold of on the phone were service representatives, who could only refer my parents to the steps listed for appeal on the denial letters. The service representatives were unable to connect my parents with a person who could discuss my dad's case or even give my parents a phone number to reach such a person. All correspondence with BCBSMT occurred in front of a faceless fax machine, and all of BCBSMT's communications with my parents was via USPS mail that lagged by critical days the decision dates on the denials of prescribed treatments and the decisions on my dad's expedited appeals.

One would think the paying member would be valued enough that he/she shouldn't have to rely on third parties such as hospital staffs, group plan representatives, or staff members of the state insurance commissioner's office to notify him/her of appeal process outcomes as they happen. Why should third parties be notified via phone or fax while the member waits for the USPS to carry letters across the country?

August 17, 2006: Due to the selfless diligence of an anonymous donor who had been scheduled and rescheduled, was subject to multiple physical exams, received daily drug injections for five days prior to the donation to help move blood-forming cells out of his/her marrow into his/her bloodstream and for 4-6 hours donated his/her stem cells at an apheresis center, my dad did have his bone marrow transplant on August 17, 2006. It took from June until mid-August for him to finish the last inpatient chemo regimen begun on May 31 at his local hospital, be re-evaluated once again for transplant at Shands, go through several weeks of blood growth factor injections to increase his blood counts to a level where it was safe to start pre-transplant treatments and enter into the transplant protocol of chemo and radiation at Shands in Gainesville in the Bone Marrow Transplant Unit. The protocol that was finally used was midway between the mini- and full transplants.

January 3, 2007: Though the results of the transplant initially looked promising, within a couple of months, the cancer cells in my dad's bone marrow began winning the fight against the healthy donor cells. My dad was never able to return home to Ormond Beach from Shands in Gainesville. He celebrated Christmas in his hospital room in the Bone Marrow Transplant Unit with my mom Marjory, my husband Dan, and me—a room that we decorated with a small tree, garlands, and lights. My dad, from his hospital bed hooked up to IVs, told us in all sincerity that it "was the best Christmas I ever had." He made it into the New Year, but on January 3, 2007, at the age of 59, he passed away.

Would there have been a different end to my dad's story if he had been given approval of the first transplant request in April 2006? Would he be alive today to play with his only grandchild, Eliza, who was born 17 months after his death? We don't know. What we do know is that his chance for survival most assuredly did not increase because, after supporting and paying for the prescribed treatments deemed necessary for the control and suppression of his disease for 19 years, Blue Cross Blue Shield of Montana built the bureaucratic roadblocks that changed the course of my father's treatment and made him wait four months for his potentially life-saving bone marrow transplant.

Respectfully submitted by,

Erinn C. Ackley
Red Lodge, Montana

Mr. KUCINICH. The Chair recognizes Dr. Stern.

STATEMENT OF MELVIN S. STERN

Dr. STERN. Thank you, Chairman Kucinich, members of the committee, for this opportunity to appear before you today. I am here on behalf of the patients and families that I take care of, the American Academy of Pediatrics, the Maryland chapter, and the National Physician Alliance.

As has already been noted, I've been in practice in primary care pediatrics for approximately 30 years in Maryland and have spent a fair amount of that time advocating for my patients and my families in the public policy arena. And one of the templates that I utilize for reviewing public policy is if it makes sense for children, it makes sense for the community. If it doesn't make sense for children, we better go back and reexamine it, and based on that, go forward with the remainder of my evaluation here.

We've discussed the bureaucracy, the bureaucracy of both the private insurer, the for-profit, as well as the not-for-profit.

In 2003, Steffie Woolhandler observed that 30 percent of our health care budget, 30 percent of the dollars that we sent in, is now spent on administration, and that's in the private sector.

As an example of what goes on and how that impacts and has resulted in what happens in the private office, when I started private practice over 30 years ago, there were two full-time equivalents that were supporting me. One was a nurse who was fully involved in patient care, did nothing in terms of administration, and the other was a secretary-receptionist who basically handled the scheduling and the billing.

Today I'm still the solo practitioner. I have four full-time equivalents in the office. I am the only one who is exclusively involved in patient care. The other individuals are involved in chasing after insurance companies; doing things like referrals, prior authorizations; and arguing for benefits for my families, certainly a dramatic increase in bureaucratic meddling, as it were, in the office procedures.

For the bureaucracy that we see in the private sector, the impact, as you've already heard—and I'll give you a scenario in my office of a newborn with a tumor. This baby was born with a tumor at a world-class hospital in Baltimore and was insured by a for-profit insurer. From the time the baby was born, this insurer required referrals.

Now, recognize, I had never seen this baby. I was not medically in charge of this baby. For me to begin to refer this baby for additional services at an institution that had world authorities in regards to what should be done and how this tumor should be handled was just sheer nonsense and an obstruction for the care. It obstructed it to the point where there were therapies and evaluations that were remiss, were not obtained in a timely manner. But in the end, those therapies went forward initially.

The administrative burden was very real. The institution itself had people working in conjunction with my office to get the referrals, to do the paperwork; not to do the medical care, but to do the paperwork to get this child the care that she needed.

Following the inpatient treatment, which required surgery, the child underwent—began outpatient chemotherapy. It was at that point that the insurance company became obstructionist and, utilizing the Milliman and Robertson criteria for evaluation of whether this service should be paid for, denied inpatient chemotherapy services for this infant.

Now, you need to understand, there are no Milliman and Robertson criteria for infants with tumors, but they refused to recognize that and proceeded to say, no, they were not going to permit this baby to have inpatient services.

The only reason that we're able to move forward with that is I bluntly told them, look, either provide this infant with what are clearly standard treatments in the hospital, or we will have to go public. This is a beautiful baby, it will attract a great deal of attention; you can either deal with this in the media or deal with this appropriately. And they chose at that point to say, OK, we'll get things organized.

That's not the way we need to run the health care system. That's not the way I need to be spending my time. This invasion and obstruction is not very productive.

And finally, I'd like to leave you with a notion or the issue of two things. One, this is not really an issue of insurance coverage. Please understand, this is an issue of access to quality health care, and Mr. Cummings is painfully aware of a youngster in our community, Deamonte Driver, who had coverage but did not have care and died in this very city as a result of lack of care because providers weren't available.

The last thing is at the current way—we know the liabilities that we're generating in the health care area are being left at the feet of our children. Let us make sure as we move forward that the assets are in their hands.

Thank you very much.

Mr. KUCINICH. Thank you very much, Doctor.

[The prepared statement of Dr. Stern follows:]

Testimony
Of
Melvin S. Stern, M. D.

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, September 16, 2009
2154 Rayburn HOB
10:00 a.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

My name is Mel Stern. I am here on behalf of the families I care for, the Maryland Chapter of the American Academy of Pediatrics and the National Physician Alliance. I wish to thank you for the opportunity to testify on this very important, and in fact critical national issue. I am a board certified pediatrician and have been in solo practice for thirty years. I am a member of the volunteer faculty of the University Of Maryland School Of Medicine, and for the last 20 years I have been chairman of the Legislative Committee of the Maryland Chapter of the American Academy of Pediatrics.

As a result of my public policy work it has become apparent to me that any public policy that is good for children is good for the entire community, whether it involves economics, environment, education or national security, or health. If it is not good for the kids, it should be re-examined. It probably is not beneficial for the community. Simply stated, if we do not get healthcare reform done right our children and grandchildren will bear the burden.

With that in mind the purpose of my testimony today is to highlight two areas of concern in our healthcare delivery system:

○ the first is the current burden of bureaucracy on the delivery of health services.

○ the second equally important issue is the recent shift in control of standards of appropriate medical care from the medical academic and research community to the corporate boardroom and the halls of legislation.

On the macro level, Steffie Woolhandler in an article in the New England Journal of Medicine in 2003 noted that in 1999 health administration costs in the United States accounted for 31 percent of total health expenditures or $1,059 per capita. The impact of this is clearly demonstrated by the business operation required by my practice as well as several vignettes of patient management issues.

As a solo practitioner, I have approximately 75 to 100 patient encounters in my office and an additional 3-5 hospital encounters each week. At the current time I have a staff of four individuals which approximates 3.5 full time equivalents. All personnel are directly involved in non-medical administrative functions ranging from communicating directly with insurance carriers regarding coverage of medical services, to preparing carrier mandated documentation for patient referrals to other medical specialist, as well as required documentation for prior approval for testing, medication and necessary durable medical equipment. Two of the employees are exclusively tasked to non-medical administrative functions. **I am the only individual delivering direct medical care services.**

It is important to note that when I began practicing in rural Washington State in 1975 I only required a single office receptionist dealing with scheduling, and billing. My nurse was exclusively involved in direct patient care. Despite the tripling in the ratio of non-clinical support staff I have not noted a significant improvement in the delivery of medical care.

Moving from the business impact of this expanding non-governmental bureaucracy to the patient, and with permission of the family, I have provided you with my notes on my interaction with Aetna Insurance regarding Ciana Rutledge, an infant with a life threatening tumor. I need to emphasize that while my example highlights an exchange with Aetna it is illustrative of the many interactions that are required with all insurers, **virtually on a daily basis!**

In brief, Ciana was born following a normal pregnancy and delivery. At the time of birth she was noted to have a very large pelvic mass which was rapidly diagnosed as a malignant tumor. Her birth occurred at an internationally known hospital in Baltimore. As a result world renowned pediatric experts in surgery, pediatric urology and oncology were immediately available to participate in her care, and they did!

However, from the very outset the insurance bureaucracy interceded with irrelevant and unnecessary paperwork and reviews. At my first encounter I informed the insurer that this was a rare occurrence and the expertise for diagnosis and management was appropriately in the hands of international experts at this hospital. However, Aetna threatened to withhold payment if the referral papers from my office were not in the hands of the hospital physicians. Please understand that at this point the infant had been strictly under the care of the hospital physicians. I had not had an opportunity to examine the child and in fact was **not medically responsible for the care**.

In coordination, with the institutional provider we produced and delivered the initial paperwork to comply with Aetna's demands. In the initial phase, Aetna never disapproved of any service. They only added additional administrative burden to the provision of these services. Not only was it a significant burden on my office and in fact my other patients, but it required significant resources from the institutional staff. Did it improve care? Did it reduce cost? Did it responsibly support the patient? No, it did not!

Despite the fact that Aetna staff was aware that the treatment was long term and on a very specific timeline, they continued to require "referral forms" at unpredictable times. On several occasions this required rescheduling needed clinical intervention.

At the time that Ciana required chemotherapy Aetna was supplied with the requested prior authorization information. At this point they became intrusive in the medical management and indicated that they would only authorize outpatient chemotherapy. While they did not disclose the standard they were referencing, I assumed it was Milliman and Robertson.

Milliman and Robertson with its "Optimal Recovery Guidelines" has been widely used to reduce hospital costs[1]. While the guidelines were developed by a panel of physicians, they are not based on patient specific physiological data. Most importantly, in this case **there were no Milliman and Robertson guideline for infants**. Yet, in the face of repeated requests from the institutional providers and myself, Aetna personnel were adamant about applying these adult standards to an infant.

They only relented when I threatened to go public with this abuse, when I threatened to alert the media to Aetna's inappropriate and potentially life threatening intervention in the care of this infant.

This is a clear illustration of private free enterprise bureaucracy (not government) functioning in a manner that attempts to ration care and impedes the optimal, and efficient implementation of best medical practices.

Aetna as you are well aware is a for-profit corporation which has an absolute fiduciary responsibility to generate a profit for its stockholders. What about the non-profit or not for profit insurer? Unfortunately, despite the fact that their charter requires that they do not generate profit, and if they do so they are to return all such profits to the community, their performance in clinical interactions are generally indistinguishable from the for-profit sector.

Johnny (not his real name) is a four year old who has been afflicted with reactive airway disease or asthma since age one. Since diagnosis he has been treated according to national guidelines with inhaled corticosteroids and beta-adrenergic medication for rescue. He has been on the same medication for the entire time. As may be surmised this family is insured by the major non-profit insurer in the region.

For reasons that remain unclear to me, four months ago, they refused to renew the beta-adrenergic medication he had been using for almost three years. They requested additional documents from my office which we provided several times. This failed to result in the approval of the medication. It was only when I moved this matter up to the level of the Vice President of Governmental Affairs (not a medical director) that medication was approved and the family was assured this inappropriate interference in care would not occur again.

[1] http://www.ama-assn.org/ama/no-index/about-ama/13663_print.html

Here again the medical care was straight forward and efficient. However, my office as well as the family had to invest an inordinate amount of resource to effect appropriate, and cost effective medical care.

It is unfortunate that in both the case of for-profit as well as non-profit insurers their bureaucracy has served to increase the cost medical care, decrease provider productivity and adversely impact medical care.

It is appropriate to note that this national non-profit insurer has also been at the forefront of the media campaign against obesity. However, they have persistently refused to pay for any services where the diagnosis is obesity. This illustrates the unfortunate dichotomy of an industry which recognizes what should be done and simply doesn't do it.

My second issue of concern is the movement of medical care policy from the research and academic community to the corporate board room. As I noted earlier, the other hat I wear is that of Chairman of the Legislative Committee of the Maryland Chapter of the American Academy of Pediatrics. It was in this capacity that I had occasion to institute medical policy in the halls of the legislature rather than the medical school.

Beginning in 1986 the Academy introduced legislation in the Maryland General Assembly which was to mandate well child care including immunizations as a standard insurance benefit. Despite the fact that the effectiveness of immunizations and the benefit of routine well child visits had been previously well established, the insurance industry fought this bill for five years.

In 1991 the benefit was finally passed after five years of battle with the insurance industry. It is very telling that at that last hearing the lobbyist of the major non-profit insurer turned to me and stated that "I hate arguing against your position, because it is right." Today, child well care visits and immunization rates are used to evaluate the performance of insurers.

A second major initiative began in 1992 when a part-time admitting clerk at a local hospital commented to me, "don't these insurance companies know that these babies cannot go home in 24 hours or less." The problems resulting from early discharge were easily observed and remarkable to a part-time clerk. However, it required a three year battle with insurers in the Maryland General assembly to pass a mandated benefit requiring a minimum of 48 hour stay for a routine delivery and 4

day stay for mothers and infants undergoing a caesarian section delivery. As many of you know this particular issue moved onto this body and culminated in The Newborns and Mothers Health Protection Act of 1996 (PL 104-204 Title VI). In both these instances the money saved by not providing important and at times life saving medical care was profit which went directly to the bottom line of the insurers. However, the real cost of this business decision was placed on our children. While industry profited the community suffered.

As a matter of public policy it must be recognized that **healthcare is not a commodity where pricing and availability can or should be left to the free market. The free market requires the free flow of necessary information, as well as consumers and providers equally capable of analyzing the available information. This is virtually never the case in healthcare.**

Additionally, it must be noted that there has been a lot of attention paid to the uninsured. While this is very necessary, it is far from sufficient. As the unfortunate death of Diamonte Driver has pointed out, coverage is not the issue. People must have access to care. In the case of Diamonte Driver he had medicaid coverage for dental care. However, the reimbursements were so poor that very few providers were available. Diamonte Driver died of a dental abscess with coverage but no available services.

Similarly, a leader in the Maryland General Assembly revealed during a recent hearing on healthcare that his primary care provider had retired and he had to contact four other practices and "name drop," before he was accepted into the practice. Even then, in eight months in the practice and several visits he had yet to see a physician. Again I emphasize that we must keep our eye on the real issue of access to medical care.

In summary, it is clear that our health care budget cannot continue to grow at the current rate. A major area of cost in the system is in non-medical overhead. Finally, the provision of services must be evaluated on a community wide basis, and not simply on the profitability that might accrue to a corporate entity. We must recognize that to deliver care to the public in a manner that is effective, affordable and medically appropriate demands a "public option." I hope that the examples I have

given above illustrate that a system which is based upon equity in search of return is not working. "The system" of healthcare requires real change.

Please remember we need to do this for our children and grandchildren!

Thank you.

Mr. KUCINICH. I want to acknowledge what you said about mentioning Deamonte Driver. Mr. Cummings and I have had an ongoing conversation about that young man's death, and I think that before the end of the day, we'll have a chance to recount what happened with him and this system.

Dr. Peeno, you may proceed.

STATEMENT OF LINDA PEENO

Dr. PEENO. Mr. Chairman, members of the committee and staff, I appreciate the opportunity to be here.

I am a former company doctor who made those kinds of life-and-death decisions Mr. Cummings referred to. In fact, one of my prior appearances here was in 1996 to talk about how company doctors cause harm and death to patients, and the fact that little has happened is evidenced by the fact that a quote of that hearing has resurfaced and is very timely still.

After 1996, I continued to work on health care issues, and I've worked on more than 150 legal cases on behalf of patients and assisted patients in appeals. So I have a wealth of acquired information about the inner workings of the health insurance companies.

The one thing that I think, in summary of my experience which I've detailed in my written comments, is that this has never been a more deadly time for patients in terms of insurance practices. They've become more sophisticated and more expert in achieving the cost cutting and saving goals.

The four areas that I would like to talk about specifically, at least to address and make you aware of, the first has to do with claims. And I see a lot of insurance rhetoric that says that they're kinder and gentler, and they deny fewer claims, but a recent study in California showed that at least in that study, as much as—as many as 40 percent were denied.

But the more interesting thing is what we don't know, because the evolution of managed care has been to shift the process of limitation, denial and substitution more prospectively. So if you can co-opt the treating physician in the office or the bedside, we can create conditions like we have already heard today where you will obstruct and delay and wear people down. Then those are things that are never recorded. There's no data or statistics we can go to to show the amount of care that has been altered through those processes.

The second thing is that the shift in health care has been to move everything more technical. So the goal over the past decade has been to eliminate the independent medical judgment of physicians and of the health care professionals, to normalize through criteria and other scientific-based ways, and to eliminate the patient particulars.

Coinciding with that is the attempt to make other agents the denial factors by, one, co-opting physicians and altering their medical ethics to achieve the goal of the company, but more disturbing is making patients themselves the agents of their own denials through economic changes.

The fourth one, I think, has kind of been touched on already by several remarks here, and that is the expert use of terms like "medical necessity," "investigational," and "experimental." I actu-

ally testified in a case that you mentioned, Mr. Kucinich, on the Dardinger case, which was a very interesting case because the definition of "experimental" changed as it went through layers of review in order to constantly shift—justify the denial. And, in fact, part of the e-mail communication that came out in that case is that the health plan employees were deliberately delaying because they knew Mrs. Dardinger was going to die soon, so they were avoiding making a decision to avoid even dealing with the issue of paying for it in hopes that she would die before they would have to address it.

The recent attention on medical criteria and evidence-based medicine, it sounds wonderful to talk about best practices. We should be focused on that, but there is a layer of rhetoric there that hides what goes on underneath. Companies—you know, for example, the criteria for the appropriateness of a hysterectomy should be the same whether it's in, you know, Boston or Los Angeles. It should be the same whether it's Humana or CIGNA, and yet these tools are used and wielded. They're proprietary. A company would never purchase criteria that would cause it to be more generous and to spend more money. So these criteria are used deliberately to justify denials and to limit care and—and these tools are being developed using public research and should be transparent and should be publicly available.

There are so many things that I could go into that I have seen in all the cases. As I said, I went into detail in the written remarks, but I think the last two things I would like to sum up is that patients are not mere anecdotes, and that's the way the insurance company would like to dismiss any claims of adverse affects on patients' well-being or health.

And the last thing is that they operate in a medical—in an ethical and legal void. There's no medical ethics when you're working on behalf of stockholders, and the legal situation is that most Americans have no legal recourse because of ERISA and other complications holding these companies accountable.

So I personally believe we will have no health reform unless we reform the health insurance industry to a system that is ethical and patient-centered.

Thank you very much.

Mr. KUCINICH. Thank you, Doctor.

[The prepared statement of Dr. Peeno follows:]

Testimony
Of
Linda Peeno, MD*

Domestic Policy Subcommittee of the Oversight and Government Reform Committee

Wednesday, September 16, 2009
2154 Rayburn HOB
10:00 a.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Oral Statement

Mr. Chairman, members of the Committee, thank you for inviting me to this hearing today.

My name is Linda Peeno. Over three decades ago I obtained a hard-earned M.D. degree, expecting to practice medicine for the *benefit* of patients. After finishing medical school I had a series of jobs in which I functioned as a company doctor for several health plans. As I began to witness and participate in harm and death to patients, I left my lucrative corporate career and have spent the past 2 ½ decades working to educate others about the inner workings of the American health insurance industry.

I made one of my first appearances here before Congress in 1996, when I came as a former medical reviewer to talk about the way I had caused the death of a patient. I naively expected the country to be shocked into action. Little changed happened since we are here again, and clips from that testimony have re-emerged with shocking timeliness. I come back here today with 13 years of additional insider experience from work on over 150 legal cases against managed care companies, as well as extensive knowledge gained by helping thousands fight for needed care. I am here today representing no special interest group, and without any agenda except to urge you to force open the black box of corporate health insurance and to hold them accountable for the practices that destroy the lives of patients, families and communities, and the health professionals who must bear the consequences of their damaged care.

Things have never been worse for patients. The corporate machines are well-developed and expertly operational. The methods are more insidious, covert and devious. In

addition to outright denials of care, new tactics proliferate to avoid, delay, limit, substitute, and manipulate care for the maximization of profits. The difference between the kinds of denials I testified about in 1996 and the current system is akin to the difference between surgery with a kitchen knife and a scalpel. Cost-cutting, –saving, and –making tactics have never been so expert and deadly.

I come here today with several warnings:

- **There is an abyss between what insurance companies say and what they do:** Do not be fooled when the health insurance industry claims that it has abandoned its "old" practices of managed care. Although they say they have become more efficient, this "efficiency" works can be deadly for patients. It is easier to target high costs conditions and patients, more tactics can be recruited to deny care either directly or indirectly. Methods can be more oblique and hidden. For example, I have seen a case in which an insurance company claimed to cover a certain type of transplant, but when specific patients needed that particular category of transplants, they encountered delays, obstacles, hidden policies and other strategies that prevented them from ever receiving what they needed. Companies claim to deny less, even though a recent study shows that denial rates ranged up to almost 40%. (LA Times, September 3, 2009) Even this rate does not take into account all the de facto "denials" that occur when care is altered in ways that do not leave a record to monitor, e.g. "requests" and "encounters" that never make it to a claim. Furthermore, insurers defend their reported denial rates by claiming that they are mostly "technical," and not "medical." This distinction is an artificial shift that companies have perfected as they have systematized medicine into something that can be codified and contractual, eliminating clinical judgment and patient particulars that are the essence of the practice of medicine. The increase in new "health information networks" that integrate administrative, financial, and clinical date and services is a troubling sign of this trend.
- **There are new "agents" of denial:** Treating doctors and other health professionals often become a company's "agents" for limitation, avoidance, substitution, delay and denial: Over the past two decades, insurance companies have learned how to manipulate criteria, data, contracts, payment schemes, performance evaluations, profiling, marketing and other means to co-opt physicians in their profit schemes. These sophisticated forms of behavioral modification force many physicians to adjust their ethics to fit corporate economics. When treating physicians become company doctors there is no record of denials and nothing to regulate. I have recently become aware of a situation in which a treating physician not only withheld care, he actually subjected a patient to harmful care in order to ensure that she did not qualify for a more costly procedure. Even a medical director does not have that kind of denial power. Yet this pales before the best denial method of all: forcing patients to limit their own care. I know of a case in which a woman will die because she does not have the money to pay for something she needs. She has insurance but it will not cover her condition. There is little need for company doctors when patients themselves

become the agents of their own denial. More and more patients discover that the copayments, co-insurance, and other cost-shifting tactics mean that they may have "insurance" but it will be useless at a time when they most need it.

- **The dirty work of denial and other cost-cutting practices are increasingly outsourced:** Insurance companies have learned to diffuse responsibility by shifting risk to other entities. For over two decades, they have perfected the means to "carve-out" and outsource the management of diseases and other processes to subcontracted companies. This is booming business as indicated by the rise in disease management companies, evidence-based/criteria companies, and other third party management companies. I am aware of a case in which a single patient had a primary care gatekeeper with financial incentives to control access to tests, treatments and referrals to specialists, a disease management company for congestive heart failure, a case management company for another separate condition, a pharmacy benefits manager, and a managed mental health company. None of these entities communicated with the others. They were paid by "capitation" – a payment method by which the insurance company's costs for the services was fixed and paid per member per month. Under this arrangement, the insurer fixes its costs and the outsourced company manages the costs of care within a fixed budget, making money to the extent that it spends little by developing its own definitions of medical necessity, experimental and investigation, and other methods for delay, substitution, avoidance, and denial.
- **Adverse insurance actions cause harm and death to real individuals – these are not statistics or "mere anecdotes":** Every adverse insurance action, whether it is direct or convoluted, whether it medical or technical, involves a real patient, a real human being with family, friends and community. Insurance companies have mastered the rhetoric necessary to discount the harm and death of their practices. They keep the focus on the majority of claims that are routine and relatively low cost, failing to disclose their aggressive efforts to mitigate or eliminate the high costs of the smaller percent of patients who must be managed. Stories of suffering in this group are quickly discounted as "mere anecdotes" – an unconscionable way to disregard the value of a fellow human being
- **The terms "medical necessity" and "experimental/investigational" are proprietary business tools supported through the huge medical guideline/criteria/evidence-based medicine industry.** These are terms of art and contractual terms that are used like rapiers to limit and deny care. They have no standardized meanings. They differ not only among companies, but can vary even within the same company. I have seen cases in which the "medical necessity" definition in the insurance plan was more generous than the hidden definition used by a carve-out group, but when members needed treatment managed by the third-party company, care they should have received under their insurance contract was denied based on the more restrictive and undisclosed definition of the subcontractor. I have seen a case in which the definition of "experimental" grew more detailed and restrictive as it went through the various review processes. The definitions shift and are often adjusted to make a denial "stick." Companies may appear to cover something generally, for example a particular kind of transplant, but when that category of transplants is needed

almost no individual patient will meet the hidden criteria that excludes their particular condition. Various companies have grown up to supply increasingly restrictive criteria for medical services, so that almost any medical treatment or service can have medical judgment systematically eliminated. The new field of "evidence based medicine" is also an area that should be examined carefully. The so-called "evidence" is by its nature, public (from academic centers, peer-reviewed journals, research supported by tax dollars, etc.) and yet it become "criteria" to be manipulated and controlled by companies for their proprietary ends.

- **Health insurance companies operate in an ethical and legal void.** Companies do not believe that the ethics of medicine apply to their business practices, yet their practices can hold greater life and death power over a patient than any other entity in the system. For-profit health insurance is a business with obligations to stockholders, not the best-interests or well-being of patients, families and communities. Even when their actions cause harm and death, legal accountability is difficult. Americans who received their insurance through an employer will find their insurers have legal immunity provided by ERISA. Even those who have some legal recourse, find that the industry is adept at using the legal system to protect itself from disclosure of practices, key documents and accountability. I initially believed that a few key lawsuits would demonstrate how insurance practices are systemic and calculated, however the past thirteen years have taught me that insurers see the few legal cases as the cost of doing business. In addition, insurance battles have become lucrative for many. Over the past decade I have seen many—even other doctors, plaintiff lawyers, legislators, and other advocates who were supposed to help people—find ways to benefit from the broken system. I too reached a point where health care battles in the press, court rooms, legislative halls, and speaking events rewarded me more than patients I tried to help, which is why I have been mostly silent thus far in the health care debate.

I could continue for hours, but our time is brief. My written testimony includes more details about these practices and others.

I would like to close with this last warning: we will have no health reform unless we change or eliminate the for-profit model of insurance with their growing sophistication in profit maximization. We will have no health reform unless we have a medical and health care ethic – from the boardrooms to the bedsides – that is patient-centered.

Thank you for the opportunity to speak to you.

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Bio

*Linda Peeno is a physician who has spent over two decades educating and advocated for ethical systems in health care. In the early 1980's, which the advent of "managed care," Dr. Peeno moved from clinical work to executive positions in a variety of health care corporations, including an insurance company, an HMO, and a hospital. In the early 1990's, she left this corporate work to focus on the ethical issues emerging from changes in health care organization, financing and delivery. Dr. Peeno's struggle to bring these issues to public and professional attention is the subject of a movie, *Damaged Care*, first aired in 2002 by Showtime and Paramount, and now used all over the country in medical and health care ethics classes. A clip from her 1996 Congressional testimony recently appeared in the movie, *Sicko*.

Dr. Peeno is recognized as a leading authority on the operation of health care organizations, corporate effects on medicine, and health care and medical ethics. She has testified before Congress, state legislatures, and various policy groups, and regularly provides analysis and consultation to business, medical, legal, policy and media professionals. In the past two decades, Dr. Peeno has written and spoken nationally and internationally on health care changes and reform. Her current passion, however, is teaching anatomy, physiology and pathology to students who will be entering into complex and demanding health care work.

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Supplemental Material

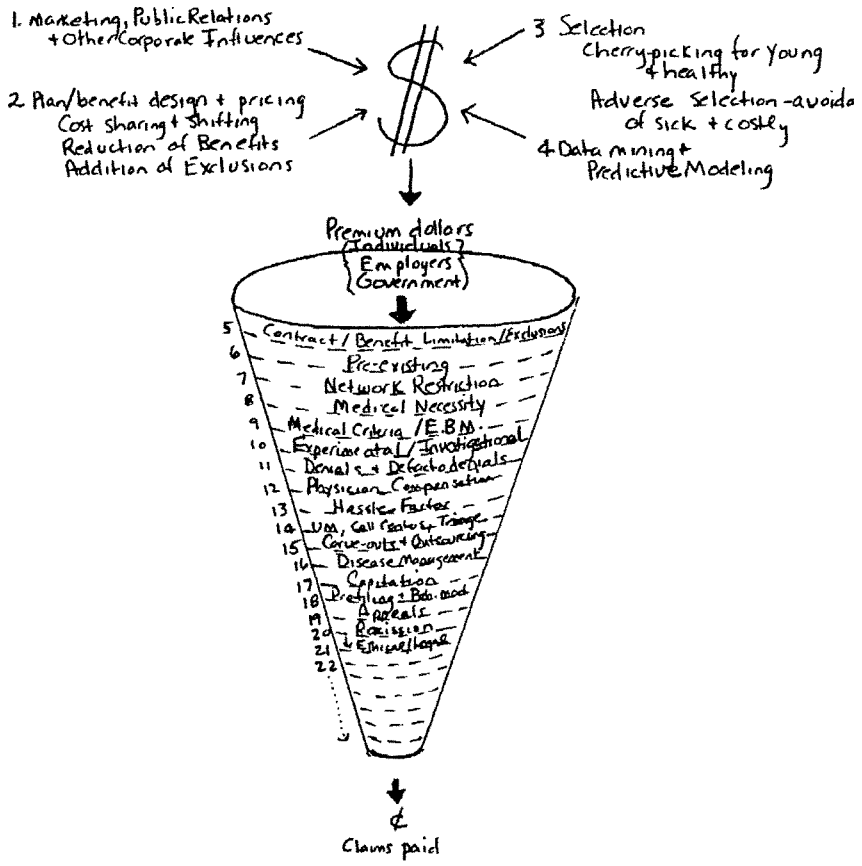
Introductory comments:

- The for-profit insurance industry in not about health care or cost control – it is about increasing the profits of the companies. Despite the existence of several major companies which appear to compete in the market place, they all engage in well-designed, resourceful methods to systematically increase their earnings and satisfaction of stockholders. Individual companies will try to claim that they are unique, that their methods are distinct and more competitive. However, the practices are the same (take in as much money as possible and limit/deny as much as possible). No health care reform can proceed without serious attention to how this system really works and the consequences for the American people. Once understood, it should be obvious to anyone that this is an industry that cannot be controlled by either competition or regulation. It is an industry that can no longer justify its existence as it now operates.

- The effects of the insurance industry spread beyond just a single denial for an individual patient. In a poignant story recently told about a "wrenching family experience," a woman writes that "having insurance does not mean being able to afford health care when you need it the most." ("A Wrenching" Health Care Experience," Fonda Butler, Courier Journal, August 31, 2009) More and more Americans are discovering this.

- Over the years, multiple attempts have been made to hold insurance companies accountable with little effective change in their practices. I have participated in cases that have included negligence, bad faith, breach of contract, unfair business practices, interference with doctor/patient relationship, intentional misrepresentation, negligent misrepresentation, fraud, civil RICO, corporate practice of medicine, corporate negligence, negligent credentialing, vicarious liability, fraud, and many other causes of actions. Every case is an invaluable opportunity to gain a peephole into the inner, hidden practices. Although companies try to portray any particular case as unique and isolated, the documents and testimonies that come from these cases reveal that the practices are well-developed, systematic and calculated. These practices are little known and studied because they occur behind layers of protection and obscurity. It is even worse when we realize that the premiums of the insured are used to develop these tactics, creating conditions in which patients fund the development of the very tools that will be used against them in times of need.

- The model that I use to understand these practices and their collective effect is that of a large funnel with layers of filters. One can see the effects of the simple business model: increase premiums and decrease payments. Each of these tactics is based upon engaging in some practice that achieves this.



THE HEALTH INSURANCE BUSINESS MODEL:

THE FUNNEL OF PROFIT MAXIMIZATION AND COST SAVING

1. **Marketing, public relations and other corporate influences:**
    a. **Power of money and resources**: The power of money to influence policymakers and media (more recent details provided by Wendell Potter) and well-documented by reports about the influence of lobbyists and other means.
    b. **Mere anecdotes**: Public relations spin described by Mr. Potter, which extends to the discounting of any evidence of harm or death as a "horror story," a "mere anecdote," a media sensation, etc.
    c. **Censorship by prior restraint**: when the information and media are controlled to the point that "negative" (read "truthful") stories are suppressed. This occurs in many insidious ways. I have known several journalists who were forbidden to do stories or whose stories were killed ("into the buzzsaw" – a term that describes this practice) or suppressed because they were critical of a company with power in a community. I experienced the attempts by the industry to prohibit the release of *Damaged Care*. After the film was released, the major trade group for the health insurance industry entered into a large contract with an leading agency in Hollywood (William Morris – the account of this was reported in several leading newspapers in the summer of 2002) to influence the production of any future negative accounts of the industry. Wendell Potter has detailed the organized fight against the movie *Sicko*. (http://www.cjr.org/campaign_desk/excluded_voices_6.php) I personally experienced the backlash after *Sicko* has Humana tried to discount the importance of the heart transplant story and my association with the company. (See."Statement by Dr. Linda Peeno and Response to Attacks from Humana – July 3, 2007" available on www.michaelmoore.com)
    d. **Exploitation of media constraints for advantage**: Mr. Potter has mentioned the deception, misinformation, selective disclosure, and omission of facts as a way to control the message. He has also mentioned the "laziness" of many journalists, although my experience over the years has been that few journalists have the time or means to understand the industry enough to break through the rhetoric and well-financed shields. I have spent thousands of hours over the past two decades educating journalists who have worked hard to grasp the complexity of the systems of corporate health care. Even when they do grasp it, the information that is available is limited by all the corporate strategies of protection. I know from the legal cases how it is nearly impossible to acquire critical documents for evidence of practices, even with the power of courts and their orders. Nearly everything written by a journalists or an academic researcher is limited by the lack of real information about what is really going on behind the scenes.
    e. **Marketing to select and desirable populations**: There is abundant evidence about these practices over the past couple of decades. Many of the marketing practices are deceptive and some are even fraudulent. There are legal cases that address the misrepresentations, illusory promises, and

fraudulent claims regarding plans, benefits, networks, and other methods designed to acquire targeted populations who have best health and financial means.

2. **Plan/benefit design and Pricing**: We have more than enough evidence now to demonstrate that the insurance industry engages in practices that influence the products and pricing available.
    a. **Reduction of benefits/Increase in exclusions**: Over the years, benefits have been systematically reduced. For example, I participated over 20 years ago in the change for short-term and long-term benefits. The plan for which I worked has previously defined long-term rehabilitation as medically necessary as long as an individual continued to demonstrate improvement. For those conditions in which rehabilitation can be a slow process (after some head and spinal cord injuries), months of medical rehabilitation might be required. However, these are the most expensive and undesirable patients, so plans began to put artificial and unrealistic time frames on the benefits, and we shifted our policy language to that taking hold in the industry. We restricted rehabilitation to 90 days only. In the years to follow, I was involved in many cases, trying to assist patients whose care had been worsened by this definition. In one case a plan stated that the 90 days began at the time of the injury and a young patient who had had both a head and spinal cord injury ate up the 90 days while still in a coma. By the time he recovered from the coma, he was had no benefits available to assist in his recovery of basic functions. He was left to languish in a nursing home eventually at the expense of the state in which he lived.
    b. **Increased premiums and other pricing tricks**: Mr. Potter has provided details about how the health insurance industry has systematically gutted benefits while simultaneously raising premiums. We have abundant evidence by now of the most recent tactics to the financial costs to consumers and patients. (See the unpublished editorial included in the appendix regarding the evolution of health insurance tactics.)
    c. **Insurance without insurance**: These tactics and others result in our current situation in which almost no one who has insurance is really protected in the event of a significant and expensive medical event. We have research that shows that nearly ¾ of individuals bankrupted by medical bills had insurance. (See "Insured, but Bankrupted by Health Crises," by Reed Abelson, NYT, July 1, 2009.)
3. **Selection of who gets insurance**: These tactics have been well-documented as well. The industry terms "cherry-picking" and "adverse selection" reflect the strategies to select the healthiest and avoid the sickest – two companion strategies that provide the least risk to a company. Underwriting and actuarial analysis has become sophisticated and plans can select and deselect with great precision now.
4. **Data Mining and Prospective cost management**: New resources in date acquisition and management allow companies to identify and even make predictions about the potential costs of patients. (See section on "Predictive

modeling and prospective" care" in the "Second Coming of Managed Care" in the appendix.)

5. **Contract/benefits:**
    a. **Language and importance:** Few people understand that their plan documents are contracts to which the company will refer when seeking justification for an adverse action. Often members do not even receive member handbooks and are unaware of the contents until they have to challenge a plan's decision. Even if the documents are read, most consumers will find the documents full of fluffy promises for "best care," "highest quality of care," etc. – promises that are rarely fulfilled. The language is often general and vague with little to no disclosure of the company practices and organization that will be used against the patient in the event of some costly medical event.
    b. **Exclusions:** These multiply and are rarely appreciated by someone until they discover that something they need is listed as an "exclusion." For example in one plan I worked we specifically excluded dialysis, something a young couple did not know or understand until the husband needed dialysis to support him during an episode of acute renal failure.
    c. **Pre-existing conditions:** We have abundant examples of the extent to which companies use this to their advantage. I have worked in the past with a team who combed through claims kicked out by the system based on cost or service triggers. Out task was to acquire and review previous medical files in order to justify a denial based on some pre-existing conditions. We also used this process to rescind policies – see below.
6. **Pre-existing:** We have plenty of evidence that this remains an effective tool to limit liability for health insurers. Despite attempts to limit the use of this, insurance companies continue to use this abusively, often going back into medical records for years and pulling out minor complaints as justification for the denial of payment. Recent documents reveal that some insurance companies have gone so far as to claim that "domestic violence" is a pre-existing condition.
7. **Network restriction and selective contracting:** Although most people associate this with the HMO plans that restrict panels of physician and facilities, most insurance plans have limitations on who and what is available. In my hometown of Louisville, there are two current disputes that seriously affect patient care. In one, a major hospital system and insurer could not agree on a contract and overnight the care of thousands of patients was disrupted when they were told by the insurer they could no longer use the doctors and hospitals in this system. In another dispute, several leading specialists in the community were told their contracts would not be renewed by a major insurer that seeks to narrow its network. This forced many patients with long-standing relationships with these physicians and in the midst of medical treatments to seek other physicians who would be covered by their insurers. Many consumers believe they have "choice," only to discover that this choice is serious restricted and can be costly, and in some instances may be so costly as to prohibit the very care they need for their condition. :

8. **Medical Necessity:** This is addressed in the oral statement above and in the article that is appended to this list. It is the key to the goldmine for insurance profits. As the threads of this filter are tightened, fewer conditions meet proprietary definitions of "medical necessity."
9. **Medical criteria/evidence-based medicine:** This too is addressed above and at the end. Despite the advantages to having practice standards and guidelines, medical "guidelines" become company dictates. They are purchased from companies that make money by increasing restrictions and applications to deny care. A company adjusts criteria to their proprietary needs, negating their claims for standards. For example, criteria that determine the appropriate conditions for a hysterectomy should be the same whether it is Boston or Biloxi. It should be the same whether it is Humana or Cigna. However, I have seen a case in which an insurer subcontracted with a medical criteria/medical review company whose proprietary criteria for hysterectomies and their company doctors' reviews guaranteed at least a twenty-five percent denial rate.
10. **Experimental/Investigational:** This is an area that has become the most devious of all the practices. Many insurees have insurance benefits that appear to cover needed procedures and even many transplants, however most patients will discover that there are hidden policies and practices that may cause their tests, procedures and treatments to be denied for this reason. Increasingly, companies will appear to cover something like stem cell transplants, but when particular patients need one, they discover that the company will claim that that the particular medical condition does not meet criteria – for example, stem cell transplants may be covered but not stem cell transplants for certain stages of certain conditions. In addition, the definition of these terms can shift around as companies attempt to justify a denial. Language in the contract may be general and leave open consideration for many treatments that will be denied by definitions behind the scenes that can go for pages. Companies also pick and choose what information and studies they use to justify their determinations, often discounting or rejecting academic studies in favor of the patients because they included a wrong group of patients, the studies were done outside of this country, or any number of other reasons.
11. **Denials and de facto "denials" – limitation, avoidance, delay, substitution & the hidden denial record, encounter data and denial rates:** This is discussed above and at length in the attached article. However, the evolution of managed care relies upon the use of avoidance, substitution and inconvenience to shift the cost-saving actions to less obvious and less direct denial methods. In one recent case, a health plan employee discussed how physicians would call and get informal rulings on patient tests and treatments, insuring that only the "approved' were ordered and recorded. Companies understand that a "claim" represents only what has been submitted for payment after a test or treatment. All the tactics to use prospective and concurrent interference and obstruction are unrecorded and difficult to untangle.
12. **Physician compensation, corporate incentives and other forms of behavioral modification**: Although companies claim that the more direct payment methods for treating physicians and corporate employees have diminished or changed,

bonuses and other rewards remain key methods to ensure that decisions are consistent with corporate goals. Profit-sharing and bonuses based on earnings-per-share may have replaces the more direct bonuses for denials, but the results are the same. Companies have also developed systems that will identify the physicians most compliant with their rules and financial goals. One company would "gold card" its most compliant physicians, providing quick authorizations and claims payments for their allegiance and performance. There are signs that this practice has become more sophisticated and will be part of new "health information" and claims payment systems. Financial success to the companies and their agents depends directly on decisions that increase money in and decrease money out.

13. **Hassle factor – both patients and physicians:** Plans deliberately create complex, difficult, and inexplicable policies and procedures for navigating the managed care maze. The industry knows that only a small percentage will fight denials or other problems. They know too that even fewer of these will persevere through the labyrinth of rules and requirements. Some of this is calculated; some of it is the inevitable consequence of organization complexity and ineptitude. Either way the hassles can be great and overwhelming, serving as an advantage to the companies who make money for delays and denials in the process. The same kind of "hassle factor" works for physicians as well. Over twenty years ago I learned the term as we systematically beat down the physicians who attempted to challenge the medical decisions we were making for their patients. Eventually the sheer volume of patients affected, the resources needed, and threats about contracts and payments resulted in more compliant physicians willing to accommodate to the company's decisions about patient care.
14. **Utilization management, call centers, triage and other methods of prospective, concurrent and retrospective review:** These methods multiply daily and it nearly impossible to address fully here. Patient stories are full of the obstacles and tricks. However, one method is little known but widely used. Many insurees will find that they have obtained "approvals" from their plan. In fact, an authorization number will be issued for doctors and hospitals to submit claims. Hidden within the approval letter will be a clause – "authorization does not guarantee payment" – that enables a company to review the file after the service has been received and then to refuse payment based on some technicality. In addition, sophisticated claims processing allows certain claims to be targeted as they go through the system. Claims can be suspended for review based on any type of "trigger" – from specific medical codes that may indicate conditions that are expensive to financial thresholds and other variables. These targeted claims can by used for any of the other kinds of denials that are discussed in this list.
15. **Carve-outs and outsourcing:** This is discussed in the oral statement and the article included at the end. It is important to note that these new management companies fall outside of most regulatory and accreditation requirements, making it difficult to get to their inner workings and hold them accountable for consequences to patients.
16. **Disease management:** This too is discussed above and in the end article.

17. **Capitation:** In its heyday, this method was widely used to pay physicians. Despite industry claims, it is still used frequently with physicians, but more frequently for outsourced management companies. Under this form of payment, the insurers costs are fixed, and the management/cost risks are shifted to some other entity – either physicians or a company managing a condition or process. Since money is saved or made only by limiting payments, this creates incentives to withhold, delay, substitute and deny care at the level of the treating physician or the stand-alone management company that can harm patients.
18. **Physician profiling and other methods of behavioral modification:** As the amount of data increases, physicians are subjected to more comparative evaluations. If a physician shows up as an "outlier," which can have little to do with the actual quality of medicine practiced, then this can trigger reviews and other corrective measures to bring a physician into line with a company's goals. The big brother effect chills professional autonomy and judgment as well, and slowly physicians can be molded into practicing the kind of medicine that is desired and dictated by health care plans.
19. **Appeals & third party reviewers:** Although appeals are required, the process can be cumbersome and difficult for patients, especially when they are in the midst of life-threatening medical conditions. In many cases, there is a difference between the appeal policy and the actual appeal process that occurs behind the scenes. Appeals are heavily weighted in favor of the companies, and can be easily manipulated. Even outside appeal and third party reviewers have incentives that are not aligned with objective evaluation and patients find that getting a real independent consideration of an appeal is impossible.
20. **Rescission**: This has gotten much recent attention, but as far back as the late 80's, I participated in a group that was charged with reviewing certain claims that were submitted to us for review as possible candidates for rescission. At that time, our claims systems were set up to kick out certain codes that suggested conditions like HIV/AIDS and other expensive conditions. We would then request all prior medical records and comb these in detail in order to determine a way to claim that the individual had failed to disclose something and we could terminate their insurance. This practice has only grown in sophistication over the two decades.
21. **Limitation of legal and ethical constraints:** I have discussed this at length in many other documents, especially the two Congressional testimonies:
22. **Many others…** The methods continue to proliferate and are too many and too complex to list completely. In addition, new filters are added daily. Other methods include: inadequate access to specialists who are qualified for treatments; lack of physicians who will advocate for necessary treatments or do the work that is required to make an effective appeal; episodic care and single event denials that interfere with the overall plan of care for chronic, complicated conditions contributed to a downward spiral of care; illusory prevention/early intervention that is driven by short-term profit/loss concerns…

I would like to close, with the following considerations:

- **Real purpose of insurance**: What are the real purposes and effects of managed care/HMO/insurance companies? What do they really do for patients?
    - Are they Are they insurance companies that simply pay claims, while the other aspects of the health care system (physicians, academics, etc.) determine what is medically appropriate or do they influence and direct medical care (basically practicing medicine) through their various resources? If they sell insurance plans and pay claims, then their activities should be transparent and easy to evaluate based on traditional insurance law by evaluating contracts, adherence to contracts, fair claims processing, etc.
    - If they are influencing medical care and the health of members and patients, then they should be accountable for the results, both the negative and the positive. Companies focus on the positive actions – how they are engaged in prevention, wellness, etc., but the same mechanisms that allow organizations to influence patient care in these so-called positive ways are also used negatively – by restricting, substituting, delaying and denying care. We should be able to assess the effects of this, and organizations should be accountable for the consequences of their decisions and actions on individual patients with whom they have contracted.
    - Managed care plans practice medicine. While there have always been contractual limitations to what would be covered, the claims were paid after the care was delivered. There was little to no interference in the practice of medicine. With the advent of managed care, organizations began to influence, direct and determine medical care. Marketing materials and member handbooks make claims about assuring "highest quality of care," etc. These positive claims to make medical care better became the rationale for all of the interferences, e.g. restricting choice of doctors, controlling admissions to hospitals, denying "medically unnecessary" care. The member/insure/patient was and is led to believe that these actions are in the best interest of the patient.
    - With the managed care backlash of late 90's, health care companies began to mask and withdraw some of these claims. Language was changed in member materials, advertisements and other documents that would be seen by the public. However, the tactics to control doctors and patients continued to evolve.
    - In addition, the rise of HSA's and other methods to shift the financial management to consumers allowed the companies to appear to move into a type of broker role – simply managers of money. However, as many people have discovered, they may have many choices when it comes to inexpensive, low levels of medical care, but when something expensive happens, all the managed care machinery gears up and services are limited or denied as if the patient is in a HMO/managed care plan.

- **Where the dollars go**: In what way do the high administrative expenses contribute to better health care and patient care, either for individual members/enrollees or the health care of the country overall? Consider the

exorbitant resources that are spent on marketing and advertising, executive salaries and perks, and other areas that have come under question. The dramatic ethical epiphany I had in 1987 about the expense of the sculpture (which I later came to know cost 3.8 million dollars) juxtaposed with the money "saved" by denying the heart transplant (about half million dollars) remains. Even when there are legitimate savings by appropriate, patient-centered managed care, companies cannot demonstrate that the savings go back into health care and medical needs for the members/insurees. The "savings" convert to profit, further fueling the development of means to further "save" and make money. In this sense, patients are funding their own tools of rationing.

- **The history of managed care has been one of companies engaging in egregious practices and when backlash occurs, they "correct" them and call this reform. We are in the midst of such a cycle now and should be aware of the ways in which many so-called "new" tactics are illusory or deceptive.**

In summary, insurance companies have become ingenious machines for generating increased premium dollars and decreasing claims payments – an obscene business model supported by the life and death of real people – and anyone of us could be next.

Additional resources by Linda Peeno:

1. Managed Care Ethics, Congressional testimony, May 30, 1996.
2. The Menace of Managed Care, Congressional testimony, October 28, 1997
3. What is the Value of a Voice? US News & World Report, March 1, 1998
4. Burden of Oath, Creative Nonfiction Journal, Issue 21
5. Statement regarding heart transplant patient, July 3, 2007, www.michaelmoore.com
6. The Second Coming of Managed Care, TRIAL, May 2004 (appended)

The second coming of managed care

Linda Peeno[*]

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New management techniques and complex organizational structures allow the health care industry to continue placing costs above care and profits over patients.

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On one side of my office, piles of articles tout the transformation, even death, of managed care.[1] Even the media seem to have lost interest in the tragic stories that continue to

emerge from our profit-driven health care system. According to the health industry, we have entered into a "kinder and gentler" era of health insurance, one in which health plans claim they are moving away from medical gatekeepers and denials of care.[2]

The other side of my office tells a different story. Piles of e-mail messages and letters from patients, as well as mounds of evidence on how health plans really work, bring to mind a new twist on the famous words of Mark Twain: News of managed care's death may be greatly exaggerated. In fact, evidence from my files indicates that managed care is alive and thriving, so much so that one health care executive claims we are in the middle of its "second coming."[3]

Twenty-first century managed care is best defined as the organizational practices of any health care entity using business strategies to influence or control access to and availability of medical services for economic gain. Patients can become victims of systems that lead to too much care as well as too little, and they now risk danger from corporations as much as from individual agents.

This should not surprise anyone, since the provision of health care, from for-profit insurance companies to nonprofit government organizations, still works on a simple principle: Financial success and "savings" depend on maximizing the gap between money taken in and money paid out. Its face may change, but managed care is not going away. New companies, strategies, and profits continue to mushroom, with HMOs reporting $5.5 billion in profits for 2002, an 81 percent increase since 2001.[4] At the same time, more Americans are uninsured or underinsured, and patients face mounting bureaucratic nightmares and diminishing protections.

The Health Maintenance Organization Act of 1973 launched the explosion of new forms of health delivery and finance. HMOs began as prepaid health plans, organized to provide "basic and supplemental health services to [their] members . . . without limitation as to time and cost."[5] They were intended to reduce the spiraling costs of medical care through a focus on prevention, early intervention, and health maintenance.

However, it soon became obvious that this type of cost-control required lengthy business cycles, so insurers would not reap profits for many years. The companies began to focus on what would produce immediate profits.

The earliest forms of managed care focused on what the industry calls "low-hanging fruit," or areas that generated the quickest and highest "savings." Primitive forms of managed care relied heavily on "cherry-picking", that is, enrolling only healthy people and not accepting those with health problems, as well as network limitation, discounts, risk-sharing, and blunt utilization review that targeted-denial of expensive tests and treatments, specialty referrals, and hospitalizations.[6] Managed care represented an unprecedented opportunity for organizations to control medical care *before* it was delivered.

Physicians no longer practice medicine alone. Severe limitations, denials, and alterations of care led to great profitability in the early to mid-1990s, but these savings proved to be one-time phenomena.[7] High-profile effects, like 24-hour maternity stays and 48-hour mastectomy stays, caused a consumer "backlash."[8] By the new millennium, decreased profits, poor public relations, and demands for better "patient protection" sent the health insurance industry back to its drawing board.[9]

Trend toward specialization

Although earlier forms of managed care still exist, insurers' practices are increasingly subtle, refined, and disguised. Instead of one company doctor sitting in corporate headquarters making decisions about treatments and hospitalizations, several different people in many different locations manage patient care.

In addition to health plans and insurance companies, care can be managed by external utilization-management companies; third-party administrators; benefit-management, disease-management, pharmacy-management, and mental-health-management companies; hospitals; employers; and government payers, to name just a few.

I have reviewed documents in which a single patient's care was managed through the health plan's gatekeeper, a disease-management company for congestive heart failure, a case manager for diabetes-related complications, a pharmacy-benefits manager, and a managed mental-health care company. Each of these entities had a different definition of "medical necessity" and different policies and structures, with little or no coordination among them.

"Disease management" represents the newest managed care trend, as the health industry concentrates its resources on wringing out savings from a trillion-dollar health-care coffer.[10] Also, with the current focus on drug costs and new Medicare legislation, pharmacy-management companies will have increased effects on decisions related to patient care. For example, the merger of two giant pharmaceutical-benefits managers , Caremark RX, Inc., and AdvancePCS, will give a new company the opportunity to manage prescriptions for about 70 million members.[11]

Other businesses specialize in the management of networks, doctor "scorecards,"[12] credentialing, special populations (like Medicaid recipients and prisoners), and specific care areas (such as rehabilitation, home-health care, and "complementary", or alternative, medicine).

Managed care systems depend on the manipulation of patients, physicians, benefits, and medical management to achieve cost-savings and profits. Early forms of managed care relied more on blunt denials of treatment that often harmed patients. Newer forms of managed care are marked by sophisticated systems that distribute management and change care in ways that still harm patients, but are less obvious. The emerging trends include the following.

Benefit restrictions

Health insurance companies continue to limit benefits in ways that are rarely disclosed and are seldom understood by potential enrollees. Often patients do not understand the implications of certain restrictions until they need services that they expected their plan to cover.

In other situations, some contracts indicate that certain benefits will be available, but when patients need the specific benefit, they discover that tightened authorization procedures limit the benefit. Some health care organizations continue to use misrepresentation and deception to gain financial or market advantage, with potential serious consequences for patients.

Medical necessity. The term "medical necessity" can have hundreds of different meanings, interpretations, and applications, even within the same company. And as health plans fragment and outsource more of their management functions, different companies may use and apply varied definitions of "medical necessity," including some that are more restrictive than the one contractually disclosed to members.

Health plans can also delegate decision-making about medical necessity to medical groups and other vendors who are under risk-sharing arrangements, such as capitation, that is, set fees an HMO agrees to pay a physician per patient, regardless of the frequency or cost of the medical care provided. These providers have financial incentives to limit or deny care, or substitute less costly alternatives. In some cases, even reinsurance companies enter into medical decision-making prospectively, requiring health plans to seek their approval first. In these situations, the reinsurer's definition of "medical necessity" may be more restrictive than the plan's.[13]

Furthermore, nothing about this additional layer of medical management is ever disclosed to plan members. I have examined a case in which a health plan would have approved an expensive treatment but eventually denied it after the reinsurance company determined that the treatment did not meet its criteria for "medical necessity."

Despite claims that denials have decreased, a study of two California health plans reported that between 8 percent and 10 percent of requests for medical treatment and coverage were explicitly denied, an increase of 3 percent over previous reports.[14] And even though medical-necessity determinations remain critical to cost control, we know little about how they are made, and each decision must be examined carefully to determine its validity.[15]

Medical guidelines. Medical management depends on having codified criteria that provide the rules for evaluating medical necessity and making other medical determinations. For example, in the early days of managed care, authorization requests for hysterectomies were evaluated by medical directors who relied primarily on their understanding of the prevailing clinical standards of care, which would come predominantly from research and academic literature. However, when company doctors

began to review requests for medical treatment, these standards allowed too much variation in medical judgment.

Many companies sprang up to fill the gaps, so that now almost every medical treatment or service is so systematized that little independent medical judgment enters into the review for many managed care organizations. In one case, a company made the conditions for approval of a hysterectomy so narrow that they would have required conservative treatments to fail and the patient to have suffered a recurrence of invasive carcinoma before she could have the surgery. In other situations, managed care organizations applied outdated or wrong criteria and manipulated criteria inappropriately to justify a denial.

Although "evidence-based medicine" is the new buzz phrase,[16] there is a difference between legitimate clinical criteria that have been developed through research and peer review, and proprietary protocols developed by commercial companies using pseudo-scientific processes.[17]

Exclusions for "experimental and investigational" treatments. When managed care was first established, health plans often relied on prevailing clinical and government standards to determine whether a requested treatment was experimental. With advancements in technology and research, the exclusion grew to include investigational procedures. Now, definitions that used to be only a couple of sentences long extend for pages. Some plans try to exclude standard therapies simply because they are part of a researcher's data collection and study.

As with "medical necessity," patients may find that health plans apply different definitions of these terms. In one case I examined, a plan member's medical needs were not excluded under the contract's broad, two-line definition of "experimental." However, when the health plan sent the case to an outside consultant, it requested that he use a detailed definition and criteria that were nearly two pages long, giving the physician more technicalities on which to justify a denial.

New plans

Traditional HMO membership is decreasing, and more members are choosing preferred provider organizations (PPOs) and other managed care hybrids. Although PPOs are generally viewed as less restrictive, they continue to use many of the managed care practices associated with HMOs, such as hospital precertification and authorizations for certain tests, treatments, referrals, and drugs.

Although many PPOs do not use gatekeeping, that is, they don't use physicians to control patients' access to treatments, tests, and specialists, they have other ways to control patients and their physicians. Some PPOs delegate utilization management to physician groups such as individual practice organizations, which in turn use contracts, payments, and even peer pressure to influence and control treating physicians' decisions. PPOs also

use disease management, pharmacy management, selected networks, and medical criteria in making "medical necessity" decisions that can emphasize cost rather than care.

Managed-indemnity plans. Many people buy "indemnity" health insurance that they believe is closer to traditional coverage, without managed care. However, these insureds often discover that when they need medical treatment, they face managed care practices that are often associated with more restrictive health plans.

For example, I reviewed a case in which a health insurance company used a medical-necessity requirement as a basis for a denial, even though the insured's contract did not contain such a provision. Further investigation revealed that the company was channeling all its medical management through a utilization-review department designed for its HMO business. Even though some consumers were paying more for a less-managed health plan, they were essentially treated as if they were HMO members.

Tiered plans. Health care companies continue to rely on network restrictions as a means to control costs and care, although new health plans appear to be less managed, with their various "tiers" of providers and benefits. Many patients in these tiered plans discover that to receive medically necessary, high-quality care, they must choose the most expensive tiers, if they can afford to do so.

For example, a plan's lowest tier will restrict the network of doctors and require HMO-type restrictions for referrals and specialty care. If a patient chooses this tier, out-of-pocket costs will be minimal and care might be limited. The highest tier will allow more open access to doctors and hospitals with fewer restrictions, at increased patient expense.

In tiered plans, patients assume their own health care management and might find that they will have to deny themselves quality care for financial reasons. If patients remain in the lowest-cost tier, they will be in an HMO-type plan, with most of the more restrictive managed care practices. These tiered plans have the potential to affect quality of care: "More efficient" physicians and other providers who provide the least expensive treatment are placed in lower-cost tiers, putting sicker patients and the physicians who care for them at serious economic disadvantage.[18] The physicians in the lowest tiers are the most "cost effective," so they provide the least amount of care and will not want to treat sicker patients. Patients, both well-off and poor, who need more care may need to go to other tiers.

The sheer complexity of these arrangements may result in significant savings and profits to health plans.[19] The administrative complexity makes it hard for patients and physicians to get access and payment, so delays and payment hassles multiply, and plans benefit from anything that allows them to keep the money longer.

Illusory choice and cost-shifting. The managed care backlash and decreasing profitability have driven insurance companies to develop new plans that capitalize on consumers' demands for choice and freedom in treatment and the doctors they can

choose. Some consumers can put together their own networks and choose levels of benefits according to how much they want to pay.

Few consumers understand the implications of these new plans, especially the amount of cost-shifting that occurs when patients require medical treatment. This shifting of the economic burden becomes the most sophisticated cost-management tool yet. In one case, a couple discovered after they had a child that they had chosen a network that did not include the specialized neonatal care their child needed. They had to assume greater out-of-pocket costs so their child could receive appropriate medical treatment.

These new arrangements also engage in their own forms of stealth managed care. Companies that offer these new plans have their own networks and even pay providers under capitation arrangements.[20] Consumers will have to be clairvoyant about which benefit levels and networks they will need to design their plans. They now design their plans by making choices about how much they want to pay in premiums, deductibles, and copayments; what type of pharmacy benefits they want; and what network they want.

Although the structures of these new plans vary widely, most arrangements have a threshold at which some care management occurs. In such situations, patients will have the illusion of choice and freedom for medical needs like acupuncture, laser eye surgery, and other discretionary medical expenses, but will be surprised to find themselves at the mercy of a company that will decide the medical necessity of critical hospitalizations, surgeries, and expensive medical treatments.[21]

Targeted management

Through sophisticated information-management systems, a managed care organization can identify particular codes, patterns, profiles, cost thresholds, or other identifiers of medical conditions and treatments for focused review and adjust its management strategies to fit current trends.

For example, as more care shifts to outpatient services, utilization management can target office-based surgeries, home health care, new diagnostic tests, high-cost injectable drugs, and durable medical equipment. Specific diseases, conditions, treatments, and even particular patients can be targeted, identified, and selectively managed. I have examined documents in which cost accounts were kept for particular members, and certain levels of review kicked in at different cost thresholds or when preset cost triggers were reached.

Disease management. This is the most rapidly growing medical-management industry, with over 150 companies now vying for the managed care of specific patient populations and medical conditions, such as congestive heart failure and renal disease. Many of these companies enter into risk-sharing arrangements with health plans that create financial benefits from shorter hospitalizations, decreased emergency room visits, cheaper drugs, and provisions of fewer medical services.

Although new forms of managed care are often portrayed as patient-friendly, there is no clear data showing that "disease management" reduces the cost of health care while improving its quality.[22] In fact, I have reviewed many files that suggest that disease management adds to patient risk in dangerous ways. For example, in one case, a renal-care company discouraged treatment for medical complications because approving the treatment would cut into its profits.

Pharmacy management. Changes in Medicare drug benefits and the rising costs of pharmaceuticals suggest that prescription-drug management will be critical for the future of managed care. I receive calls frequently from patients who are unable to obtain necessary medications or who are forced to accept substitutes that are often less effective. In some cases, serious harm and death result from a managed care organization's interference with drug treatments.

Many health care plans include new "incentive-based formularies," in which patients choose among tiers of drugs grouped by cost and copayments. For example, a patient might need a specific drug that places him or her in a tier that requires higher copayments or cost-sharing, forcing him or her to use another less costly drug that might be less effective or even dangerous. Health plans reap significant savings with these arrangements,[23] but patients' lives are endangered when these plans are misrepresented or poorly disclosed. Patients, especially those with chronic illnesses, can suffer and die needlessly if they are unable to afford necessary drugs that should be covered.

Pharmacy management will continue to evolve, with new and refined attempts to increase restrictions by using pharmacy networks, limiting the availability of certain drugs, tightening precertification requirements, and expanding drug-specific utilization management.

Hospital and other institutional management. Precertification for facility care, including acute hospitalization, skilled nursing care, inpatient rehabilitation, psychiatric treatment, and other forms of institutional care, remains a critical focus for medical management. Controlling admissions and lengths of stays in these facilities provides immediate, lucrative economic returns for managed care organizations.

Many companies use software programs with detailed medical protocols for their assessments. The so-called guidelines used by these programs often become rigid rules that are applied without regard for a patient's age and sex or the presence of other medical problems. A "reviewer," who may not even be a nurse, can apply rules that assign the number of days that a patient with a particular medical condition will be allowed to be treated in a hospital or other facility.

In addition to tighter precertification, managed care organizations use "concurrent review", meaning health plan nurses directly monitor a patient's care in a medical facility through daily phone calls or on-site visits. This kind of micromanagement gives a managed care organization the means to control the entire course of inpatient treatment, especially decisions about transfer, discharge, and follow-up care.

Predictive modeling and "prospective" care. The health industry understands that a small percentage of patients incur the largest percentage of costs. Traditional managed care depends on identifying high-cost patients through diagnosis or "cost triggers," but cost management may occur too late.

New models depend on making predictions about particular patients who are likely to be costly. Through methods of data analysis, pattern recognition, and new techniques like "time-series analysis" and "neural networking," managed care organizations can target specific individuals, and even physicians, to proactively "manage" healthy patients long before they need care.[24] For example, a plan can use data patterns to identify patients who might be at risk for heart disease, and then it can concentrate on limiting the future costs of these patients before they have even developed any signs of the disease.

Even prevention is giving way to new strategies of "prospective" medicine, with the development of "health coaches" and earlier intrusion by health plans into lifestyle choices.[25]

Health plans have also discovered that scouring claims for the "worried well", patients who seek frequent health care, convinced that they are ill even though they are physically well, enables them to control the potential costs of another population of patients before the patients need care. Health plans might use this kind of data for aggressive underwriting and marketing as well as for management, providing increased opportunities to avoid patients whose care might be costly.[26] The next phase of this kind of management will no doubt include genetic testing.[27]

Behavior controls

The development of ways to influence physician behavior and practice patterns continues to be critical to managed care.

Physician profiling. As information management and technology become more sophisticated, managed care organizations can use physician profiling to identify specific providers according to costs and quality, and use this information to influence practice patterns. This area of physician control is likely to grow more extensive and effective.[28]

Studies show that physicians who have been subject to profiling linked to financial incentives, meaning that managed care organizations have detailed reports on the physicians' hospital admissions, test orders, and referrals to specialists, and they link payment to those numbers, giving higher payments and bonuses to physicians who stay within those numbers and penalizing those who exceed them, reported difficulties with making appropriate medical decisions for their patients. These physicians said they were often torn about doing what is best for the patient while working under a health plan that rewards physicians who control costs by limiting treatment.[29]

Physician profiling has already succeeded as a means to do economic credentialing, in which plans choose physicians based on economic performance and cost-effectiveness. Plans award the most economical physicians by placing them in networks and plans that will bring the physicians the most financial return. In some cases, economic credentialing has been coupled with targeted reviews to remove noncompliant, difficult, or costly physicians.

Expanded capitation. Although some reports claim that capitation is waning, it still remains an effective method to control costs by shifting the financial risk of loss for medical treatments to many different providers. Initially, health plans used capitation for primary care physicians (PCPs) or physician groups in an attempt to fix the amount of money available to pay for the medical care of a panel of members.

A panel is a group of patients who use the same primary care physician. If 500 members have Dr. A as their PCP, for example, Dr. A has a panel of 500, for which he will be paid a fixed amount. The panel members do not even have to be patients that Dr. A has seen. This is the idea behind capitation: Get your panel number up as high as possible, then do as little as possible for members. The ideal would be for none of the 500 panel members ever to visit the doctor.

Now health plans have expanded capitation to specialists, especially in fields that have high frequency and costs of surgery like gynecology, orthopedics, and otolaryngology. Under these arrangements, specialists are induced to behave more like gatekeepers.

Health care companies also use capitation for outsourced management firms, such as disease- management companies. Like traditional HMOs, these companies profit to the degree that they can control the costs of medical treatments, services, hospitalizations, drugs, and equipment.

Organizational incentives and disincentives. In addition to financial arrangements with providers, managed care organizations set up cultural, administrative, and economic controls to influence their employees' work. Some health plans have used cash bonuses to reward doctors and nurses for decreased costs. Other incentives are less blatant. Various methods can be used, from bonuses tied to overall company profitability or performance, to cultural and employment pressures such as audits and evaluations designed to meet cost-management objectives.

I have examined many situations in which employees who work for health plans and other health care organizations were directly and indirectly influenced to make decisions that adversely affected patients' health.

For example, in one case, when a medical director told a patient that he had been hospitalized for as long as the plan would allow, the patient's treating physician released him, putting the patient's health at risk but saving him the cost of paying out of-pocket for a hospital stay that the plan wouldn't cover. In another instance, company nurses and doctors ignored indications that a patient's condition was too serious to discharge him

from the hospital. They denied continued hospitalization, and they received bonuses for doing so.

Payment for quality. The newest trend in physician payment is providing incentives for quality. Under some arrangements, physicians receive additional payments or bonuses for meeting certain goals like high immunization rates or increased patient satisfaction. But several quality-based plans have significant utilization or financial incentives that result in high-quality care for some, not all, patients.

For example, physicians under plans in which quality bonuses are paid for meeting certain goals, like ordering more mammograms, may feel pressured to give special attention to patients from whom they will benefit the most, leaving other patients at rink of different standards of care. So a plan might emphasize screening for breast cancer but not treating it.

Appeals

Health plans and insurance companies create streams of disputes that result in hassles, delays, and denials of care. Although many disputes involve less than life-and-death decisions, an analysis by the Center for Health and Public Policy Studies, a research and policy-analysis group at the University of California, Berkeley, revealed that significant numbers of patients whose treatment was delayed or denied reported that their health worsened and that they suffered permanent disabilities as a result.[30]

The appeal process serves as an effective management tool. Health care companies benefit financially from anything that produces delays or obstacles, from patients who are too ill to fight for their treatment to personnel who are too overworked to care. Often little is known about the outcome of an appeal[31] until a particular patient's experience unravels in litigation.

Internal correspondence, medical case files, and other documents in patients' legal cases reveal that reviews are sometimes poorly investigated and performed. I have evaluated cases in which health plans based decisions on wrong protocols, or ignored or even hid reports from outside consultants that were favorable to patients. Even external companies that consider patient appeals do not ensure accessible, unbiased, high-quality reviews.[32]

In addition to continued delays and denials of care, the new consumer-directed and tiered plans will introduce layers of complexity that can result in a bureaucratic nightmare of unimaginable proportions. Countless patients have faced complicated claim problems after they were treated for serious illnesses, and these problems affected their future medical care. When patients and their families exhaust their energy and finances struggling through administrative mazes, medical treatment may be compromised.

Patients' future

If these new strategies do not support continued profitability, health plans may return to older, more stringent forms of managed care. Already, there is evidence that earlier forms of managed care are re-emerging, as medical directors and physician advisers report that they are pressured to review more "tightly."[33]

Medical, legal, academic, business, and political professionals have duties to ensure that individuals and organizations are accountable, not only for specific decisions but also for the systems they create and set in motion. Until we create a health care system based on effective administrative, clinical, ethical, and legal accountability, managed care will move toward its "third coming." In this phase, the privileged will experience management by excess as they seek boutique care and enhancement medicine, and the disadvantaged will suffer management by the brutal rationing that will be necessary to keep the health industry ever more profitable.

It is not enough to focus on medical errors and malpractice without a careful examination of the underlying systems in which unsafe or negligent acts occur. It is not enough to focus on institutional safety or individual professional negligence without also addressing issues of organizational and corporate responsibility. Until we have substantive ethical, legal, and political change to our health care system, managed care will continue to endanger patients.

Notes

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Mr. KUCINICH. Mr. Potter, you may proceed. Thank you.

STATEMENT OF WENDELL POTTER

Mr. POTTER. Thank you, Chairman Kucinich, Ranking Member Jordan and members of the committee for this opportunity.

The title of today's hearing serves as an important antidote to some of the rhetoric about who or what stands between a patient and his or her doctor. I know there are many who fear the idea of a government bureaucrat in that space, but the alternative has proved much more fearsome. The status quo for most Americans is that health insurance bureaucrats stand between them and their doctors right now, and maximizing profit is the mandate that has simply overtaken this industry.

As Members discuss the various compromises that undoubtedly will be floated in the coming weeks, I encourage you to look very closely at the role of for-profit insurance companies in particular and the role that they play in making our health care system both the most expensive and one of the most dysfunctional in the world.

I know this hearing and others you are holding will help Members of Congress look beyond the misleading and destructive rhetoric making the rounds and the headlines and help provide a real sense of what life would be like for most of us if the kind of so-called reform the insurers are lobbying for is enacted.

An estimated 25 million Americans are now underinsured for two principal reasons. This is in addition to 45 million people who are uninsured. First, the high deductible plans that many of us have been forced to accept require us to pay more out of our own pockets for medical care, whether or not we can afford it. Second, the number of underinsured people has increased, and far more have fallen victim to deceptive marketing practices and bought what essentially is fake insurance.

The industry is insistent on being able to retain the so-called benefit design flexibility so insurers can continue to market these kinds of often worthless policies. The big insurers have spent millions of dollars acquiring companies that specialize in what they call limited benefit plans. An example of such a plan that is marketed by one of the big insurance companies is under the name of Starbridge Select. Not only are the benefits extremely limited, but the underwriting criteria established by this insurer essentially guarantees big profits. Preexisting conditions are not covered under the first 6 months. The employer must have an annual turnover rate of at least 70 percent. So most workers don't even stay on the payroll long enough to use their benefits, and the average age of employees must not be higher than 40, and no more than 65 percent of the work force can be female.

I'm sure you've all heard insurance executives say over the past few months that they are bringing solutions to the table this time to help you address the problems of the uninsured and the underinsured. If they were to be completely honest, however, they would tell you that the solutions they really have in mind are moving millions more of us into high-deductible and limited-benefit plans. If Congress goes along with these solutions, the bill it sends to the President might as well be called the Insurance Industry Profit Protection and Enhancement Act.

That said, the executives you will hear from tomorrow rarely use the term "insurance" to describe their businesses these days. They refer to their companies now as health benefit companies or health solutions companies, and for a very good reason. They have been moving rapidly away from the risk that insurers used to assume for their customers and toward a business model that enables them to administer benefits for large self-insured companies, and also to shift the financial burden of health care to individual workers if their employers are not big enough to self-insure.

If I were a member of this subcommittee, I would ask the executives tomorrow about this trend. I would ask them what has been happening to their fully insured books of business in recent years. If they're honest, they will tell you that it has been shrinking, and that they have been taking deliberate actions to make it shrink.

According to a recent story in The Wall Street Journal, the seven largest for-profit health insurance companies have seen a decline of 5 million members in their fully insured books of business just since 2007. I would ask the executives why this has happened, and if they expect this trend to continue, and I would ask them what kind of businesses are fully insured these days. Again, if they're honest, they will tell you that they are primarily small to midsize customers that are not large enough to self-insure. And that does not bode well for the future of this country or our economy as most of the job growth in the United States is occurring in small to midsize businesses.

I would ask the executives what kind of health benefits—health benefit plans they're marketing now to small businesses and to businesses with a high rate of turnover among employees. If they're honest, they will tell you they're marketing limited-benefits or high-deductible plans to these businesses.

I would ask Aetna and CIGNA in particular why they are sponsoring the first annual voluntary benefits and limited medical conference in Los Angeles next month. And I would ask them what "voluntary" really means. If they're honest, they will tell you that workers enrolled in voluntary benefit plans pay the full premium as well as high out-of-pocket expenses. Their employees do not have to pay a dime—their employers don't have to pay a dime toward their employees' health care benefits. Many of these plans actually prohibit employers from subsidizing the premiums.

As the organizer of the Los Angeles conference notes on its Web site, voluntary benefits and limited medical plans are a multibillion-dollar industry and one of the fastest-growing segments in the health insurance industry.

Another question you might consider asking is how much money insurance companies make from investments by delaying payments to health care providers. As you know, doctors now have staff members dedicated solely to trying to get insurance companies to pay claims that have been denied. The longer an insurance company can avoid paying a claim, the more interest it can earn from the float.

Mr. Chairman and members of the subcommittee, this is the current state of the inadequately regulated free-market system the health care companies want to preserve. We already have 25 million Americans who are underinsured. If the insurance industry

gets what it wants out of this forum, that number will grow very, very fast in the years ahead. People you know, your constituents, maybe even your sons and daughters and your grandchildren, will be joining the ranks of the underinsured, and they will be forced by law to pay private insurance companies for their lousy coverage, and you and I and other taxpayers will have to subsidize the premiums for those who cannot afford them. I implore you not to let that happen.

Thank you for considering my views.

Mr. KUCINICH. Thank you very much, Mr. Potter, for your testimony and also your expression of civic consciousness.

[The prepared statement of Mr. Potter follows:]

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Testimony
Of
Wendell Potter
Senior Fellow on Health Policy
The Center for Media and Democracy

Domestic Policy Subcommittee
Oversight and Government Reform Committee
2154Rayburn HOB
Wednesday, September 16, 2009

"Between You and Your Doctor:
the Private Health Insurance Bureaucracy "

Thank you Chairman Kucinich for the opportunity to address the House Oversight and Government Reform Subcommittee on Domestic Policy. Mr. Chairman, Ranking Member Jordan, and Members of this Subcommittee, my name is Wendell Potter, and I am humbled to be here today and testify beside fellow Americans who have been so harmed by the deplorable practices of an industry I worked in for many years.

The title of today's hearing serves as an important antidote to some of the rhetoric about who or what stands between a patient and his or her doctor. I know there are many who fear the idea of a government bureaucrat in that space but the alternative has proved much more fearsome. The status quo for most Americans is that health insurance bureaucrats stand between them and their doctors right now, and maximizing profit is the mandate that has simply overtaken this industry. As my fellow panelists know firsthand, the bureaucracy of private health insurance is a labyrinth of deliberately misleading terms of art designed to help companies minimize the coverage provided and maximize profits to appease Wall Street and investors. Or, rather, it is a minefield that leaves every American at great risk of not just going bankrupt over uncovered medical expenses but of losing their lives and the lives of their loved ones.

For 20 years, I worked as a senior executive at health insurance companies, and I saw how they confuse their customers and dump the sick — all so they can satisfy their Wall Street investors.

1. First, an Apology

So, I would like to take this opportunity to apologize to you and my fellow panelists for the role I played over a decade ago in, essentially, cheating you out of a reformed health care system. Had it not been for greedy insurance companies and other special interests, and their army of lobbyists and spin-doctors like I used to be, we wouldn't be here today.

I'm ashamed that I let myself get caught up in deceitful and dishonest PR campaigns that worked so well, hundreds of thousands of our citizens have died, and millions of others have lost their homes and been forced into bankruptcy, so that a very few corporate executives and their Wall Street masters could become obscenely rich.

But it was only during the last few years of my career that I came to realize the full scope of the harm my colleagues and I had caused, and the lengths that insurance companies will go to increase their profits at the expense of working families.

I know from personal experience that members of Congress and the public have good reason to question the honesty and trustworthiness of the insurance industry. Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand — or even to obtain — information consumers need. There is simply no solid basis for trusting that the insurance companies will make good on the promises they are making right now in order to avoid crucial reforms that would literally save countless American lives.

And, I know there is a perception out there that we cannot achieve major reform because the insurance industry employs so many people. But, in general, the companies today have fewer employees than they did when I first started working in this field. Many jobs that used to be in-house have been outsourced. And, the most numerous jobs are low-paying positions that are tasked with helping to deny peoples' claims for coverage. If a public option were adopted, I bet new government jobs would be created that would provide employees like these not just more secure positions but more satisfying ones, which would not have the high burn-out and turn-over rate in the industry right now where these workers suffer tremendous stress from being on the front-lines of telling desperate families that the insurance company is refusing to allow or pay for needed medical treatment. The existence of so many jobs devoted to denying coverage should not be an excuse to thwart reform. Surely, there has to be a better way.

As Members discuss the various compromises that will be floated in the coming weeks, I encourage you to look very closely at the role for-profit insurance companies play in making our health care system both the most expensive and one of the most dysfunctional in the world. I know this hearing, and others you are holding, will help Members of Congress look beyond the misleading and destructive rhetoric making the rounds and help provide a real sense of what life would be like for most of us if the kind of so-called reform the insurers are lobbying for is enacted.

When I left my job as head of corporate communications for one of the country's largest insurers, I did not intend to go public as a former insider. However, it recently became abundantly clear to me that the industry's charm offensive — which is the most visible part of duplicitous and well-financed PR and lobbying campaigns — may well shape reform in a way that benefits Wall Street far more than average Americans.

2. Here's How the Private Insurance Bureaucracy Really Works, or Rather Doesn't Work for You

A few months after I joined the health insurer CIGNA Corp. in 1993, just as the last national health care reform debate was underway, the president of CIGNA's health care division was one of three industry executives who came here to assure members of Congress that they would help lawmakers pass meaningful reform. While they expressed concerns about some of President Clinton's proposals, they said they enthusiastically supported several specific goals.

Those goals included covering all Americans; eliminating underwriting practices like pre-existing condition exclusions and cherry picking; the use of community rating; and the creation of a standard benefit plan. Had the industry followed through on its commitment to those goals, I wouldn't be here today.

For weeks now, we have been hearing industry executives saying the same things and making the same assurances. And, I am sure you will hear the same refrain tomorrow. This time, though, the industry is bigger, richer and stronger, and it has a much tighter grip on our health care system than ever before. In the 15 years since insurance companies killed the Clinton plan, the industry has consolidated to the point that it is now dominated by a cartel of large for-profit insurers.

The average family doesn't understand how Wall Street's dictates determine whether they will be offered coverage, whether they can keep it, and how much they'll be charged for it. But, in fact, Wall Street plays a powerful role. The top priority of for-profit companies is to drive up the value of their stock. Stocks fluctuate based on companies' quarterly reports, which are discussed every three months in conference calls with investors and analysts. On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical-loss ratio, or medical "benefit ratio," as some companies now call it. That is the ratio between what the company actually pays out in claims and what it has left over to cover sales, marketing, underwriting and other administrative expenses and, of course, profits.

To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9% to 79.4% a year later, a change of less than two percent.

To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick. Insurers have several ways to cull the sick from their rolls. One is policy rescission. They look carefully to see if a sick policyholder may have omitted a minor illness, a pre-existing condition, when applying for coverage, and then they use that as justification to cancel the policy, even if the enrollee has never missed a premium payment. Asked directly about this practice just last week in the House Energy and Commerce Committee, executives of three of the nation's largest health insurers refused to end the practice of cancelling policies for sick enrollees. Why? Because dumping a small number of enrollees can have a big effect on the bottom line. Ten percent of the population accounts for two-thirds of all health care spending. The Energy and Commerce Committee's investigation into three insurers found that they canceled the coverage of roughly 20,000 people in a five-year period, allowing the companies to avoid paying $300 million in claims.

They also dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether — leaving workers uninsured. The practice is known in the industry as "purging." The purging of less profitable accounts through intentionally unrealistic rate increases helps explain why the number of small businesses offering coverage to their employees has fallen from 61 percent to 38 percent since 1993, according to the National Small Business Association. Once an insurer purges a business, there are often no other viable choices in the health insurance market because of rampant industry consolidation.

An account purge so eye-popping that it caught the attention of reporters occurred in October 2006 when CIGNA notified the Entertainment Industry Group Insurance Trust that many of the Trust's members in California and New Jersey would have to pay more than some of them earned in a year if they wanted to continue their coverage. The rate increase CIGNA planned to implement, according to USA Today, would have meant that some family-plan premiums would exceed $44,000 a year. CIGNA gave the enrollees less than three months to pay the new premiums or go elsewhere.

Purging through pricing games is not limited to letting go of an isolated number of unprofitable accounts. It is endemic in the industry. For instance, between 1996 and 1999, Aetna initiated a series of company acquisitions and became the nation's largest health insurer with 21 million members. The company spent more than $20 million that it received in fees and premiums from customers to revamp its computer systems, enabling the company to "identify and dump unprofitable corporate accounts," as The Wall Street Journal reported in 2004. Armed with a stockpile of new information on policyholders, new management and a shift in strategy, in 2000, Aetna sharply raised premiums on less profitable accounts. Within a few years, Aetna lost 8 million covered lives due to strategic and other factors.

While strategically initiating these cost hikes, insurers have professed to be the victims of rising health costs while taking no responsibility for their share of America's health care affordability crisis. Yet, all the while, health-plan operating margins have increased as sick people are forced to scramble for insurance.

Unless required by state law, insurers often refuse to tell customers how much of their premiums are actually being paid out in claims. A Houston employer could not get that information until the Texas legislature passed a law a few years ago requiring insurers to disclose it. That Houston employer discovered that its insurer was demanding a 22 percent rate increase in 2006 even though it had paid out only 9 percent of the employer's premium dollars for care the year before.

It's little wonder that insurers try to hide information like that from its customers. Many people fall victim to these industry tactics, but the Houston employer might have known better — it was the Harris County Medical Society, the county doctors' association.

A study conducted last year by PricewaterhouseCoopers revealed just how successful the insurers' expense management and purging actions have been over the last decade in meeting Wall Street's expectations. The accounting firm found that the collective medical-loss ratios of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. That translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients.

There are many ways insurers keep their customers in the dark and purposely mislead them — especially now that insurers have started to aggressively market health plans that charge relatively low premiums for a new brand of policies that often offer only the illusion of comprehensive coverage.

An estimated 25 million Americans are now underinsured for two principle reasons. First, the high deductible plans many of them have been forced to accept — like I was forced to accept at CIGNA — require them to pay more out of their own pockets for medical care, whether they can afford it or not. The trend toward these high-deductible plans alarms many health care experts and state insurance commissioners. As California Lieutenant Governor John Garamendi told the Associated Press in 2005 when he was serving as the state's insurance commissioner, the movement toward consumer-driven

coverage will eventually result in a "death spiral" for managed care plans. This will happen, he said, as consumer-driven plans "cherry-pick" the youngest, healthiest and richest customers while forcing managed care plans to charge more to cover the sickest patients. The result, he predicted, will be more uninsured people.

In selling consumer-driven plans, insurers often try to persuade employers to go "full replacement," which means forcing all of their employees out of their current plans and into a consumer-driven plan. At least two of the biggest insurers have done just that, to the dismay of many employees who would have preferred to stay in their HMOs and PPOs. Those options were abruptly taken away from them.

Secondly, the number of underinsured people has increased as more have fallen victim to deceptive marketing practices and bought what essentially is fake insurance. The industry is insistent on being able to retain so-called "benefit design flexibility" so insurers can continue to market these kinds of often worthless policies. The big insurers have spent millions acquiring companies that specialize in what they call "limited-benefit" plans. An example of such a plan is marketed by one of the big insurers under the name of Starbridge Select. Not only are the benefits extremely limited but the underwriting criteria established by the insurer essentially guarantee big profits. Pre-existing conditions are not covered during the first six months, and the employer must have an annual employee turnover rate of 70 percent or more, so most of the workers don't even stay on the payroll long enough to use their benefits. The average age of employees must not be higher than 40, and no more than 65 percent of the workforce can be female. Employers don't pay any of the premiums—the employees pay for everything. As Consumer Reports noted in May, many people who buy limited-benefit policies, which often provide little or no hospitalization, are misled by marketing materials and think they are buying more comprehensive care. In many cases it is not until they actually try to use the policies that they find out they will get little help from the insurer in paying the bills.

The lack of candor and transparency is not limited to sales and marketing. Notices that insurers are required to send to policyholders—those explanation-of-benefit documents that are supposed to explain how the insurance company calculated its payments to providers and how much is left for the policyholder to pay—are notoriously incomprehensible. Insurers know that policyholders are so baffled by those notices they usually just ignore them or throw them away. And that's exactly the point. If they were more understandable, more consumers might realize that they are being ripped off.

3. A Cautionary Note about All the Spin Going on in the Debate over Health Reform

I would be remiss if I did not add a note of caution about how the industry has conducted duplicitous and well-financed PR and lobbying campaigns every time Congress has tried to reform our health care system -- and how its current behind-scenes-efforts may well shape reform in a way that benefits Wall Street far more than average Americans.

Just as the industry did 15 years ago when it led the effort to kill the Clinton reform plan, it is using shills and front groups to spread lies and disinformation to scare Americans away from the very reform that would benefit them most.

Make no mistake, the industry, despite its public assurances to be good-faith partners with the President and Congress, has been at work for years laying the groundwork for devious and often sinister campaigns to manipulate public opinion.

The industry goes to great lengths to keep its involvement in these campaigns hidden from public view. But I know from having served on many trade group committees that industry leaders are always full partners in developing strategies to derail any reform that might interfere with their ability to increase their companies' profits.

My involvement in those activities goes back to the early '90s when insurers joined with other special interests to finance the activities of an organization called the Healthcare Leadership Council, which led a coordinated effort to scare Americans and members of Congress away from the Clinton plan.

A few years after that victory, the insurers formed a front group called the Health Benefits Coalition to kill efforts to pass a Patients Bill of Rights. While it was touted as a broad-based business group, the Health Benefits Coalition in reality got the lion's share of its funding from Big Insurance.

Like most front groups, the Health Benefits Coalition was set up and run out of a big and well-connected PR firm. One of the key strategies developed by the PR firm as the coalition was gearing up for battle in late 1998 was to stir up support among conservative talk radio hosts and other media.

The PR firm formed alliances with the Christian Coalition, the Family Research Council, and other groups on the right and persuaded them to send letters to Congress and to appear at press conferences. The firm also launched an advertising campaign in conservative media outlets. The message was that President Clinton owed a debt to the liberal base of the Democratic Party and would try to pay back that debt by advancing the type of big government agenda on health care that he failed to get in 1993. Those tactics worked. Industry allies in Congress made sure the Patients' Bill of Rights would not become law.

The insurance industry has funded several other front groups since then whenever the industry has been under attack. It formed the Coalition for Affordable Quality Healthcare to try to improve the image of managed care in response to a constant stream of negative stories that appeared in the media in the late '90s and the first years of this decade.

It funded another front group when lawyers began filing class action lawsuits on behalf of doctors and patients.

The PR firm the industry hired to create that front group, by the way, had planned and conducted a similar campaign for the tobacco industry a few years earlier.

The insurance industry hired that same PR firm again in 2007 to help blunt the impact of Michael Moore's movie, "Sicko." It created and staffed a front group called "Health Care America" specifically to discredit Moore and to demonize the health care systems featured in the movie.

Among the tactics the PR firm used once again was to enlist the support of conservative talk show hosts, writers and editorial page editors to warn against a "government-takeover" of the U.S. health care system. The term "government-takeover" is one the industry has used many times over the years to scare people away from reform.

Health Care America also placed ads in newspapers. One of those ads carried this message, "In America, you wait in line to see a movie. In government-run health care systems, you wait to see a doctor."

With this history, you can rest assured that the insurance industry is up to the same dirty tricks, using the same devious PR practices it has used for many years, to kill reform this year, or even better, to shape reform so that it benefits insurance companies and their Wall Street investors far more than average Americans.

Americans need to be alert to how the industry and its allies are working to influence their opinions and lawmakers' votes. I know from years as an industry PR executive how effective insurers have been in using scare tactics to turn public opinion against any reform efforts that would threaten their profitability.

I warned earlier this year that Americans and the media should pay close attention to the efforts insurers and their ideological buddies would undertake to demonize health care systems around the world that don't allow for-profit insurance companies to have the free reign they have here.

Americans must realize that the when they hear isolated stories of long waiting times to see doctors in Canada and allegations that care in other systems is rationed by government bureaucrats, the insurance industry has written the script.

And Americans must realize that every time they hear we will be heading down the "slippery slope toward socialism" if Congress creates a public insurance option to compete with private insurers, some insurance flack like I used to be wrote that, too.

Our nation has many fine publicly funded services that Americans depend on and that reveal the absurdity of this line of argument. America has some of the finest public universities in the world—this isn't socialism or radical. And, modern-day Americans rely on the "public option" of firefighters who come to your house or business to put out fires, without checking to see if you have special firefighter insurance or a pre-existing condition that would permit them to stand by and let your house burn down. That's not socialism. It's common sense. We shouldn't let this silly rhetoric to create a result that values our homes more than our lives. If someone proposed private insurance as the only solution to fighting fires, they would be rightly viewed as a radical. Defending the status quo is just as radical.

We should ask the skeptics of a public option, who are afraid that giving people a choice of a government-run plan will lead to socialism, if they would want to go back to the day when Americans had to buy private fire insurance. If they lived in Ben Franklin's day and they didn't have a shield on the outside of their house indicating they were insured, their town's private fire insurance companies would let their house burn down. The private insurance companies would keep your fire from spreading to your insured next-door neighbor's house, but your house would soon be nothing more than a pile of ashes.

The bottom-line is that every time you hear about the shortcomings of what they call "government-run" health care, remember this: what we have now in this country, and what the insurers are determined to keep in place, is Wall Street-run health care.

And know that we already have one of the most insidious means of rationing care in the world -- not by people we can hold accountable on election day but by insurance company executives who answer only to a few wealthy investors and hedge fund managers who care far more about earnings per share than your health and well-being.

I am very worried that if Congress goes along with the "solutions" the insurance industry says it is bringing to the table and fails to create a public insurance option to compete with private insurers, the bill it sends to the president might as well be called the Insurance Industry Profit Protection and Enhancement Act.

Some in the media believe the health insurers have already won. That's not only because the debate over reform seems to have been hijacked recently by insurance company shills and people who believe the lies they have been spewing, but because of the billions of dollars the insurers have been spending on these efforts.

It is not too late to keep the insurers from winning, but time is running short. We need to think of the coming weeks as some of the most important weeks in the history of this country. We need to think that way because they will be. I implore each Member of Congress to put the interests of ordinary, extraordinary American above those of private health insurers and others who view reform as a way to make more money.

For skeptics out there who say they don't want to saddle their children and grandchildren with additional debt taxes, ask them if they have thought what might happen to their children and grandchildren if they found themselves among the millions of people without health insurance or, maybe more likely, among the underinsured. It's almost unfathomable to believe that this is what is happening every day, just so insurance companies can continue to pay their CEOs $30 million a year and meet Wall Street's profit expectations.

So in the coming weeks, to those who are worrying needlessly about a government-takeover of our health care system, I believe that what we all should really be concerned about is the Wall-Street takeover that has occurred while we were not paying attention. It is that takeover that has led to more and more working Americans being forced into the ranks of the uninsured. It is that takeover that has forced millions more of us into the ranks of the underinsured because insurers are making us pay thousands of dollars out of our own pockets before they'll pay a dime.

It is that takeover that has forced many of our neighbors out of their homes and into bankruptcy. And it is that takeover that is causing more and more small businesses to stop offering coverage to their employees because of the exorbitant premiums that greedy, Wall-Street-driven insurers are charging them.

In Conclusion

I want to conclude by thanking you, Chairman Kucinich and other Members of this Subcommittee who are making genuine and comprehensive health insurance reform a priority. Over these past few months, I have repeatedly told audiences around the country that the public option should not just be an "option" to be bargained away at the behest of insurance companies who are pouring money into Congress to defeat substantial and essential reforms. It must be part of the solution or reform will fail to truly fix the root of the severe problems the Subcommittee is examining this week.

I know that tomorrow you will be hearing from executives of some of the nation's largest insurance companies, although, as you may know, they rarely use the term "insurance" to describe their businesses these days. Executives refer to their companies now as "health benefits" companies or "health solutions" companies and for a very good reason: they have been moving rapidly away from assuming the risk that insurers used to assume for their customers and toward a business model that

enables them to administer benefits for large self-insured companies and also to shift the financial burden of health care to individual workers if their employers are not big enough to self-insure.

If I were a Member of the Subcommittee, I would ask them about this trend. I would ask them what has been happening to their fully insured books of business in recent years. If they are honest, they will tell you that it has been shrinking—and that they have been taking actions to make it shrink through purging actions, as I described in my testimony earlier.

According to a recent story in *The Wall Street Journal*, the seven largest publicly traded health insurance companies have seen a decline of five million members in their fully insured books of business just since 2007. I would ask the executives why that has happened and if they expect this trend to continue. And I would ask them what kinds of businesses are fully insured these days. I expect they will tell you that they are primarily small- to mid-sized customers that are not large enough to self-insure. If that is indeed the case, it does not bode well for the future of our country or our economy, as most of the job growth in the United States is occurring in small- to mid-sized businesses.

I would ask them what kind of health benefit plans they are marketing now to small businesses and to businesses with a high rate of turnover among employees. If they are honest, I suspect they will tell you they are marketing limited-benefit and/or high-deductible plans to these businesses, as CIGNA does under the name of StarBridge and as Aetna does under the name of SRC.

I would ask Aetna and CIGNA in particular why they are sponsoring the first annual Voluntary Benefits and Limited Medical Conference in Los Angeles next month—and I would ask them what "voluntary" really means. If they are honest, they will tell you that workers enrolled in voluntary benefit plans pay the full premium as well as high out-of-pocket expenses. Their employers do not have to pay a dime toward their employees' health care benefits. Many of the plans actually prohibit employers from subsidizing the premiums.

As the organizer of the Los Angeles conference notes on its Web site, "Voluntary benefits and limited medical plans are a multi-billion dollar industry and one of the fastest growing segments in the insurance industry in America."

A look at the enrollment totals of some of the largest insurance companies bears that out. While their fully insured books of business have been shrinking, enrollment in their voluntary and limited-benefit plans have been growing rapidly. Aetna and CIGNA are leaders in the voluntary and limited-benefit movement. According to the organizer's Web site, "The conference will feature key speakers from CIGNA, Aetna, McDonalds, Black and Decker, CKR Restaurants and some of the largest associations in the country."

As *Voluntary Benefits Magazine* reports in its August 31 edition, "limited coverage plans are becoming more and more appealing to small business owners as their primary plans because they can no longer afford the high monthly premiums associated with major medical group coverage." In addition, the magazine reports, "it's simply not feasible for someone making $20,000 a year to spend several thousand dollars to meet his or her annual health plan deductibles."

I would ask the executives if the reason they are insisting on maintaining "benefit design flexibility" is so that the federal government does not ban them from selling these kind of plans and also so they will be able to charge older Americans up to 7.5 times as much as they charge younger people.

I would ask these questions because there is abundant evidence that these voluntary and limited benefit plans are the kinds of plans insurers have in mind when they think of the millions of people who currently do not have coverage but who will have to buy insurance from them if they can persuade Congress and the President to include an individual mandate in health care reform legislation—and not to include a public insurance option.

Mr. Chairman and other Members of this Subcommittee, I believe you will agree after hearing honest answers from the executives tomorrow that insurance companies are counting on health care reform to provide them with millions of new customers, a steady stream of new revenue from those new customers and the federal government in the form of subsidies, and the ability to continue to shift more and more of the cost of health care away from them and employers and onto the shoulders of working men and women.

We already have 25 million Americans who are underinsured. If the insurance industry gets what it wants out of reform, that number will grow very, very fast in the years ahead. People you know, maybe even your sons and daughters and grandchildren, will be joining the ranks of the underinsured—and they will be forced by law to pay private insurance companies for their lousy coverage. And you and other taxpayers will have to subsidize the premiums for those who cannot afford them.

I implore you not to let this happen.

Thank you for considering my views.

Mr. KUCINICH. I want just—before I begin my questions, I just want to say how deeply moved I was to hear the testimony of Mr. Gendernalik and Ms. Ackley.

How's your daughter?

Mr. GENDERNALIK. She's improving gradually. Her condition is—it is hard to treat seizures. It's hard to treat seizure disorders. We've been through many pharmaceuticals, and currently she's now on what is called a ketogenic diet. It's a diet designed to alleviate seizures. We're having some success, but she's way off her benchmarks. If we don't arrest the seizures, her cognitive development will leave her severely mentally retarded.

Mr. KUCINICH. Well, your family shall remain with our thoughts.

I just also want to say to Ms. Ackley, I had the chance to read the exhibits, but in particular the obituary of your dad, who was obviously a wonderful person, and I can imagine what it's like for you to testify.

I have to tell you when I was listening to both your testimony, I'm sure this is true of other Members, I wasn't just hearing the words, I could feel it in my heart. And this is the kind of testimony I think that can move the country, and, you know, I just—you can feel this. Thank you for being here, and our condolences to your family. From your experience, perhaps Congress will become better informed about the actions that we need to take.

I want to thank Dr. Stern for sharing with us his testimony, as well as Dr. Peeno for her understanding of the inner workings of the industry.

Now, I want to begin questioning with Mr. Potter, who, as I said earlier, is the former head of corporate communications for CIGNA in Philadelphia. First, I want to ask Mr. Potter about the business profit model of the private insurance industry. What is the business model of the insurance companies? How do they make money?

Mr. POTTER. They make money by avoiding as much risk as possible, and often by dumping people who are sick, and they do this through a variety of means. One is delaying or denying care. Another is to rescind policies that we've read about in the news and has been the subject of some subcommittee hearings in which people who have been paying their premiums for many years, when they get sick and have high medical bills, the insurance company will review their original applications, and if they find any reason to cancel it, they will; and also purging small businesses.

Mr. KUCINICH. Doing what?

Mr. POTTER. Purging small businesses. They deliberately look to see if there are small businesses and midsize businesses that are customers whose medical claims are higher than was otherwise expected, and they will jack those rates up, the premium rates, when those books—when those customers' accounts come up for renewal, and they will jack them up so high that these businesses have no alternative but to drop their insurance coverage. They can't afford—that's why we've had such a drop in the number of small businesses over the years. It's declined from 67 percent in the 1990's to just about 38 percent now.

Mr. KUCINICH. And you've talked about the denial reduction of coverage. Would you explain to this subcommittee what is policy

rescission, and how widespread was that practiced while you were in the industry?

Mr. POTTER. Policy rescission happens. This is in the individual market, not so much in the market in which people get their coverage from, through their employer. Many people don't have the option of getting their coverage through the employer. And you have to fill out an application if you want to get coverage, of course. And you have to include in that application whether or not you have been sick in the past, why you've gone to the doctor if you have been hospitalized; in other words, what preexisting conditions do you have that we should know about? And if you are—and in many cases, a preexisting condition will mean you can't get coverage at any cost. And also, children who are born with birth defects ultimately will not be able to get coverage in this system we have now.

So it is a means of being able to again cull the sick, to avoid paying claims. And if you fail to disclose something and you get sick and there are high medical bills that are sent for payment to your insurance company, they'll look at your application, and they'll look to see if maybe you have inadvertently or even purposefully not disclosed something.

Mr. KUCINICH. One of the things that we have been hearing in the past few weeks is how the private insurance industry uses special interest groups to craft market and send a message that the industry wants to send. Could you explain how this happens, and can you comment on how the industry wants us to believe that they are there to help us to get healthier? What do they think they are doing? And, you know, who are they talking to?

Mr. POTTER. The industry, and I know this from having worked in a lot of trade association committees over the years and serving on strategic communications committees; they plan and carry out duplicitous PR campaigns. One is, I call the charm offensive, in which they will come here and they will tell you that they are in favor of reform and will be working with you as good-faith partners and with the President. And they will say the same thing they said in 1993 and 1994, that they are in favor of getting rid of the preexisting condition clauses and in favor of avoiding or making—or of the cherry picking that goes on.

Mr. KUCINICH. So they will say one thing and do another.

Mr. POTTER. Exactly.

Mr. KUCINICH. Do they do that consistently?

Mr. POTTER. They do it consistently. They say what they want you to hear, and that is the charm offensive that they carry out. And they will talk about how much they are in favor of bipartisan reform, for example. Behind the scenes, they will be conducting these covert PR campaigns, and they work through big Washington-based PR firms or New York-based PR firms that set up front groups for them. Like in the 1990's, a group called the Health Benefits Coalition was set up, and it was presumably a business coalition but the funding came largely from health insurance companies, and the soul purpose was to kill the Patients Bill of Rights.

Mr. KUCINICH. When you say front groups, you mean they are groups that are then mobilized to try to present themselves as representative of public opinion?

Mr. POTTER. That is right. And they employ a lot of PR tactics, and they work also with the media and with Members on Capitol Hill. But with the media, the PR people who have connections with producers and reporters will feed messages to them, talking points, and there are a lot of reporters and producers and pundits who are very sympathetic to them.

Mr. KUCINICH. I am looking forward to having a chance to ask Mr. Potter some more questions, but my time has expired, and I want to, before I recognize Mr. Jordan, I want to acknowledge the presence of the gentlelady from Ohio, Ms. Kaptur, who has joined us.

And, Mr. Jordan, you may proceed for 5 minutes.

Mr. JORDAN. Thank you, Mr. Chairman.

And I apologize to the committee and to our witnesses. I have to jump out. I am in another committee next door.

Mr. KUCINICH. Mr. Jordan, we are always in awe of how you can be in two committees at one time. But we are glad you are here.

Mr. JORDAN. Thank you for this important hearing and for the witnesses' testimony.

And to Mr. Gendernalik and Ms. Ackley, your stories—I think every single American would agree what you went through is wrong. You pay your premiums. You're honest when you sign up for your contract. You should not have to go through the harassment and the things. I mean, this is coming from a conservative Republican who says what happened there is wrong.

Americans, it seems this whole health care debate as it has unfolded over the last several months, Americans hate being told what to do. And this idea that somebody is going to get between them and their family and their doctor, whether it is the insurance company or, frankly, whether it is the Government, it is just something that just doesn't sit well with them. So I think there are things that we have to focus on that empowers the family and doesn't have what you described take place.

I liked what I think Dr. Stearns said earlier, and I am old enough to remember as well when I was a kid going into the family doc, and there was typically one person out front, and in those days, it was typically a lady, taking care of things and the reception work, and maybe she was—that individual was a nurse as well. Today, there are more people out front complying with all the bureaucracy, whether it is government or insurance; there are more people out front than there are in the back trying to get you well. And that's a problem, and that is what is so frustrating to so many Americans.

Let me just walk through some of the things I outlined in my opening statement and just see. And I'll go to Dr. Stern, if I could. Do you think we need some liability reform in our current health care system? Do you think that is appropriate?

Dr. STERN. The short answer is, very definitely, yes.

Mr. JORDAN. Do you think there is the need for more empowerment, say, health savings accounts, association health plans? I can remember, just 2 weeks ago I was giving a speech. Before I even talked to the group, had a husband and wife walk up to me, small business owners. They own the business, and they have two employees.

And they said, "Congressman, we would love the ability to pool together with other similarly situated—other small business owners and use the economies of scale." Do you think that makes sense in our health savings accounts, association health plans, as part of a way to empower people and help with our costs and help with our system?

Dr. STERN. There is a conflict there. The issue of pooling together and generating much larger insurance pools makes an infinite amount of sense, and in fact, in Maryland, we do have a small business pool.

The issue of the health savings account and the notion that the consumer can be empowered to spend that dollar more wisely just flies in the face of what the actual market is. Medicine is not a free market.

Mr. JORDAN. I agree with that.

Dr. STERN. No way. A free market demands the free flow of information both ways.

Mr. JORDAN. And I was going to go there. So how do we get that? How do we get that transparency? How do we get to where—there's a great piece, at least I read on the plane flying in this week, in The Atlantic about a businessman who talks about the experience his father went through getting an infection in the hospital. And he outlines what he thinks needs to happen in health care, and he talks about the fact that it is not a free market, and it is always somebody else paying the bill, and that is a fundamental problem. So tell me what you think needs to happen so we do get the transparency we need to get the right market out there.

Dr. STERN. The transparency has to be within the health care system itself, to have the broker. The insurance companies are not in the health care business; they are a broker. I am in the health care business; I deal directly with the patient. The University of Maryland is in the health care business; they deal with the patient. Johns Hopkins is in the health care business; they deal with the patient.

To have the broker intercede in that interaction is simply not productive. And you have in my written testimony some very specific actions that we have had to take. One of those is a bill that I worked on in the Maryland General Assembly and moved, fortunately, moved forward on the national scene, was the issue of the mandated benefit for maternity care. There is no way to have the private insurer intercede and make that determination that a child and a mother should be going home at such and such a time. That is a medical decision. It should be left to the medical authorities.

Mr. JORDAN. I agree.

Dr. STERN. If there is malfeasance in that, it is the medical profession that should be taking care of it. And we do.

Mr. JORDAN. OK.

Dr. STERN. But to assume that this is a marketplace issue I think simply isn't going to fix the problem. That is how we have been dealing with it. It is not a free market. And we don't have—the consumer doesn't have the information that they need to make that analysis. Even if they had the information, they don't have the understanding. I mean, I went to medical school. I did additional training just to be able to make that——

Mr. JORDAN. Well, I don't know that's always the case. I'll use my—our—we have a health savings account in our family, a high deductible health savings account. I did what so many of my colleagues do, every couple of years go for the physical that they offer here with the doc on Capitol Hill. Did the blood work, did everything. He says, "You know what? We can have you—we can schedule you for a colonoscopy as well." I said, "I'll think about it," and decided I would rather do it at home.

Found out our insurance doesn't cover it. But I also know I'm 45, and 50 is kind of the recommended time you do this. So I could have depleted our account, or I can just wait, and we decided to wait. So there was a situation where we made the decision as a family, or I made the decision, that we would just wait. So I do think it can work and has a place.

But what I am interested in getting at is a more—what we need to do so that we empower the patient, the consumer, the family as much as we can and eliminate this bureaucracy, whether it is the government or the insurance companies that gets between the patient and the caregiver.

And my time went way too fast, Mr. Chairman. So I will I yield back.

Mr. KUCINICH. I thank my colleague from Ohio.

Before I introduce Mr. Cummings for questions, I want to acknowledge the presence in the audience of some visitors who have come to Capitol Hill to indicate their concern about the reimbursement policies with respect to prosthetics.

So I want to acknowledge your presence. I see the young man in the front row. We are glad that you are here. Maybe some day you will be on the other side of this dais here. So thank you so much for being here.

At this time, we'd like to recognize Mr. Cummings of Maryland for 5 minutes of questioning.

Mr. CUMMINGS. Dr. Potter, first of all, thank all of you for your testimony. It's been very eye opening and very helpful.

Dr. Potter, one of the things that really bothers me is that when you talk about insurance companies, the media—health insurance companies, the media—and you complain about them, the media it seems to bend in the direction of saying that you are beating up on them. And that really bothers me, because when I listen to your testimony—and I can tell you as a lawyer, the things that you talked about to me are, if not fraudulent, are very, very close and are criminal.

In other words, when you say that you are going to—when a person or an insurance company has people paying, say, for 16 years, and when it comes time—they are loyal in paying their payments. But when it comes time for them to get what they are due—and that is a simple concept of contract law: You bargain for something, and you get back something. But when they come to get it, what they are saying, I mean, listening to the testimony here, when you hear Dr. Stern, basically what he said is that he has to fight to get what he needs for his patients. And not everybody is a Dr. Stern. I know there are 99 million great doctors. But he has to fight, and he has to double and—to double the number of employees in the fight.

So I am trying to figure out, do you think it is an unfair statement when—do you think it's a fair statement when you say you are beating up on the insurance companies?

Mr. POTTER. Absolutely not. It is part of the PR campaign of the industry to protest that they are being demonized. And as someone who was in PR for the industry for 20 years as part of what I did when I was there, they want you to see them as, again, good-faith partners and working with Congress and with the President, and behind the scenes doing all they can through a lot of ways of essentially laundering money through big PR firms and setting up groups that they don't want anyone to know that they have any association with but which they are funding to try to gut reform or to shape it in ways that will benefit them more than Americans.

One thing that's happened over the years, and I saw this from my role initially as a journalist but then later as a PR guy, our media has changed a lot. The newsrooms are shrinking. There is very little investigative reporting. And reporters are so stretched for time that they'd often just take a statement that I would write and go with it and say, "Well, I've got the insurance company's point of view here." The insurance companies and other industries of the special interests have really benefited from the change in the way that the media operates and the growth in power of corporate public relations.

Mr. CUMMINGS. Dr. Peeno, I am wondering, when I listen to testimony here and then I watch some of the town hall meetings where people were loudly protesting—and that is all well and good. But I sat there and I wondered how many people, if they really read the legislation, would understand that this probably would help them. And I get the impression—I know there are many reasons that have been given for these protests, but I get the impression that part of it must be what I call, "It won't happen to me" syndrome; in other words, that people assume that, oh, that happened over there in Indiana. That happened over there in Baltimore, but it won't happen to my family. It won't happen to my friends. I won't have a similar experience as Ms. Ackley.

And so, I mean, so how—so I take it that this, the things that you are talking about are pretty widespread.

Dr. PEENO. Absolutely. And I think you are right. I mean, people assume that this isn't going to happen to me until something tragic does. But I can tell you, as one of those doctors that sat there and put the nod on pieces of paper, that it did not make any difference what somebody's income level was, whether they were Democrat or Republican, rich, poor, black, white, yellow, green, or whatever. The only thing that made a difference was what they were costing and how quickly we could avoid any cost or claim that was going to hurt profits. I mean, I was told when I was first hired that I was to use my MD degree to give economic justification to the company's decisions.

Mr. CUMMINGS. And were you rewarded for that? In other words, was that part of your evaluation?

Dr. Peeno. I was significantly rewarded. I mean, I quit one company before I got my bonus because we were put on a bonus system. But when I went to another company, we—my job evaluation depended upon the number of denials and how much cost savings

I generated. And, you know, the 150 cases that I worked on as an expert witness, you know, I have read depositions and seen documents, internal documents, that will never see the light of day because they are sealed that show the reward system and the compensation system for the medical doctors that work for the insurance company.

Mr. CUMMINGS. Just one last question. Is there anything that you have seen to make you, over—since you left the system—I think—when did you leave the system, the last insurance company?

Dr. PEENO. 1990, 1991.

Mr. CUMMINGS. Is there anything that you have seen in your present work that would indicate that things are better in that regard that you just talked about?

Dr. PEENO. Absolutely not. It is far worse. Everything is more evolved, more sophisticated, more technical. The methods—the difference between the methods I used to deny care and the methods that are used now is the difference between surgery with a kitchen knife and a laser gamma knife now. It is just that much more expert.

Mr. CUMMINGS. Thank you very much.

Thank you, Mr. Chairman.

Mr. KUCINICH. The Chair recognizes Mr. Tierney.

You may proceed.

Mr. TIERNEY. Thank you very much.

Mr. Gendernalik and Ms. Ackley, I can't think of any question for either of you that would do a better job than what your testimony did in laying out what some of the issues are. I do want to thank you for being with us here today. I know how difficult it must be on that.

Mr. Potter, I want to go back to you again, because I—someone is going to get between the patient and their medical provider one way or the other the way our system is set up. Not everybody in my district, certainly not even a majority of the people in my district, can afford to put money into an account of some sort. And, if they do, they are still going to have an insurance company somewhere involved in that. So clearly that is not the answer that we are talking about here.

We can regulate, or we can try to regulate prohibiting rescission, prohibiting a cap on the insurance, and perhaps prohibiting exclusion for preexisting conditions, but we would have to be pretty good at policing to make sure the companies don't just do it anyway, or that they don't try to pay fewer claims in some other way.

It would seem to me that one way to do it is to just say that a certain percentage of a premium dollar has to be spent on medical services, so the medical loss ratio—maybe go back to where it was in the 1990's, to 95 percent. That would be one way of going at it. Do you agree?

Mr. POTTER. I do agree.

Mr. TIERNEY. And the second is competition with somebody or something that doesn't play by the rules that they play. Right now, they are happy with competition. Let's have competition as long as we are all in on this game of trying to make sure our medical loss ratio is low, our salaries are high, our profits are high, and we

have these different ways of excluding coverage. And I think—would you agree that's where the public option comes in? That if you don't have something like that, we are never really going to get at the crux of this?

Mr. POTTER. Absolutely. There is some competition, but it is far less now than there was back in the 1990's. That's one reason why the medical loss ratio has been able to drop so much. There is such power concentrated in the hands of now seven very large for-profit insurance companies that one out of every three of us is enrolled in some kind of a benefit plan managed by one of those seven big companies.

They are accountable to Wall Street; they are not accountable, really, to you and me. And we can become victims of their striving to meet Wall Street's relentless profit expectations. There is no counter to that right now. They are all playing by the rules that they establish in a marketplace. There is no government benchmark. They set the rules. They determine what kinds of policies we'll be able to have, what kinds of policies your employer will offer to you. They run the show. They have an enormously tight grip on our health care system, far, far more now than they did in 1993, 1994. And they are richer and stronger and more powerful and more influential than ever before. A public option is absolutely, absolutely vital.

Mr. TIERNEY. I would think that people on the streets ranting and raving would be ranting and raving about that kind of practices that we're talking about engaged in by the insurance companies. I mean, that would really get your blood boiling. Now, that would be a populous motion. People would be out in the streets saying, "Why is our government letting them get away with that? Why aren't they stepping in and protecting us?"

So on the Oversight Committee here, we're used to following the money. So we know where the money is going: It is going to Wall Street. It is going to the people who invest in these companies. What role do you think those companies are playing in inciting people to go in and, instead of railing against bad insurance bureaucracy practices, trying to tell how bad their government is?

Mr. POTTER. I was speaking at a town hall meeting a few days ago, and a woman—and I was describing how this works, how the PR firms work for the industry and feed pundits talking points.

And she came up, and she said, "No one paid me to come here." And I said—I was thinking, well, no one had to. You don't get the money. That is not where the money goes. The money goes into the big PR firms who have the influence to manipulate public opinion. That's how it happens.

And I did ask her, to Congressman Cummings' point, are you absolutely certain that tomorrow your insurance is going to be there, that your son or daughter is going to be enrolled in a benefit plan that provides protection? And she didn't have a good answer to that, because there is no guarantee. You do not know if you are going to have your insurance coverage tomorrow. You do not know if you are going to be losing it because you lose your job, or if you are going to be forced into a plan that makes you pay so much out of your own pocket that you might as well—you will be forced, in some scenarios, to buy insurance from private insurance compa-

nies, but your benefits may be so limited that you will be sending in money every month for almost nothing.

Mr. TIERNEY. Which has been going on.

Just, I'll tell you one little anecdote from an individual that came into my office, just ranting and raving about the public option. And I tried to explain what that would do.

He said, "Look, I like my company now."

I said, "Fine, then stay with your company."

And then he said, "Well, except if I get really sick or someone in my family gets really sick, I don't use the company; I go to the VA, because if I use the company, they will jack up my premiums."

Case in point.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes the gentlelady from Ohio, Ms. Kaptur.

Ms. KAPTUR. I thank the chairman very much, and compliment him for his steadfast efforts to try to bring health insurance at affordable prices and quality care to all the American people. I'm very, very proud to serve with you.

I wanted to say to the panel that I view my job as defending our citizenry against those who might harm or exploit them or our Republic. And these are very important hearings today.

As I have listened to your testimony, I keep thinking about pharmaceutical companies being the third most profitable sector in our economy. In the district that I represent, you can't turn the TV on without being besieged by all these ads from the pharmaceutical companies. I don't know if that is true in every district in the country, but they are sure spending a lot of money on advertising. I keep asking myself, if you have a doctor, what do you need all those ads for on the television?

It is very curious what has happened. That wasn't true 20 years ago. It is true today. And I can see, with the kind of profits they are making, where they are putting some of those dollars.

Yet, I have people in my district, I border Canada up in northern Ohio, and I can't tell you how many people from my district have to go to Canada because they cannot afford medicine in the United States of America. Yet, I see these ads on television, and I am thinking, what doesn't fit here? How are these dollars being used versus what the need is?

The insurance companies are the ninth most profitable industry in this country, and, Mr. Potter, I think you talked about seven companies now having a third of the market?

Mr. POTTER. Yes. That's right.

Ms. KAPTUR. And we heard that yesterday at a hearing by the former head of CIGNA Corp., who I believe will be before this committee this week.

I remember, back to our beloved Uncle Skip from our family, and he used to confide in me as he became older and had infirmities. He said, "Marcy, here's all my insurance." Now, this is a man that was on Medicare. And he emptied out his billfold, and he pulled out all these policies, Art Linkletter policy and this policy and that.

And I said, "Uncle Skip, why do you have these policies? You don't need these policies. You have a supplemental, and you have your Medicare."

He says, "Well, just in case."

And I keep thinking to myself, I thought, "Uncle Skip, why didn't you tell me about this before? You don't need to spend your money on these." I said, and, "frankly, with some of the exclusions, this wouldn't give you anything."

But he really didn't know. He was not an uninformed person, but he was afraid. He did not have a college degree. And I asked myself, how many Uncle Skips are out there in our country who are buying unnecessary policies that are duplicative? And even with our offices on aging and so forth, we can't reach every citizen to help them make wise insurance choices.

So my questions to you really are, the bill that the President has proposed has language that only encourages for the pharmaceutical companies price negotiation for the cost of prescription drugs. Within the VA, within the Department of Defense, we actually negotiate. It is mandatory.

I want to ask you to comment on the language that is in the base bill that merely encourages negotiation, and what that might mean down the road. And, No. 2, on the insurance companies and the fact that seven control so much, can you give us a sense of what you see happening in the insurance market in our country? Is it consolidating like we see happening in other segments of our industry, the banking industry, mega banks that just caused this huge implosion in our economy, these very big private companies that seem to be terribly irresponsible? Could you give us a sense of what is happening in the insurance market?

Anyone that wants to respond on the pharmaceutical question or on that would be much appreciated.

Mr. POTTER. I think that encouraging is not strong enough. You are exactly right. Another gentleman I heard was talking about he got his care through the VA, and he needed medication that cost him a modest amount of money. But he needed it. And in private insurance, he would have to pay about $300 for this medication. He was able to pay through the VA a small fraction of that. So it makes a big difference.

And in the lives of people who are—the median household in this country is just $50,000. The average price of a premium that you get through the workplace for a family is $12,500. So you are shifting more of the financial burden for either drugs or care for the doctor, whatever, there's not much money left over to pay the rent or buy the groceries.

To your point about the seven large companies that control the industry. They have become so big through mergers and acquisitions over the years, and I think a part or a lot of that—or managing communications around them. There are far fewer companies than there used to be. There is not nearly as much competition as the industry would like you to believe. They say on their Web site and they will say in testimony that there are 1,300 insurance companies that compete. There's nothing like that. If you look closer on their Web site, you might see, if you can count up, 287. And then that includes vendors to these companies. So it's a fabrication.

There's been so much consolidation in the industry that last year alone $250 billion flowed through the seven—just these seven companies in revenues. So you have enormous concentration of power.

It is really a cartel of large companies. And they are so big that small companies—and there's been talk about maybe establishing co-ops—there's not a chance that a co-op, a fledgling co-op could ever get the resources or have the clout in the marketplace to compete against these big companies.

Ms. KAPTUR. You are talking about the insurance companies.

Mr. POTTER. I am.

Ms. KAPTUR. Do you see the same concentration in the pharmaceutical industry?

Mr. POTTER. Absolutely. The power of the pharmaceutical companies is—absolutely is great, and they are gigantic companies that are very, very profitable.

Ms. KAPTUR. Could I ask, sir, if there are any of the witnesses that have any articles that you could reference that we could incorporate in the hearing record on the nature of that concentration, I personally would appreciate it very much.

Mr. POTTER. Certainly. We'll do that.

Ms. KAPTUR. Anyone else want to comment on pharmaceutical profits and insurance company consolidation?

Mr. GENDERNALIK. Very briefly.

My daughter's delay in treatment at UCLA, the first significant delay we received was because the pharmaceutical she required is a drug called ACTH. There was one manufacturer who produced it, Questcorps. They have been the subject of Senate hearings due to what they did with their pricing scheme.

In doing my parental due diligence, I went online to look up what this drug was that they were going to put in my child, stumbled across investment journals, online investment journals, where one of the corporate officers from Questcorps was speaking freely to investors. So he wasn't speaking—I wasn't the intended audience.

His remarks were that the drug was an underutilized asset; and because they were the sole manufacturer, they could change their pricing strategy and significantly increase the company's portfolio, which they would then be able to put into—he tried to cast a noble light on—other FDA approvals and such.

The drug went in July 2007 from roughly $1,000 a vial to over $23,000 a vial based on published reports. My insurance company doesn't let me see what the actual costs are. So, published reports, multiple published reports had it at that point, when my daughter needed it in December 2007, $23,000 a vial. And just to get to how ludicrous this is, we had to order it from out of State; we had to inject it ourselves. Two untrained people had to inject our daughter nightly with this. We had a syringe explode. We thought, how many thousands of dollars just exploded over dad's face? They had a delivery man in a beat-up Nissan probably making $8 an hour deliver four vials of this stuff to my house. And I thought, wow, does he know what he has? He can quit this job, drive across to Mexico and sell this stuff.

Clearly we've had our brush with the pharmaceutical industry. My solid opinion is that they delayed service to my daughter because of the hit they were going to take. Now, that is the HMO medical group.

The pharmaceutical company on the other hand knew by the open drug status they had the leverage. There was no competition in the marketplace for this drug that serves a minority of people. Very few children are afflicted with my daughter's disorder. Their primary market for that drug are MS patients, and, therefore, they leveraged it, as the man was candidly speaking in investment journals, up to 23,000.

Other published reporters after my daughter's required time period on the drug, we were on it for 4 months, I don't know, estimated cost was $80,000 to $100,000. The drug went up to over $40,000 a vial. Absolutely exacerbating and unwarranted and immoral. Thank you.

Ms. KAPTUR. Thank you.

Mr. Chairman, may I just say, if there are any witnesses that have any kind of a study on the advertisements paid for by pharmaceutical companies across this country in order of the most, the biggest buys, for which drugs, and then in rank order, I would love to have that for the record.

Mr. KUCINICH. I want to say in response to the gentlelady's question, I think that as we begin preparing for the continued work of this committee, that would be a proper subject for a separate hearing. And I want to thank the gentlelady for making that suggestion.

Ms. KAPTUR. Thank you.

Mr. KUCINICH. We are going to go to a second round of questions of the witnesses before we go to our second panel. And given the fact that we are going to be holding a hearing tomorrow with top insurance executives in this same subcommittee and the fact that we have two distinguished individuals here who have had direct experience working inside the industry, we are going to hopefully be able to engage a little bit more in this second round.

I want to start with Dr. Linda Peeno, who is the former review physician for Humana, Inc., out of Louisville, KY.

Dr. Peeno, the evidence on which evidence-based medicine is supposed to rely is by its nature public, peer-review journals, for example. But the detailed standards of care used by private health insurance companies are proprietary, meaning that it is their business and not ours. If the coverage decisions are based on publicly available evidence, why doesn't it follow that the standards these companies use to determine care should also be public? Why aren't they? And what is the reason?

Dr. PEENO. Well, the main reason is that their basic purpose is to be able to deny or limit care. So what happens—and this has been a part of the evolution of managed care. Twenty years ago, one of the real difficulties for an insurance company back when I was functioning as a medical director was having some sort of objective grounds to deny something. So, for example, if we wanted to deny a hysterectomy, we needed criteria to do that. And that was very labor-intensive for a company to develop. So these companies emerged that would actually develop criteria, like we've heard Milliman & Robertson, Dr. Stern referred to them, which is now Milliman USA, and other companies that have gotten into the business of developing criteria specifically for health care companies to

have—it is like a filter, you know, and the tighter the threads of the filter, the more you can limit or deny care.

Mr. KUCINICH. So you're saying the criteria is set up on denying care.

Dr. PEENO. Right. I mean, it's like I said in my testimony here, you don't purchase criteria in order to provide more care or more generous care. You know, the reason these companies spend millions and millions of dollars to buy the criteria, to set up the computer system, is to enable, as requests are made for the more costly or the more frequent and costly services, is for nurses up front, or not even nurses sometimes, to be able to say, well, this doesn't meet our criteria, and we can't authorize it.

Mr. KUCINICH. So the standards are proprietary. But are these standards based on evidence? Or are they just basically accounting devices to try to whittle away the claims?

Dr. PEENO. Well, they are loosely based on evidence. I mean, there is material that is available and research that comes out of academic centers that say you take this information, that is public and has been developed using public funds, and then you tweak it as an accounting denial tool.

Mr. KUCINICH. Now, Dr. Stern, you wanted to get in on this?

Dr. STERN. The criteria in one case has a focus that is the standard criteria, the standard practice, that are publicly available has a sole criteria of cost-effective quality care. That is the criteria.

Milliman & Robertson is focused on cost reduction. That is the criteria. And everything that is generated in that criteria is to support the cost reduction. It is a highly different mission.

Mr. KUCINICH. So let me ask Dr. Peeno and Dr. Stern, if you want to join in on this. I understand, Dr. Peeno, that insurers pay subcontractors to do utilization review as well as handle specific appeals of denials of coverage. Do insurance companies carve out any specific disease for internal special reviews or for outside contractors to review?

Dr. PEENO. Oh, yes. And——

Mr. KUCINICH. Why?

Dr. PEENO. They kind of carve out—or, outsourcing is increasing.

Mr. KUCINICH. Why? I mean, under what circumstances?

Dr. Peeno. It began, one of the earliest carve-outs were mental health management, you know, where you could carve out the amount of premium that was used for mental health and you subcontract it out to a for-profit mental health management company. You capitate them, so you fix your costs. I mean, they have to take care of all the medical conditions within that. And then that has slowly emerged and grown into now we have disease management companies that will manage a single disease like congestive heart failure or asthma or diabetes or other conditions.

Mr. KUCINICH. Say a whole industry that is set up around trying to figure out how to lessen the amount of claims.

Dr. PEENO. Exactly.

Mr. KUCINICH. I have a limited time here to just ask one final question. A person signs up with an insurance company. They receive a policyholder's book that describes all the procedures and costs that are supposed to be covered. Does this mean an insured

person will then be covered for all the things listed in the book? Yes or no?

Dr. PEENO. No.

Mr. KUCINICH. And is it one standard of medical necessity across the industry?

Dr. PEENO. No. It can even differ within the same company and the same plan.

Mr. KUCINICH. Is there any one standard of medical necessity within each company?

Dr. PEENO. No.

Mr. KUCINICH. OK.

My time has expired. I am going to now go to Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Let me ask Mr. Gendernalik and then Ms. Ackley. The harassment that you went through dealing with the insurance companies, are you in favor of a single-payer system, government-run system, public option that has received so much discussion of late? Or do you think that just replaces one—instead of having the insurance companies give you harassment, you now have the government? We know from many countries that have this, at least from what I have read, there are waiting lists. There are difficulties. There is rationing of care eventually when you go there.

So do you want us to fix what happened in your situation, make the insurance companies do what they said they were going to do when you bought your policy, paid your premiums, did everything right? Or are you in favor of like throwing it all out and going to a single-payer, government-run system?

And, I mean, you obviously know where I am coming from. I look at this, the most recent example of government starting a big program. I just talked with a car dealer the other day. He's still waiting on 75 percent of the dollars that the Cash For Clunker program was supposed to get to him. And I think there's lots of examples where you have bureaucracy that don't meet the customers' needs and demands at least in a timely fashion. So fill me in.

Ms. ACKLEY. Well, I am in support of a public system. But from our experience, things that would have been beneficial with the private industry would include Federal oversight of that.

You know, the appeals process that we went through, supposedly once my dad's appeals went to the reviewing foundation, we were supposed to get a decision within 48 hours. The first appeals process——

Mr. JORDAN. Was that a State review? Was that through the State insurance commissioner?

Ms. ACKLEY. That was coming from the insurance company itself.

Mr. JORDAN. Internal. OK.

Ms. ACKLEY. That we would get a response.

The first appeal process, the hospital received the decision 6 days later, and then my dad received the decision 9 days later.

On the second appeal process, the insurance commissioner's office received a decision 10 days later, and then my parents received it 13 days later. So there was nothing to hold them accountable for that.

Some other things we encountered was the foundation who was reviewing my dad's case is getting paid directly by the insurance company. So, I don't know, that seems a little odd.

Mr. JORDAN. But Ms. Ackley, your short answer is you think a single-payer, government-run system—you would be for moving completely to that type of system?

Ms. ACKLEY. I think there are benefits with a public-run system. But I don't see the private industry being eliminated.

Mr. JORDAN. OK. I guess my question, you don't think we substitute one set of hassles for another if we go in that direction?

I'll go to you, Mr. Gendernalik.

Mr. GENDERNALIK. Thank you for the chance to address the question.

I think to revert to what you were speaking about earlier, health savings accounts as a sole measure for health care, are woefully inadequate.

Mr. JORDAN. I am not saying they——

Mr. GENDERNALIK. I don't believe putting things totally in the hands of government is the solution. I believe that a public option is a necessity to provide a baseline. I think—as a Member of the Republican Party myself, I think we talk out of both corners of our mouth when we express concerns about government inefficiencies on one hand not being able to get it done, and on the other hand, we say that if the government provided a public option, we would undercut, low-ball the price in health care and run the private sector out. Which is it? It's one way or the other. It isn't both, unless we are not dealing direct.

I think there's a desperate need for regulations so that the consumer, the end consumer, the end user, has recourse. We have none now. The way it is set up now, our employers largely negotiate with a limited pool of providers to figure out what choices we have. Then the employee gets to select from that menu. And then we get to subselect a doctor who is covered under that.

Now, I did it backward. I found good doctors and then went up the chain of command. I am fortunate. I work at a huge bureaucracy with 80,000 employees, and the employees pick our contracts. If I worked at a small mom-and-pop who is nice enough to give us coverage, I wouldn't have had that luxury, or we would have been audited repeatedly. And we have some of the most effective policies in this country, thanks to the employee unions who negotiated it.

That all said, my doctor is handcuffed because they do—they determine through their best judgment what the proper care is, and it is constantly meddled and interfered with by people who are looking at one thing: How can they do this less expensively?

I don't believe that for the United States a single-payer government system is what would be best in this point in history.

I do believe that it is incumbent upon all of you to survey the world, just like a business would, if you want to continue on the business model. If I want to know how my competition is beating me, I am going to go find out what they're doing; I'm going to take their best ideas and make it work within my——

Mr. JORDAN. Let me ask you this question, because I think your statements sort of beg this question; if in fact the government's

running it, what is our recourse then if we don't like what they decide? You get hassled. What is our recourse then?

Mr. GENDERNALIK. I can tell you that the services I do get through the Government for my daughter, we have had almost no problem with. And when we do, there is a clearly identified appeal process with a clearly identified timetable with a clearly identified resolution. Nobody is going to be happy all the time. That is just not realistic.

As the proud son of a Dutch mother, I can tell you that the waiting lists that you speak about are not a reality in the Netherlands. And it hurts me as a father and an American, and my relatives have offered to take my daughter and I in because we wouldn't be facing the delays and denials that we are here.

As the proud husband of a Belizean American, when we travel to Belize, a third-world Central American country, my daughter got sick on the flight over. We were hospitalized for 4 days. The bill was $7; $7 in a country where children don't have shoes to go to school. A proud country, a beautiful country. I certainly don't want anyone to take out of context and malign any country, but clearly a poverty-stricken nation, 4 days of hospital care with medication, $7.

Mr. TIERNEY. Mr. Chairman, let me just—15 seconds by unanimous consent. I think the answer to the gentleman's question clearly is, what happens if you don't like the government doing it? It's government. You have a vote, and you change it. That's where the people get to have a part in it. We don't get that vote with the insurance companies, and that's the problem. We can rant and we can rave and we can do it, but all we get to do is go to another company with the same bad practices if we don't like the first one.

Mr. JORDAN. I appreciate the gentleman. But we can also change the law and make it—we do have a say in this as well. We can make the system work better and do one that doesn't turn it all over to the government as well. That's Congress. I mean, I agree with you. We can act.

Mr. TIERNEY. If the gentleman's for strict regulation, we can all get there pretty soon.

Mr. KUCINICH. I want to thank both of my colleagues for that exchange. A great thing about this committee is that we like to hear what each other has to say.

Mr. Cummings, you are recognized.

Mr. CUMMINGS. Mr. Gendernalik, I think you are saying what I am feeling. I just want us to have an effective and efficient system that also has an element of empathy.

The President used to talk about, and I guess he still does, a society where we have an empathy deficit, because we can put all of the rules and regulations in place, but if we don't have people in those places that see people as more than a number or more than a statistic or not worrying about a bonus over the life of a person, it won't make a lot of difference. So I agree with you.

Mr. Potter, what is the—I mean, let's put you in the place in your old position. And somebody walked in to your office and said, "Potter, we've got a problem. Those folks over there on Capitol Hill, they have come up with this thing called a public option. What do we do about that?"

I mean, in other words, I am trying to figure out, what I hear the insurance companies on the one hand say that they are worried about being—not being able to compete, but on the other hand saying that there are certain things that they have to have in order—well, the first thing they don't want is a public option. And I am trying to figure out, what would be the concern? What are those concerns?

And then I would like to hear from you, Ms. Peeno, also. Go ahead.

And are they legitimate?

Mr. POTTER. The insurance industry actually has had this concern and has been preparing for opposition to the public plan since before Barack Obama was elected President. And I was there during a lot of the meetings in which we reviewed every Presidential candidate's platform for health care reform. And as you probably know, President Obama, Senator Clinton, and Senator Edwards all had the public option as a central component of their campaign platform. So the industry had a long time to develop a strategy to try to oppose that, and what we are seeing now is it being carried out.

And they have been saying the things that we've been hearing that make no sense: that it will put them out of business because it will be run too efficiently, on the one hand; or, that we should oppose it because it is a government-run system.

They want to try to make—they want to defame it and make it seen as if this is a government takeover of a health care system. Those are the terms that they use. That's part of the strategy that was developed a long time ago. It has been an ever-green phrase that works for them every time there is an attempt to reform the health care system.

What are they afraid of? They are afraid of having something that might take a little bit of revenue from them. If there's no public option and if you have an individual mandate, look what happens, everybody has to buy their product. And if the person can't afford that product, then you and I and other taxpayers will have to pay the subsidies. And those subsidies, the premium dollars that the people will pay and the tax dollars that subsidize them, will flow right into those for-profit companies—or all those companies for that matter—and then a lot of that will be taken away and go into shareholders' pockets.

That is what they—they don't want to have another competitor. They have been consolidating for many, many years, taking the small players out, gaining control of markets and market share. So of course they are going to try to oppose anything that would compete with them, but certainly anything that could operate more efficiently.

Mr. CUMMINGS. What I see and what I see and I hear the insurance companies say, we are ready to come to the table, we will get rid of the preexisting conditions; we will get rid of the rescissions. And they go through all of that. It makes it sound as if they are basically admitting that this stuff is wrong.

Mr. POTTER. Absolutely. And they said exactly the same thing in testimony before Congress in 1993, and I can point you to it. They know it is wrong. But after the plan failed, the Clinton plan failed,

did you see them coming here to Congress and asking them to change the laws? No. Of course, they didn't. They have thrived. They've made tons and tons—they made billions of dollars with the system that we have now. They are not sincere. It's just rhetoric.

They would agree to it if—they could thrive in a system in which these things are made illegal, but they know how to make money. It is kind of like squeezing a balloon. You could make them do certain things, you can regulate them, but what you would have is pressure from Wall Street to figure out ways, unique ways for them to deny care or to shift more of the financial burden to consumers.

Mr. CUMMINGS. Without a public option, do you see any way where we can control costs? In other words, costs of premiums?

Mr. POTTER. In a word, no. In two words, absolutely no.

Mr. CUMMINGS. Can I just hear from Dr. Peeno, just real quick?

Mr. KUCINICH. The gentlelady may respond briefly.

Please go ahead, Dr. Peeno.

Dr. PEENO. Well, a general question about why they would oppose the public option is because I think, you know, Mr. Potter referred to them as a cartel and that it's a cartel that works with very secret hidden practices that suddenly would possibly be disclosed if they had to compete with a real competitor. So, all of these methods, these secret hidden methods for profit maximization would become more public.

And they could come to the table, and they could say, oh, well, we will give up preexisting conditions; we'll give up rescission. But that is only because they have so refined all of the other methods behind the scenes. And I see this in case after case after case where I've worked as an expert witness, where after all of the labor of finally getting documents that have to be compelled by a judge, and we see the inner practices. You know, these systems are so refined. And they could give up these other things and still have the methods to maximize profits. That's why they no longer worry about possibly having all of these other persons who are uninsured, because they now can control the cost of the people who are going to be costly. You know, it's a process that's been refined over the past decade in ways that are just unimaginable and would take days to explain how all these devious methods work.

Mr. CUMMINGS. Thank you very much.

Mr. KUCINICH. I would say that it would probably be to the great benefit of Congress to have still another hearing of this subcommittee where we actually would go into great detail about how all these meetings and ways are used to deny coverage.

The Chair recognizes Ms. Kaptur for 5 minutes.

Ms. KAPTUR. Thank you, Mr. Chairman.

Mr. Potter, do you have the ability to put on the record the profit margins of the largest insurance companies that you have been referencing?

Mr. POTTER. Sure. I can get that data.

Ms. KAPTUR. How would it compare to the profits that are made, let's say, by the supermarket industry, the food industry, or the clothing industry? I mean, how would you compare, from your knowledge of the industry?

Mr. POTTER. The profit margin is higher than grocery stores. And I haven't compared all the other sectors of the economy. In fact, I

just heard this week that the insurance industry was putting out propaganda saying that only 3 percent of the premium dollar goes to profits or something like that.

It varies widely from company to company and product to product. Some of these products are extraordinarily profitable, and the ones that they want to move us all in to, these high deductible plans and similar plans, profit margins will expand greatly. They can make tons and tons of money on this. So that's what they want to do in the future. That's why the trend is the way it is.

But think of it this way. Let's assume that it is 3 percent, and let's assume—and that's not an assumption, that's the truth, that $250 billion of the money that we spend on health care flowed through those seven companies last year alone in revenue, 3 percent of that is a ton of money. That is a lot of money in profit. So they will use sometimes small numbers to make you think that it is inconsequential, but it is a huge, huge amount of money.

Ms. KAPTUR. Let me go back to my example of Uncle Skip. How much duplication—how do we get a handle on how much money is wasted in the system because consumers are innocently or fearfully buying numerous plans to cover themselves when they're unneeded? How do we get at that? What's the mechanism to get at that? I know the standard benefit plan; that's one of the goals of the reform legislation, to have a benefit plan that people know they can depend upon. But how does one get at that waste inside the system?

Mr. POTTER. There's a lot of waste. McKenzie & Co., which does a lot of consulting work for big insurance companies and other large corporations, did a study of health care systems and compared our system with those abroad, and I think the doctor noted that 30 percent of the money we spend here is on administration that is not spent in other countries. And that is not just because you have that much inside the insurance industry, but it's caused by the industry. The multipayer system we have now, there's an enormous amount of administration that goes on within these companies, but it requires doctors and hospitals to hire big staffs just to deal with them. So that is 30 percent.

Ms. KAPTUR. I understand the administrative point or about a third of the money. But I am talking about citizens who—millions of them out there in our country who are buying policies they don't need because they are victims in the marketplace, in essence. They are fearful of the future. They don't believe that what they have is secure. How much money is being wasted on that?

Mr. POTTER. I think that would be a good research project. I haven't seen the data myself on that because it is not so easily found. But you would need to look at the kinds of policies that the companies are selling, what benefits they have, and whether or not they are really worth a dime.

And then you can also look at the policies that are being spent on fake insurance or—that I have talked about. These big companies are now getting into that. It's not just fly by-nights that are doing that. And these are plans that people—it's not just supplemental. It's what is being sold as the choice that they have available to them that's affordable.

Keep this in mind: Don't be blinded by just this talk about affordable premiums, because they will sell you—they'll market something that has the premiums being affordable, but the benefits will be so lousy you might as well not be insured.

Ms. KAPTUR. If there are senior citizens listening today, if they have a Medicare policy with a supplemental plan that is recognized by the Department of Health and Human Services, do they need extra catastrophic coverage?

Mr. POTTER. I don't think they would. I mean, the basic Medicare benefits are pretty good. If you've got a reasonably good supplemental plan, then I can't imagine why you would need to shell out a lot more of your scarce resources.

Ms. KAPTUR. And where the fault line is, is the public—large numbers in the public don't understand that.

Mr. POTTER. Exactly, they don't.

Ms. KAPTUR. So there are people that play that portion of the market. There are firms that play that portion of the market, and they force product on people that is really unnecessary. And I can't think of a place—I know we have a State Insurance Commissioner in the State of Ohio; you can call that number. But this issue of consumer protection and insurance plan buying is very important, and money is being wasted all over this country by people who are so scared that they are buying what is unnecessary. We really need to look at that arena. It's huge.

Mr. POTTER. It is. And it brings up a point that I would like to make in the inadequacy of State regulation. They do review marketing materials, but they don't have the resources to do an appropriate job. That's why you have stuff like this going on. The regulators are well intentioned, but they just don't have the resources. States are not wealthy enough to provide all the resources that are needed to regulate this industry that is so bent on taking advantage of consumers.

Ms. KAPTUR. I thank you very much.

I know, Mr. Chair, my time has expired.

Mr. KUCINICH. I want to thank the gentlelady. And as she has pursued twice in her line of questioning, the issue of people, particularly seniors, buying policies beyond their basic Medicare extra policies that they may not need and which in fact may represent kind of a consumer fraud that people are trying to sell to seniors, I just want the gentlelady to know that I have just talked to staff, and that is something that we are interested in pursuing to the level of a hearing to work with the gentlelady.

And perhaps we could get Uncle Skip here to testify.

Ms. KAPTUR. Thank you very much.

Mr. KUCINICH. You are welcome. And I just want to say, this is the Ohio committee now. We have Mr. Jordan from Ohio, myself from Ohio, and also Ms. Kaptur. So Ohio is very concerned on this. Some of our colleagues may be rejoining us momentarily.

I want to thank this panel. Each one of you has made a contribution through your testimony here today, some of it heart-wrenching, and other of the testimony infuriating. We will continue with our investigation tomorrow. But I will say that the testimony that came today was very helpful in preparing us for tomorrow as well

as to remind the American people that I think it's good to communicate with each other about our experience. It's not theoretical.

You know, Mr. Gendernalik has real experience with the system.

Ms. Ackley, your family has some real experience with the system.

We need to hear those stories, not anecdotes; what really happens. And, as Dr. Stern told his experience as well. So this is very important. I think, frankly, whatever kind of system we end up with, the transformation is going to be driven by the power of the narratives which we hear from across the country.

So, with that, I want to thank each and every one of you and also to salute Mr. Potter and Dr. Peeno for your courage in coming forward and giving an insider's point of view that we rarely get a chance to hear. And so I just want to thank you personally and on behalf of the committee for being here, and we look forward to your continued work and cooperation. This panel is now dismissed.

Mr. KUCINICH. We're going to ask our second panel to come forward.

As the staff is getting the table ready, I just want to remind everyone that this is the Domestic Policy Subcommittee of Oversight and Government Reform. The topic of today's hearing: Between You and Your Doctor: The Private Health Insurance Bureaucracy. I'm joined by the ranking member, Mr. Jordan of Ohio. We have Ms. Kaptur from Ohio and other Members who have been here throughout the hearing.

We want to thank the first panel. We're now going to go to the second panel. We're fortunate to have an outstanding second panel of witnesses. I would like to first introduce Ms. Karen Pollitz; is that correct? Welcome.

Ms. Pollitz is the project director of the Health Policy Institute at Georgetown University here in Washington. She's also an adjunct professor of Georgetown's graduate public policy school. Professor Pollitz directs research on health insurance reform issues as they affect consumers and patients, focusing on the regulation of private health insurance plans and markets, managed care consumer protections and access to affordable health insurance.

Ms. Pollitz is a member of the National Academy of Social Insurance. She's also a member of the advisory board of the California Health Benefits Review Program and has served on the board of directors of the Maryland Health Insurance Plan, as well as the National Committee on Quality Assurance. Previously, Professor Pollitz served as Deputy Assistant Director for Health Education at the U.S. Department of Health and Human Services from 1993 through 1997, acting as the Secretary's legislative liaison on all Federal health care issues, including national health care reform, Medicare and Medicaid, and U.S. Public Health Service agencies and programs.

Mr. Michael Cannon. Welcome, Mr. Cannon. Mr. Cannon is the CATO Institute's director of health policy studies. Previously he served as a domestic policy analyst for the U.S. Senate Republican Policy Committee under Chairman Larry Craig, where he advised the Senate leadership on health, education, labor, welfare and the Second Amendment. He coauthored a book on competition in health care. Mr. Cannon has had his work published in numerous national

media publications and has also appeared as a commentator on television and radio.

I want to thank you, Mr. Cannon and Ms. Pollitz, for appearing before the subcommittee today. It is the policy of the Committee on Oversight and Government Reform to swear in witnesses before they testify. I would ask that you rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Thank you very much.

Let the record reflect that the witnesses have answered in the affirmative.

I'm going to, as we did with the first panel, ask each witness to a give summary of his or her testimony and to keep the summary under 5 minutes in duration. Keep in mind your complete written statement will be included in the hearing record.

Professor Pollitz, you will be our first witness for this panel. You may proceed. We'll get your testimony in, and maybe we'll be able to hear from both of you before we run to votes. Go ahead.

STATEMENTS OF KAREN POLLITZ, PROJECT DIRECTOR, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC; AND MICHAEL CANNON, DIRECTOR, HEALTH POLICY STUDIES, CATO INSTITUTE, WASHINGTON, DC

STATEMENT OF KAREN POLLITZ

Ms. POLLITZ. Thank you, Mr. Chairman, members of the subcommittee. I just want to open by saying I'm also from Ohio. I grew up in the Cleveland area when you were mayor, Mr. Chairman, so it's very nice to be here today.

Mr. KUCINICH. Thank you.

Ms. POLLITZ. I want to thank you for holding this very important hearing.

I hope and expect that health care reform when it is enacted will create rules to prohibit or at least limit a lot of the practices that you heard about this morning on the first panel, but rules will not be enough. There will always be a strong incentive in a competitive insurance market for insurance companies to try to avoid risks, avoid enrolling, keeping them enrolled, or avoid paying their claims. And so transparency and accountability in insurance is essential, and it's very important that health reform try to accomplish that as well.

Transparency in insurance will involve a number of key changes, and the most important of these will be data reporting. When I was invited to testify at this hearing, I was asked could I provide data on how often practices like these happen, and the answer was I could not, and neither can the regulators or other policymakers, but the information is knowable.

Regulators need to have ongoing, detailed information about marketing and enrollment practices and about how coverage is administered so that it will be possible to see when insurers are avoiding risk that they are supposed to cover. We don't do that today. The Federal Government collects no data on health insurance consumer protections, even though Federal law requires cer-

tain important protections already, including guaranteed renewability of coverage.

For the most part, States don't collect a lot of data on consumer protection and health insurance either. Instead, most data collected on an ongoing basis by State insurance departments relates to financial solvency, and regulators rely largely on consumer complaints as an indicator of problems. However, a body of research shows that rarely do consumers lodge formal complaints with regulators, even about serious health insurance problems that cost them a lot of money or that delay their access to care.

A series of hearings about health insurance rescissions that were initiated in this committee provides a sobering case study of how little we know about how well health insurance works for consumers and how vulnerable they are to discrimination.

This committee asked all 50 State regulators what data they collect on health insurance rescissions, and in response only 4 States could provide any data on the number of rescissions that had occurred. Only 10 could provide the number of individual insurance policies that were enforced in their States, and more than a third of States could not supply a complete list of companies that sell individual health insurance within their borders.

The NAIC pulled all 50 State insurance departments and provided summary complaints data about health insurance rescissions. They found a total of 181 complaints about health insurance rescissions had been lodged over a 5-year period. By contrast, when this committee asked just 3 insurance companies how many policies they had rescinded over the same period, the answer was almost 20,000.

A new approach to health insurance regulation must require ongoing and detailed reporting by insurers of data that will enable regulators to evaluate how the market works, especially for the sickest consumers. That would include data on enrollment, retention, disenrollment, on rating practices at issue, and at renewal.

Regulators must also track measures of coverage effectiveness to see what medical bills are paid and how many are left for consumers to pay on their own. That means insurers also need to report data on provider participation fees, insurer reimbursement levels, health insurance policy lossratios, and data regarding claims payments and utilization review practices. If regulators have access to this kind of information, patterns of problems that affect the sickest consumers won't be as easy to hide.

Finally, Mr. Chairman, health insurance must also be held accountable for compliance with market rules and consumer protections. As Ms. Kaptur talked about her uncle buying additional policies, that is illegal. So it's not enough to have rules. We have to enforce the rules, and that requires resources for oversight and enforcement.

In addition, it's time for the Federal Government to take a more proactive role in health insurance regulation. Current Federal capacity for private health insurance oversight and regulation is practically nonexistent. Last year a witness from CMS testified that agency dedicated only four part-time staff to HIPAA private health insurance matters for the entire Nation.

Further, despite press reports alleging abuse of rescission practices in violation of Federal law, the agency did not investigate or even make inquiries as to whether Federal guaranteed renewability protections were being adequately enforced. This outcome is not surprising.

When you enacted HIPAA in 1996, Congress created important Federal rights for consumers, but limited Federal enforcement authority. Instead, Congress opted to rely primarily on State enforcement by adopting a so-called Federal fallback enforcement structure. Federal enforcement is triggered only as a last resort once a finding is made that States have not adopted and substantially enforced Federal minimum standards. Under the structure it's not surprising that the Federal Government lacks oversight and enforcement capacity. It doesn't make sense to build and maintain capacity that you don't expect to use. So you rely on the States instead, but unfortunately, limited regulatory capacity is a problem at the State level as well. Insurance department staff have been cut, and States are overworked.

It's time for the Federal Government to assume an active and effective role in enforcement of Federal health insurance standards and to require transparency so that we can see how coverage works.

Mr. KUCINICH. I thank the gentlelady.

[The prepared statement of Ms. Pollitz follows:]

GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE

Statement of

Karen Pollitz, Research Professor
Georgetown University Health Policy Institute

On Transparency in Health Insurance

Hearing of the
Oversight and Government Reform Committee
Subcommittee on Domestic Policy
US House of Representatives

September 16, 2009

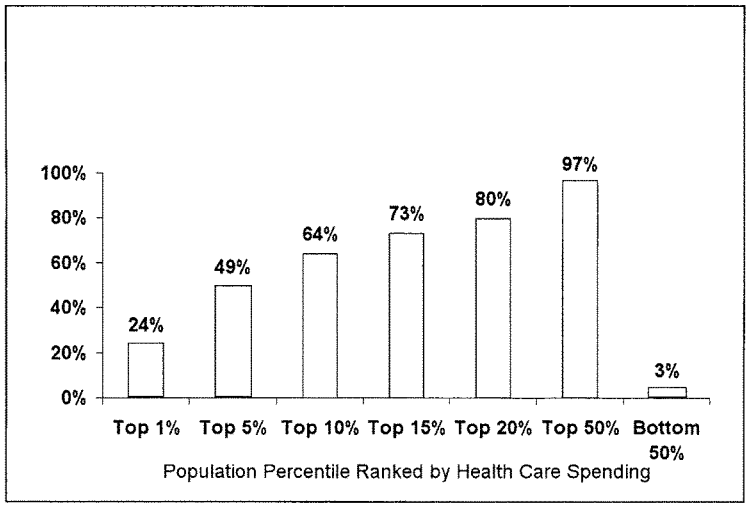
Good morning, Mr. Chairman and Members of the Subcommittee. My name is Karen Pollitz. I am a Research Professor at the Georgetown University Health Policy Institute where I study the regulation of private health insurance.

Thank you for holding this hearing today on transparency and accountability in health insurance. These characteristics are lacking in private health insurance today and must be strengthened as part of health care reform.

The paradox of risk spreading

It has long been true that a small proportion of the population accounts for the majority of medical care spending. (See Figure 1) Most of us are healthy most of the time, but when serious or chronic illness or injury strikes, our medical care needs quickly become extensive and expensive.

Figure 1. Concentration of Health Spending in the U.S. Population



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003. Population includes those without any health care spending. Health spending defined as total payments, or the sum of spending by all payer sources.

Because of this distribution, we buy health insurance to spread risks and protect our access to health care in case we get sick. However, the same distribution creates a powerful financial incentive for insurers to *avoid* risk. In a competitive market, if an insurer can manage to avoid enrolling or paying claims for even a small share of the sickest patients, it can offer coverage at lower premiums and earn higher profits.

Today, insurance companies employ many methods to discriminate against consumers when they are sick. Medical underwriting may be the best known – a process used to assess the risk of applicants. People who have health problems may be denied health insurance when they apply. Or they may be offered a policy with a surcharged premium and/or limits on covered benefits including pre-existing condition exclusions.

However, underwriting is not confined just to the application process. New policyholders (both individuals and small groups) who make large claims during the first year or two of coverage will likely be subject to post-claims underwriting. During this process insurers will re-investigate the applicant's health status and history prior to the coverage effective date. Any discrepancy or omission, even if unintentional and unrelated to the current claim, can result in coverage being rescinded or cancelled. At a hearing of the House Energy and Commerce Committee this summer, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who was in treatment for breast cancer testified that her coverage was revoked for failure to disclose a dermatologist visit for acne. At this hearing, when asked whether they would cease the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not.[1]

Health care reform legislation will likely include rules to prohibit these practices – guaranteed issue, modified community rating, and prohibition on rescissions and pre-existing condition exclusions. These rules are important, but alone, will not put an end to health insurance discrimination. The incentive to compete based on risk selection will not go away.

Insurers can use other formal and informal methods to discriminate based on health status. For example, they can make strategic decisions about where and to whom to market coverage, avoiding areas and populations associated with higher costs and risk. So-called "street underwriting" can be used to size up the health status of applicants before deciding whether to continue with the sales pitch. Insurers can also design covered benefits and provider networks to effectively attract healthy consumers and deter sicker patients from enrolling or remaining enrolled. Claims payment practices and care authorization protocols can also create hassles for patients that discourage coverage retention. Fine print in policy contracts may limit coverage or reimbursement for covered services, leaving consumers to pay out of pocket for medical bills they thought would be covered.

Therefore, rules will not be enough. To ensure health coverage is meaningful and secure, greater transparency and accountability must also be achieved.

Transparency in Health Insurance

A health expert from *Consumer Reports* magazine recently testified that health insurance is one of the least transparent consumer products sold today. There is ample evidence that consumers do not understand their coverage and are confounded by complexity.[2] Discriminatory practices by insurers too often go unnoticed and unchallenged.

Transparency in health insurance will make it easier for consumers to understand coverage and for regulators to detect when coverage is not working as it should. Transparency involves three key elements:

- data reporting to regulators on health insurance company products and practices;
- disclosure to consumers of how their coverage works and what it will pay; and
- standardization of health insurance terms, definitions, and practices so that consumers can make informed coverage choices.

Data - The primary purpose of health insurance data collected by state regulators today is to monitor solvency. Very little information is collected on an ongoing basis to monitor the accessibility, affordability or security of health insurance for consumers or how accurately, completely or dependably health insurance pays claims when consumers are sick.

There are also sparse data to monitor consumer protections in health insurance. For example, this Committee recently queried all 50 state insurance departments about health insurance rescissions. In response to that query,

- only 4 states could provide data on the number of rescissions that occurred
- only 10 states could provide the number of individual health insurance policies in force, and
- more than one-third of states could not supply a complete list of companies that sell health insurance within their jurisdictions.[3]

Enforcement of consumer protections in health insurance today is largely triggered by complaints. Unfortunately, complaints are not a sufficient basis on which to judge compliance with health insurance consumer protection or the need for stronger oversight and enforcement. Only a fraction of consumer problems with health insurance ever are translated into formal complaints. For example, data provided by the NAIC on behalf of all 50 state insurance departments found that nationwide only 32 complaints about health insurance rescission were filed in 2007, 181 from 2003-2007.[4] In stark contrast, last year this Committee requested data on health insurance rescissions from just three national carriers and learned those companies alone had rescinded nearly 20,000 health insurance policies from 2003-2007.[5]

According to a national survey of health insurance consumers, a majority (51%) of consumers experienced some type of problem with their health insurance in the past year. Yet only 2 percent contacted their state regulator for help. Nearly 90 percent of consumers surveyed could not name the agency that regulates health insurance in their state.[6] Another recent survey found patients rarely register formal complaints about health insurance. Instead, most just "stay quiet and stay put." Even when problems generate costs of more than $1000, or when they delay or deter access to care, rarely (less than 3%) do consumers file complaints with state regulators.[7]

While state-level data are limited, at the federal level we know even less. The Center for Medicare and Medicaid Services (CMS) – the agency responsible for oversight of federal minimum standards for health insurance established under HIPAA – does not collect compliance data or closely monitor the status of state enforcement of federal minimum standards.[8]

A more proactive approach to health insurance oversight is clearly needed. Regulators must be able to monitor patterns of health insurance enrollment and disenrollment in order to know whether insurers are avoiding or shedding. For this to happen, insurers should be required to report regularly on their marketing practices. Data on the number of applications received and new enrollments, as well as enrollment retention, renewals, non-renewals, cancellations, and rescissions will be needed. In addition, data must be reported on health insurance rating practices at issue and at renewal.

Regulators should also be able to monitor coverage practices in order to evaluate the protection health insurance provides and to detect problems that may discourage patients from remaining enrolled. Regulators must know what policies are being sold, what they cover, and who is covered by them. Measures of coverage effectiveness will also be needed to track what medical bills insured consumers are left to pay on their own. Tracking of provider participation, fees, and insurer reimbursement levels is essential. Health insurance policy loss ratios (the share of premium that pays claims, vs. administrative costs) must be monitored. So must be insurer practices regarding claims payment and utilization review.

The Tri-Committee health reform legislation, HR 3200, would give broad authority to federal regulators to collect this kind of data. In addition, HR 3200 would establish a new health insurance ombudsman to provide consumers with information and to help resolve their health insurance problems. The ombudsman would also collect data on consumer experiences in health insurance. Importantly, it would be required to report annually to federal regulators and Congress on its findings regarding consumer experiences and recommendations for strengthening consumer protections.

When health insurance regulators have access to this kind of information, patterns of problems affecting the sickest consumers won't be easy to hide.

Disclosure – Consumers need much more information about their coverage and health plan choices. Adequate disclosure to consumers begins by ensuring that complete information about how coverage works is readily available. Policy contract language should be posted on insurance company websites so that it can always be inspected by consumers and their advocates. Current provider network directories and prescription drug formularies should also be open to public inspection at all times.

More detailed, descriptive information about how coverage works will also be important. Earlier this year we issued reports analyzing coverage under seemingly similar health insurance policies and found consumers might owe widely varying amounts for medical bills due to policy differences that may not be so easy to detect. We recommended the

development of standardized labels that illustrate how insurance policies would cover certain common health conditions and estimate the level of remaining medical bills consumers might expect to pay out of pocket.[9]

Consumers will also need to know other information about how health insurers operate, including rates of prompt payment of claims and claims denials, loss ratios, and the number and nature of complaints and enforcement actions taken against an insurer. Health plan report cards should be developed to provide this information. As people shop for coverage, they must be able to compare differences in efficiency and the level of customer service that insurers provide.

Standardization – People clearly value choice in health coverage, but so many dimensions of coverage vary in so many ways that choices can become overwhelming and sometimes even hide features that limit coverage for needed care. An important goal of health care reform must be to adopt a minimum benefit standard so consumers can be confident that all health plan choices will deliver at least a basic level of protection. Key health insurance terms and definitions must also be standardized. For example, the "out of pocket limit" on cost sharing should be defined to limit all patient cost sharing, not just some of it. If a plan says it covers hospital care, the entire hospitalization should be covered, not all but the first day.[10]

Accountability in health insurance

Insurers must also be held accountable for compliance with market rules and consumer protections. That will require resources for oversight and enforcement. In addition, it is time for the federal government to take a more active role in health insurance regulation.

Regulatory resources –Resources to regulate private health insurance at the federal level are particularly lacking and must be increased. At a hearing of this Committee last year, a representative of the Bush Administration testified that CMS then dedicated only four part-time staff to HIPAA health insurance matters. Further, despite press reports alleging abusive rescission practices, the agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.[11]

Limited regulatory capacity is also a problem at the state level. In addition to health coverage, state insurance departments oversee all other lines of insurance. In several states the insurance commissioner also regulates banking, commerce, securities, or real estate. In four states, the insurance commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent.[12] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee consumer protections in health insurance are limited.

Federal/state enforcement – With the enactment of HIPAA in 1996, Congress created new federal minimum consumer protections in health insurance but limited federal authority to enforce those rules. Instead, Congress opted to rely primarily on state enforcement of federal minimum standards. Federal enforcement is triggered only as a last resort once a finding is made that states have not adopted and substantially enforced federal minimum standards. Further each provision of HIPAA is evaluated separately to determine whether federal fallback enforcement is triggered. This cumbersome process presumes federal action will be rare and, indeed, it has been so. Ironically, the federal fallback structure also provides justification for the lack of federal regulatory resources – it doesn't make sense for the federal government to build and maintain enforcement capacity it does not expect to use. This federal fallback enforcement model is an unfunded mandate on states – the federal government passes laws but expects states to carry them out.

It is time for the federal government to assume an active and effective role in enforcement of federal health insurance standards. Congress should provide adequate resources, including staff in sufficient numbers and with sufficient expertise in private health insurance oversight and enforcement. A federal regulatory presence should not come at the expense of state regulation. Rather, the federal government and states must work in partnership to accomplish effective oversight and enforcement of consumer protections in private health insurance. Congress should also provide resources to strengthen states regulatory capacity, and should take steps to ensure close coordination and cooperation between state and federal regulators.

Notes

[1] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times,* June 17, 2009.
[2] Testimony of Nancy Metcalf, Senior Program Editor of *Consumer Reports*, before the Committee on Commerce, Science, and Transportation, U.S. Senate, June 24, 2009. See also ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008, available at http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712
[3] Staff memo to Members of the Energy and Commerce Committee Subcommittee on Oversight and Investigations, June 16, 2009.
[4] Roger Sevigny, Therese Vaughan, Sandy Praeger, and Joel Ario, letter on behalf of National Association of Insurance Commissioners to the Honorable Bart Stupak and Greg Walden, July 24, 2009.
[5] Staff memo, *ibid.*
[6] National Survey of Consumer Experiences with Health Plans, Kaiser Family Foundation, June 2000.
[7] Brian Elbel and Mark Schlesinger, "Responsive Consumerism: Empowerment in Markets for Health Plans," *The Millbank Quarterly,* Vol. 87, No. 3, 2009.
[8] Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.
[9] Karen Pollitz, et.al., "Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?" May 2009. Available at http://www.rwjf.org/pr/product.jsp?id=42248
[10] A discussion of plans that include these kinds of features is available in "Hazardous health plans: Coverage gaps can leave you in big trouble," *Consumer Reports*, May 2009.
[11] Testimony of Abby Block, *ibid.*
[12] National Association of Insurance Commissioners, *2007 Insurance Department Resources Report,* 2008.

Mr. KUCINICH. Mr. Cannon, you may proceed for 5 minutes.

STATEMENT OF MICHAEL CANNON

Mr. CANNON. Thank you, Mr. Chairman, for this opportunity to present my perspective on providing secure health insurance to American consumers.

How do we ensure that insurance plans honor their commitments to care for the sick? It's a problem whether we're talking about private insurance plans or government plans. Private plans, whether through indifference or incompetence, do sometimes shirk on those commitments. So does government.

In 2007, a 12-year-old Maryland boy named Deamante Driver died because his mother could not access the care that Deamante was supposedly guaranteed under a government health plan. As former Senate Majority Leader Tom Daschle acknowledges, even if we achieve universal coverage, some percentage of patients will fall through the cracks. Health care is a human endeavor. That means perfection is not an option. Our task is to find a set of rules that least often leaves Americans in the position of Deamante Driver and his family.

In my written testimony, I cite a growing body of economic literature that finds that rightly regulated insurance markets perform actually much better than critics suggest, providing secure coverage to millions of Americans with high-cost illnesses. And I also express my concerns with the four measures that Congress is considering. For example, legislation before the House would compel tens of millions of Americans to purchase private health insurance and would shower private insurance companies with billions of dollars in taxpayer subsidies, and not, I would add, because insurance companies are doing a fantastic job.

Another provision of the legislation would impose price controls on private health insurance premiums. As President Obama's economic adviser Larry Summers has said, "price controls inevitably create harmful economic distortions. An example of one of those distortions, if you think insurers try to avoid the sick now, wait until the government price controls force insurers to sell a $50,000 policy for just $10,000."

It is worth noting that the insurance lobby supports both the proposal to make health insurance compulsory and the proposed price controls because they would subsidize and protect private insurance companies from competition. Whether we support a new government health program or oppose it, I think we should all be able to agree that we don't need to further subsidize and protect private insurance companies from competition.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Cannon follows:]

Statement
Of
Michael F. Cannon
Director of Health Policy Studies,
Cato Institute[1]

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, September 16, 2009
2154 Rayburn HOB
10:00 a.m.

"Between You and Your Doctor: the Private Health Insurance Bureaucracy"

Mr. Chairman, members of the subcommittee, thank you for this opportunity to present my perspective on providing secure health insurance to American consumers.

The Marvel of Voluntary Health Insurance Markets

Every year in the United States, thousands upon thousands of Americans walk or are carried into hospitals. Some are in extreme pain. Some are close to death. Using the tools of modern medicine, doctors routinely heal their pain and save their lives.

No less marvelous, however, is the fact that the bill is often paid, voluntarily, by complete strangers. These benefactors do not know the patient. They do not know her illness. They may not practice the same religion or speak the same language. Were they to meet the patient, they might not even like her. And yet, without anyone pressuring or forcing them to do so, these people repeatedly purchase lifesaving medical care for complete strangers. Indeed, they play a role every bit as important as the doctors and hospitals. By some marvel, this wonderful phenomenon occurs every day in the United States.

That marvel is health insurance. When individuals choose to purchase health insurance, they make an agreement to pay for the medical expenses of those in the insurance pool who become sick or injured. They uphold that agreement by paying a periodic premium to an insurance company. To be sure, it is not compassion for others but self-interest that motivates most insurance purchasers: each wants to have her own medical bills paid in the event of a catastrophe. Yet that only makes health insurance all the more marvelous. Health insurance harnesses the self-interest of millions of strangers to produce an unquestionably compassionate result.

Of course, such generosity inevitably invites opportunistic behavior. If the insurance pool paid for all their medical care, some patients would consume more medical care than they need. And why not – those other people in the pool are just strangers. Health care providers could try to sell those patients more medical care than they need. If individuals can tap the pool members' generosity whenever they chose, many would not contribute to the pool until they became sick. By the time they join the pool, their medical expenses would well exceed their contributions. Before long, premiums would spiral out of control, and no one would want to participate. For these reasons, members of the insurance pool hire someone to protect them from opportunistic behavior.

Health insurance companies are essentially intermediaries between members of the pool. Insurers charge higher premiums to enrollees who purchase more extensive coverage, because those members will draw more money from the pool. Insurers require members to pay part of the cost of their own medical care (through deductibles, coinsurance, and copayments) to ensure that members aren't careless with other members' money. Insurers look over physicians' shoulders (with managed-care tools like capitation payment, preauthorization, and utilization review) to ensure physicians are being careful with their members' money. Insurers also calibrate each new member's premium to her expected claims. If an individual waits until she is sick to join the pool, her premiums will therefore be much higher than if she joined while healthy. Risk-based premiums thus *promote* compassionate behavior, because they encourage individuals to contribute to the pool while they are still healthy—so their premiums can help save the lives of strangers. Once in the pool, however, insurers don't increase members' premiums when they become ill.

Insurers compete and innovate to see who can best manage these features, and provide members the protection they desire at the lowest possible premium. That competition is the market's way of navigating what economists call "the Samaritan's dilemma," or the human tendency to take advantage of other people's compassion.[2]

Do Health Insurance Markets Fail?

Critics claim that unregulated insurance markets do not provide secure access to medical care; that risk-based premiums are unfair; that insurance companies drop people when they get sick; that markets will not provide health insurance to everyone; and that government must create pooling arrangements that correct these alleged market failures.

Evaluating the performance of unregulated health insurance markets is complicated by the fact that most Americans obtain health insurance in markets heavily regulated or distorted by government.

- Nearly all seniors obtain health insurance from government through the federal Medicare program.[3]

- Due to large tax preferences for employer-sponsored insurance, about 90 percent of nonelderly Americans with health insurance obtain it through an employer.[4]

- Only 10 percent of the nonelderly insured (about 16 million people) obtain insurance directly from an insurance company, i.e., through the "individual" market.

In addition, many states impose significant regulations on their individual health insurance markets. Even if a state does not, administrative costs and premiums in that market will be higher than necessary because government diverts most consumers into the employment-based market.

Researchers examining America's badly hampered individual health insurance markets nevertheless have found considerable evidence that unregulated markets provide consumers with reliable long-term protection from the cost of illness. For example, University of Pennsylvania economist Mark Pauly and colleagues find:

- "Actual premiums paid for individual insurance are much less than proportional to risk, and risk levels have a small effect on obtaining coverage."[5]

- "Premiums do rise with risk, but the increase in premiums is only about 15 percent of the increase in risk. Premiums for individual insurance vary widely, but that variation is not very strongly related to the level of risk."[6]

- "Guaranteed renewable" policies, which are intended to protect against premium increases if the enrollee becomes sick, "appear to be effective in providing protection against reclassification risks in individual health insurance markets."[7] The vast majority of insurance products (75 percent) provided guaranteed renewability before they were required to do so by government.[8]

- High-cost individuals who are covered by small employers are nearly twice as likely to end up uninsured as high-cost individuals covered in the individual market.[9]

- "On average, guaranteed renewability works in practice as it should in theory and provides a substantial amount of protection against high premiums to those high-risk individuals who bought insurance before their risk levels changed. The implication is that, although there are some anecdotes about individual insurers trying to avoid covering people who become high risk (for example, by canceling coverage for a whole class of purchasers), the data on actual premium-risk relationships strongly suggest that such attempts to limit risk pooling are the exception rather than the rule."[10]

Similarly, RAND economist Susan Marquis and colleagues find that the individual market protects enrollees with expensive conditions and that risk-based premiums are not as harsh as critics imply:

- "Purchasers derive value from having the range of choices that the individual market offers."[11]
- In the individual market, "a large number of people with health problems do obtain coverage."[12]
- "We also find that there is substantial pooling in the individual market and that it increases over time because people who become sick can continue coverage without new underwriting."[13]
- Regarding enrollees who purchase insurance and later become sick, "in practice they are not placed in a new underwriting class."[14]
- "Our analysis confirms earlier studies' findings that there is considerable risk pooling in the individual market and that high risks are not charged premiums that fully reflect their higher risk."[15]

Recent experience in California shows that insurance companies will sometimes rescind coverage when enrollees provide inaccurate information about pre-existing conditions—and perhaps even when enrollees have not done so. California insurers have since reinstated coverage for many enrollees, often under the threat of breach-of-contract suits. As one California attorney told *The Washington Post*, "These cases are very, very good in front of a jury…I wish I could tell you the amount of money they throw at us just to make it go away and keep quiet."[16]

That episode demonstrates that government enforcement of insurance contracts can prevent individuals from defrauding strangers and prevent insurers from breaching their commitments to care for the sick; that media scrutiny is an important market mechanism; and that both types of consumer protection can spur insurers to change their behavior. All told, free markets provide considerably better health coverage than critics suggest.

Should Markets Provide Universal Coverage?

Critics are correct that markets will not provide health insurance to everyone. Voluntary insurance pools often will not cover medical conditions that are known to exist at the time an individual enrolls.

Health insurance markets are completely justified in not covering pre-existing conditions – and it is crucial that government not force them to do so. Were government to force insurers to cover pre-existing conditions, few would purchase insurance until

they had an expensive medical condition, and the pool would unravel. Thus, there is a very good reason why markets will not deliver universal coverage.

That still leaves a problem. Risk-based premiums will encourage most people to purchase insurance before they become ill. Yet there will always be some people who either did not join a pool while they were still healthy or never had the opportunity because they are indigent or because their high-cost condition has been with them since birth.

Assuming they cannot afford medical care, individuals with expensive pre-existing conditions require *subsidies*, which is not to say they need *insurance*. Insurance is merely one way—and a very expensive way—of subsidizing pre-existing conditions. More than other types of subsidies, insurance resembles a blank check. In general, strangers do not voluntarily give blank checks to other strangers, again with good reason: strangers are difficult to monitor, and the beneficiaries (encouraged by their health care providers) may take more than they need. Other ways of subsidizing the needy include limited amounts of cash, vouchers, or in-kind subsidies from providers, private charities, or government. Compared with the alternatives, the added costs of subsidizing pre-existing conditions with insurance outweigh the added benefits.

Exclusions for pre-existing conditions do not indicate a lack of compassion by insurance companies or consumers. They are the consumers' way of telling us that consumers do not want to subsidize people with pre-existing conditions *through insurance*. They do not preclude other options for subsidizing the needy, both public and private.[17]

Does Compulsion Improve the Picture?

Introducing compulsion into the mix disrupts the market process and thereby reduces the ability of consumers to meet each others' needs. Congress is currently considering the introduction of three principal forms of compulsion into health insurance markets: imposing price controls on health insurance premiums; making health insurance compulsory for most or all U.S. residents; and compelling taxpayers to fund, at a minimum, the start-up costs of a new government-run health insurance scheme.

Price Controls

Compelling insurers to charge all consumers the same premium is a form of price control. According to National Economic Council chairman Larry Summers, "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."[18]

In a free market, insurers innovate and compete to provide high-quality health insurance to everyone at the lowest possible price. If Congress demands that insurers sell $50,000 policies and $5,000 policies for $10,000, however, insurers will compete to

attract only those customers that represent a $5,000 profit and to avoid customers that represent a $40,000 loss.

Congress cannot police the thousands of subtle ways that insurers would respond to price controls by courting the healthy and avoiding the sick. Health economist Alain Enthoven notes: "A good way to avoid enrolling diabetics is to have no endocrinologists on staff in the county. A good way to avoid cancer patients is to have a poor oncology department."[19]

Price controls punish insurers who provide quality coverage to the sick. In 2008, an Aetna plan in the price-controlled Federal Employees Health Benefits Program dropped coverage for the 12-hour-a-day nursing care on which spinal muscular dystrophy patients like 11-year-old Shelby Rogers depend. An Aetna spokesman explained the company dropped the benefit because other insurers do not offer it, which caused the $50,000 patients to gravitate to Aetna's plan.[20]

In the end, price controls will eliminate the plans that sick people find most attractive. President Obama's economic advisor David Cutler finds that the price controls in Harvard University's health insurance exchange reduced choice by eliminating comprehensive insurance.[21]

Compulsory Health Insurance

The $5,000 of profit that insurers would receive from low-cost patients is in fact a $5,000 tax on the healthy. To prevent the healthy from avoiding that tax, President Obama and others propose to make health insurance compulsory for most or all Americans, either through an "individual mandate," an "employer mandate," or both.[22]

The Massachusetts experience demonstrates that at a national level, compulsory health insurance would effectively prohibit low-cost health plans and force tens of millions of already insured Americans to purchase more expensive coverage.

Massachusetts belies the claim that making health insurance compulsory will bring down health care costs. Federal, state, and private-sector health care spending have all increased under compulsory health insurance. Private health insurance premiums are growing 21 percent to 46 percent faster than the national average.[23] A report funded by the BlueCross BlueShield Foundation of Massachusetts indicates that overall public and private spending on health insurance has grown 66 percent faster than it would have otherwise.[24]

In 2009, Massachusetts' compulsory health insurance scheme covered previously uninsured families of four at a cost of at least $20,000, which is 50 percent greater than the nationwide average cost of employer-sponsored family coverage.[25] That estimate should be considered conservative, because it does not include the cost of the additional coverage that Massachusetts requires already insured residents to purchase. It is even more exorbitant considering that 86 percent of uninsured Massachusetts adults were in

"good, very good, or excellent" health[26] and therefore should have cost *less* to insure than the average person.

Summers writes, "If policymakers fail to recognize the costs of mandated benefits because they do not appear in the government budget, then mandated benefit programs could lead to excessive spending on social programs."[27] Massachusetts offers a perfect illustration.

Finally, compelling Americans to purchase private insurance would give incumbent insurers a guaranteed customer base and would protect incumbent insurers from competition by standardizing product design.

Government Programs

Congress is also contemplating a new government health insurance program as an option for some or all U.S. residents under the age of 65. For my thoughts on those proposals, I refer the committee to the attached study I recently authored for the Cato Institute.[28]

To the argument I make in that study, I would merely add: It can be difficult to make private insurers to keep their commitments to provide care to the sick. Yet making government honor its commitments to the sick may be more difficult, because government wields the sole, legal, and unilateral power to breach its commitments without compensating those it harms.[29]

Conclusion

Whatever our disagreements about government health insurance programs, however, I hope we can agree that private insurers do not deserve the sort of massive bailout represented by proposals to make private health insurance compulsory.

Thank you for holding this important hearing. I look forward to discussing with the subcommittee how to provide secure health insurance to American consumers.

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[2] See, for example, Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, chp. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

[3] See Michael F. Cannon, "Medicare," *Cato Handbook for Policymakers*, 7th edition, chp. 12, p. 125, http://www.cato.org/pubs/handbook/hb111/hb111-12.pdf.

[4] See Michael F. Cannon, "Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care," Forum for Health Economics & Policy, Vol. 11, issue 2 (Health Care Reform), Article 3 (2008), http://www.bepress.com/fhep/11/2/3/.

[5] Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs* 26, no. 3 (May/June 2007): 770–79, http://content.healthaffairs.org/cgi/content/abstract/26/3/770.

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[7] Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*, vol. 25, no. 3, May 2006, pp. 395-417.

[8] Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: American Enterprise Institute, 1999), p. 18.

[9] Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?" *Health Affairs* Web Exclusive, May 6, 2008, http://content.healthaffairs.org/cgi/reprint/hlthaff.27.3.w242v1.pdf.

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[11] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[12] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[13] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

[14] M. Susan Marquis et al., "Consumer Decision Making In The Individual Health Insurance Market," *Health Affairs* Web Exclusive, 25, no. 3 (May 2, 2006): w226-w234, http://content.healthaffairs.org/cgi/reprint/25/3/w226.pdf.

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[16] Karl Vick, "When Your Insurer Says You're No Longer Covered," *Washington Post*, September 8, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/09/07/AR2009090702455.html.

[17] See Michael F. Cannon, "Medicaid and SCHIP," *Cato Handbook for Policymakers*, 7th edition, chp. 13, p. 133, http://www.cato.org/pubs/handbook/hb111/hb111-13.pdf.

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[21] See Thomas C. Buchmueller, "Consumer Demand for Health Insurance," *NBER Reporter*, Summer 2006, http://www.nber.org/reporter/summer06/buchmueller.html.

[22] In his recent address to Congress on health care reform, President Obama said, "And unless everybody does their part, many of the insurance reforms we seek - especially requiring insurance companies to cover pre-existing conditions - just can't be achieved. That's why under my plan, individuals will be required to carry basic health insurance." Transcript of Obama's Address to Congress, MSNBC.com, September 9, 2009, http://www.msnbc.msn.com/id/32765453/ns/politics-health_care_reform/.

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[29] *Flemming v. Nestor*, 363 U.S. 603 (1960). See also U.S. Social Security Administration, "Supreme Court Case: Flemming vs. Nestor," http://www.ssa.gov/history/nestor.html. ("There has been a temptation throughout the [Social Security] program's history for some people to suppose that their FICA payroll taxes entitle them to a benefit in a legal, contractual sense…Under this reasoning, benefits under Social Security could probably only be increased, never decreased…Congress clearly had no such limitation in mind when crafting the law.")

Mr. KUCINICH. I want to thank Mr. Cannon and Ms. Pollitz for their testimony.

We have votes that are on right now, and I just would like to invite you to do one of two things, and this is up to you. You can either respond to written questions from members of this subcommittee, and they will be included in the record, or you can come back probably in about 45 minutes at the conclusion of the votes, and then we can go through a second round of questioning of the panel here. So what would you prefer?

Mr. CANNON. I would be happy to come back in 45 minutes.

Mr. KUCINICH. Can you do that? OK. OK. My colleague suggests it might be, let's say, a half hour. So let's say—let's come back in a half hour then, and we'll go to questions. I thank you for your patience. We're going to go vote right now.

The committee is in recess for the vote. We'll be back in a half hour.

[Recess.]

Mr. KUCINICH. The committee will come to order. I'd like to thank the witnesses for remaining, and I'd like to begin by asking Mr. Cannon, under what circumstances do you see that making private health insurance compulsory represents a bailout to the insurance industry? How would you explain that view? Hold the mic a little bit closer.

Mr. CANNON. Mr. Chairman, in order to help Americans comply with what they call the individual mandate in the legislation before the House and in the legislation before the Senate as well, Congress has decided it would—or the legislation would offer subsidies to Americans to help them purchase health insurance. Simply mandating that people purchase health insurance doesn't mean that they will be able to. A lot of people won't be able to afford it, and so Congress would be, in its legislation, offering subsidies to a lot of people who cannot afford health insurance on their own and to a lot of people who can afford health insurance on their own, because the subsidies, as I understand them, would go up to 300 or 400 percent of the Federal poverty level, which for a family of four is somewhere around $60,000 to $80,000 per year.

Those subsidies offered to people who can afford health insurance already and to people who cannot would—would essentially help people purchase more health insurance and give the insurance industry really a guaranteed customer base and a guaranteed source of revenue.

So I think that essentially what that legislation would do is akin to a bailout of the health insurance industry. I don't think that what we should be doing is giving more to this—to this sector or to this industry. I think we should be demanding more from it, and I think the way to do that is to preserve the freedom to choose whether or not to purchase health insurance as well as the freedom to choose what goes into your health insurance policy. And the way to do that, in my view, is to let consumers control the money that government and employers now control to purchase health insurance on their behalf, and they will—they will economize on health insurance. They will—they will most likely purchase less health insurance than they do right now, and they will hold health insurers

accountable in a way that they cannot when their employers are making those decisions for them.

Mr. KUCINICH. So let's go 4 years down the road. Let's say that a health care plan is enacted which requires that people have private insurance. Let's say there's no public option—that's kind of the way it looks like right now—and people—there will be tens of millions of Americans who will be faced with a decision to either purchase private insurance or pay a fine. Would you like to comment on that?

Mr. CANNON. I think that what that really highlights is that this proposal for—to mandate people purchase health insurance, this proposal to make health insurance compulsory in the United States, amounts to a tax on a lot of middle-class families. If they purchase the health insurance, as President Obama's economic adviser Larry Summers acknowledges, then the government forces people to purchase something that they don't value or pay more than the market would demand, values in itself are taxed, and if they don't purchase the mandatory level of coverage and they have to pay what we euphemistically call a fine or a penalty, that's a tax as well.

In the House legislation, there would be a tax on the individual equal to 2½ percent of income—of adjusted gross income, and if the individual's employer does not offer them coverage, there would be a tax equal to 8 percent of payroll. Now, Mr. Summers and the Congressional Budget Office and economists broadly acknowledge that 8 percent payroll tax would be paid for by the worker because it reduces their earnings. So what you're talking there is a 10½ percent tax——

Mr. KUCINICH. Is that axiomatic?

Mr. CANNON. It is.

Mr. KUCINICH. So you're saying that if workers have a health care benefit, they're in effect paying for it?

Mr. CANNON. Absolutely, and I think, in fact, that is why—I think that's the great—the biggest drawback or the biggest problem with the tax preference for employer-sponsored insurance.

The, "employer contribution" to the average family plan in this country amounts to $10,000. That's $10,000 of the worker's earnings that the worker doesn't get to control. The government, by creating this tax preference for employer-sponsored insurance, essentially takes that $10,000 out of the worker's hands, gives it to the employer, and lets the employer make the worker's health insurance decisions for the worker.

So, yes, I think that economists—in fact, there was a survey of health economists recently, and the broadest area of agreement was on the question of whether health benefits actually come out of wages or profits or something else. Ninety percent of economists—health economists acknowledge or agreed with the proposition that, yes, workers pay for those health benefits through reduced wages, and the same is true of any tax penalties that Congress might impose.

Mr. KUCINICH. Thank you, Mr. Cannon.

Professor Pollitz, I want to speak to you about how government can help the public make better choices about health insurance. In your testimony, you pointed out something that many people may

not realize, "The primary purpose of health insurance data collected by State regulators today is to monitor the solvency of private health insurers, and that, quote, enforcement of consumer protections in health insurance today is largely triggered by complaints."

I think the average person is or would be surprised to hear this. So who does monitor things like accessibility, affordability, or security of private health insurers or how accurately do they pay out on claims?

Ms. POLLITZ. It is not well monitored or consistently monitored today. I think State insurance regulators strive mightily to protect consumers as best they can. Their resources are limited.

Mr. KUCINICH. Would you describe the State regulators as reactive to consumer complaints rather than proactive?

Ms. POLLITZ. A lot of it is reactive. A lot of times in response to a complaint, as little as one complaint, a State regulator may initiate a broader investigation of a company or of a pattern of practices. So I don't mean to suggest that State regulators aren't out there giving it their best effort, but they are very strapped in terms of resources. They are very broad in terms of the jurisdiction that they need to keep an eye on, and with limited resources—I mean, if I were one, and I had the limited resources, I would probably start with solvency myself, because if a company goes under, then no claims will be paid for anybody. So that's not an illogical place to start, but there are not enough resources to monitor closely what needs to be monitored. And with health insurance, that's a very transaction-heavy task to accomplish.

Mr. KUCINICH. Do private health insurers themselves keep data on complaints made against them that can be reviewed?

Ms. POLLITZ. That can be reviewed?

Mr. KUCINICH. Yeah.

Ms. POLLITZ. I don't actually know what data they would keep. All insurance companies have a compliance office with a lot of attorneys, and I'm sure they at least have a pretty good idea of what complaints are being filed, and they have to keep records. I mean, this is why you get urged to put everything in writing when you're communicating with your insurance company so that there will be a record somewhere.

Mr. KUCINICH. My time is expired. I'm going to go to my colleague for 5 minutes, and then we'll go to one more—one final round of questioning.

Mr. JORDAN. Thank you. Thank you, Mr. Chairman.

Mr. Cannon and Ms. Pollitz, thank you for being here.

Mr. Cannon, let me ask you about this idea of interstate insurance broadening the field, increasing the market, increasing competition. In the first panel, I believe Dr. Peeno and Mr. Potter talked about the cartel that exists in the insurance market right now. Their solution was to have the Government compete; you know, to increase competition by having this so-called public option. The approach I prefer is this interstate market.

Mr. JORDAN. Tell me your thoughts on that, what the research shows us getting. This is now being debated a lot and talked about as a possible improvement. Let me hear your thoughts there.

Mr. CANNON. Well, I think the insurance markets in most States are not unlike a cartel, and I think the reason is that—is because each State sets up barriers to competition to protect their domestic insurers.

What those are are essentially State licensing laws. Now, there's nothing wrong with a State licensing law per se, but what these laws do is they say unless your insurance policy is licensed by this State, say the Commonwealth of Virginia, then you may not sell it to residents of this State. And so what that means is that residents of Virginia cannot purchase a health insurance policy that's available in Maryland or North Carolina.

That's particularly cruel, I think, to residents of New Jersey, who face some of the highest health insurance premiums in the country. They cannot purchase health insurance from across the Delaware River in Pennsylvania where it's often less expensive.

So what happens—so I do think there is insufficient competition in insurance markets. The President and other supporters of a new government program have said that they—that a new competitor can keep insurance companies honest. If that's the case, then I think that dozens of new competitors would do an even better job, so that if Congress, using its power under the interstate commerce clause of the Constitution, were to say, look, you know, States can license health insurance, but they cannot prohibit their residents from purchasing health insurance licensed by another State, what that would do is it would bring new entrants into the markets in each State, give individuals and employers a lot more choices of health insurance plans and increased competition.

What it would also do is it would give individuals and employers the power to avoid unwanted costly State regulations. A lot of State regulations are, in fact, consumer protections. Solvency standards that Ms. Pollitz was talking about, I think, are a prime example. But when you start looking at how the States require consumers to purchase 30 different types of mandated benefits that they may not want or need, or try to impose hidden taxes on the healthy in order to subsidize the sick, those are increase—those are regulations that increase the cost of insurance and make it unaffordable for some people.

So you can't really call them consumer protections if they're keeping people from purchasing health insurance, and I think that letting people purchase insurance across State lines would allow people to——

Mr. JORDAN. Thank you. Thank you.

Ms. Pollitz.

Ms. POLLITZ. The proposals to allow sale across State lines that have been in the Congress to date are really a prescription for insurance fraud. There would be little practical ability of the licensing State to regulate insurance sold across the 50 States. Imagine if the Ohio commissioner had to keep track of policies that were sold in California and Texas and New York. They're not set up for that.

The notion of escaping mandated benefits is a total red herring. The reason that health insurance costs more in New Jersey compared to Maryland, where I live, which has been cited as the champion of mandated benefits—supposedly we have more in Maryland

than anywhere—is that in New Jersey everybody has to be offered health insurance. You can't be turned down because you have cancer, and in Maryland you can. So it's cheaper and insurance——

Mr. JORDAN. I think the chairman talked about that in his previous question.

Ms. POLLITZ. I think we have to come back to what is the basis of competition in health insurance right now, and it is competition to avoid sick people and their costs. And the more you dilute oversight and regulation, the more easy that will be and the more——

Mr. JORDAN. Let me get a response from Mr. Cannon.

Mr. CANNON. Karen raises a couple of important issues. One of them is how do you enforce these rules that are written by an out-of-State legislature or insurance commissioner, and I think there's a fairly straightforward way of doing that. You have those regulations, whatever they may be, incorporated in the insurance contract, which could then be enforced in the purchaser's home State and in their courts, and then the domestic—the purchaser's insurance commissioner could even play a role there.

What's important is that the individual consumer or the employer be able to choose the rules, and they could be enforced at home without having to rely on an out-of-State insurance commissioner.

As for the cost of mandated benefits, the cost estimates vary, but the Commonwealth of Massachusetts recently estimated that the benefits that are mandated in that State add 12 percent to the cost of premiums. So that's a substantial chunk of money.

Mr. JORDAN. Sure.

Mr. Chairman, looks like just you and me. I yield back to you.

Mr. KUCINICH. Just you and me. This town is big enough for both of us.

I'd like to go back to Ms. Pollitz. I'd like to talk to you about standards of care and a possible scenario. Are you aware of any data on the inconsistent application of standards of care by private insurers? Is it possible that within two—taking two different people with the same illness, who are insured by the same private health insurer, that they will be treated differently by the insurance company; is that possible?

Ms. POLLITZ. I believe it's possible, yes.

Mr. KUCINICH. And so is there any guarantee that if a person buys coverage, it will guarantee coverage?

Ms. POLLITZ. Not an ironclad guarantee, no.

Mr. KUCINICH. Pardon?

Ms. POLLITZ. Not an ironclad guarantee, no. There is a contract, but it——

Mr. KUCINICH. But there are no guarantees.

Ms. POLLITZ. That's correct.

Mr. KUCINICH. I'd like to ask about lack of transparency in private health insurance as compared to Medicare.

Congress and the general public are able to examine and debate the reasoning behind how Medicare pays for medical care, but the private health insurers keep their decisionmaking process and guidelines hidden behind books of confusing terminology. In other words, Medicare's actions are transparent, but private insurers are not, but they provide the same service ostensibly to cover medical

expenses. Now, is there any justification to keeping insurance company definitions of medical necessity proprietary?

Ms. POLLITZ. I don't think so, no.

Mr. KUCINICH. And why would the insurance company want to keep that information proprietary?

Ms. POLLITZ. I believe they will argue so that doctors and other providers don't try to game the system and sort of code their billing so that it matches up what the—you know, what the guidelines would be. But I think you heard testimony on the earlier panel that there is also an effort to just, you know, kind of try to hide the ball and try to, you know, create options for the insurance company to deny claims if they feel like they want to do that.

Mr. KUCINICH. Are there any data nationally about either the frequency of wrongful denials of claims or of unjustified reviews or appeals?

Ms. POLLITZ. There are not good, consistent data. I tried a couple of years ago to study the results of even external appeals programs, and the data was very sparse.

What you can find is—suggests that we need to be doing a better job and looking much more carefully and not relying on the sort of end result of a patient having to go through all of the steps and appeals before they can get to a system where records will be kept.

Mr. KUCINICH. Anything else you want to add about that you haven't told this committee about the data collection?

Ms. POLLITZ. I really do think, Mr. Chairman, that we need to think carefully about the ways that insurance companies compete now to avoid paying claims. Certainly there are reasons why we don't want to pay for care that's not medically necessary. We don't want to pay for fraud. I mean, there are reasons for vigilance for sure, but I think we need to think from the patient's perspective about what we need to track so that we can make sure that decisions are justified, that they're backed up, that they're consistent, and that they're in the patient's best interests, and then build our data-reporting requirements from that exercise.

I think we need a much more proactive and propatient approach to data gathering from health insurance companies, and I hope that will be a central part of any health reform legislation that gets enacted.

Mr. KUCINICH. I'd like to ask a question of Mr. Cannon. You're here representing the CATO Institute, and I've always found very handy this Constitution of the United States which comes from the CATO Institute, including its introduction.

Under our Constitution, you know, the general welfare clause, which there's been a lot of discussion about, there are some of us who believe that both the Preamble to the Constitution and Article I, section 8, in describing the general welfare, that as we evolve as a Nation and have specified health care, retirement security as part of the general welfare, that a logical extension of that would be to have health care for all, guided by the principle enunciated in the Constitution, both in Article I, section 8 and the Preamble. You know, tell me what—how you see that.

Mr. CANNON. The question is about the general welfare clause of the Constitution? There is a difference of opinion among legal

scholars about what that means. I'm not a constitutional scholar, but let me give you my best take on what that disagreement is.

There's some that believe that is an expansive grant of power that would, say, give Congress the power, the constitutional authority to enact, say, a single-payer system or make health insurance compulsory for all Americans. I think that the perspective of CATO's constitutional scholars is that if that were true, if the—if the Framers of the Constitution meant for the general welfare clause to be such a sweeping, broad, comprehensive grant of power from the States to the Federal Government, then the rest of the Constitution would be superfluous. They wouldn't have had to enumerate all the other powers in the Constitution, because the general welfare clause would have taken care of everything. So the very structure of the Constitution itself, I think, argues against a broad or the sort of expansive interpretation of the general welfare clause that you suggest.

Mr. KUCINICH. One of the things that I've always been impressed with is the Preamble which CATO provides to the declaration and the Constitution. And one of the things they say in there, my colleague, is that it's not—it's not political will, but moral reasoning which is the foundation of the political system.

And some of the issues that are being brought to us about conditions relating to health care in America are laden with moral consequences and moral overtones, and it's like an underlying reality of whether health care—if health care's a privilege based on ability to pay, or is health care a fundamental right in a democratic society.

There's like this arc where you go from—from economics, which can be amoral, to the imperatives of a democracy that relate directly to morality. And I just—you know, that's—in a way, that's part of the backdrop of this national discussion we're having right now, is it a right or is it a privilege, you know, and this is part of our unfolding democracy here, trying to decipher what the meaning of this document is, and also doing it within the context of what our present-day needs are and what—the various human conditions we find ourselves in and the underlying morality—you know, is it immoral for somebody to be denied care when they're paying for it?

These are questions that we are to deal with here. I appreciate having the chance to share that with you.

Mr. Jordan, you can conclude this hearing.

Mr. JORDAN. All right. Thank you, Mr. Chairman.

Let me just go to the premise. Many of the witnesses in the first panel, the premise was that the government can do it better. We know that there's been problems with the way insurance companies deal with patients and sometimes some of the things that take place, but to say that government can do it better, I'd like your thoughts on that in light of the Congressional Research Service said of over the 1 billion claims submitted each year to Medicare, 10 percent of those claims are denied.

Attorney General Holder said, "by all accounts every year we lose tens of billions of dollars in Medicare and Medicaid funds to fraud."

So, your thoughts on—you know, we met with health care professionals. We did health care roundtables in our district over the re-

cess, and, you know, we had so many people tell us that government's already 50 percent of the health care market right now, and that providers don't get compensated fully for the care they provide when they treat folks under the Medicare and Medicaid system, and therefore the folks who are in the private insurance have to pay more because that's just the way the system is set up right now.

So I'd like both your thoughts. I'd start with Mr. Cannon on this premise that has been so—kind of underlies the entire hearing today on how somehow the government can do it better, because, as you can gather, I have real reservations about that.

Mr. CANNON. Well, I think, Congressman, that the state of America's health care sector right now is pretty good evidence that the government does not do a very good job of managing health care. And I'll give you a couple of examples.

You brought up the Medicare program. That program, it has been estimated that one-third of Medicare spending does absolutely nothing to improve the health or—improve the health of patients or improve patient satisfaction, provides no value to them whatsoever. It's often cited that we have—so that's an enormous amount of waste, much—even larger than the estimates of fraud in the Medicare program.

It has been estimated that as many as 100,000 Americans die every year due to medical errors in hospitals. I submit that probably Medicare is the biggest reason for that because Medicare's payment system actually penalizes doctors and hospitals when they succeed in reducing medical errors. It makes it a losing business proposition. Rather than have competition between different payment systems that bring out different dimensions that would improve all dimensions of quality, Medicare gives us good marks on some dimensions of quality, but absolutely horrible marks on other dimensions.

One of the biggest problems that the President talks about is the problem of preexisting conditions, people with high-cost illnesses who lose their coverage and then cannot afford the premiums that they're charged on the individual market. That is a problem that has been fueled by government for 60 years, and the reason is that 60 years ago the government created a tax preference for employer-sponsored insurance coverage that has given us the employer-based system that we have right now that is so cruel and, to use the chairman's words, immoral that it takes insurance away from people the moment they need it most. And they lose their jobs, they lose their incomes, and if those people are sick, then they've got a preexisting condition. They are not going to be able to get coverage.

And if I may finish, one of the studies that I cite in my written testimony finds—looks at the empirical—looks at the data and finds that people who purchase insurance directly from an insurance company, people with high-cost illnesses who do so, are half as likely to end up uninsured as people who purchase—high-cost patients who purchase health insurance from a small employer.

Mr. JORDAN. One of the things we should deal with in the legislation I have cosponsored is for the families who have to go out and buy it on their own in the market, they should get the same tax advantages that we give to employers to provide to employees.

Mr. CANNON. That problem has been in place for 60 years now——

Mr. JORDAN. That is one of the key things we have to—Ms. Pollitz, I'm sorry, go ahead.

Ms. POLLITZ. No problem. I think the real—two real differences. One is about accountability, and there is a different level of accountability for government than there is for the private sector. There just is. I think we should try to enhance and strengthen accountability in the private sector with much stronger oversight and regulation and enforcement. Regardless of how you end up structuring health reform, I think that's essential.

But government programs will always be accountable in a different way to—directly to the voters. They will always be open in a different way compared to commercial plans. That's the way we've set up our government——

Mr. JORDAN [continuing]. These and others and Mr. Cannon and many of us that a real marketplace, you're accountable directly to the consumer.

Ms. POLLITZ. Well, but that's my second point.

Mr. JORDAN. That's where we needed to be headed is to a true marketplace.

Ms. POLLITZ. That's my second point. A marketplace of competing insurance companies will always, always in health insurance compete to avoid sick people. That is the overpowering incentive. It beats everything, and it always will. Even in a more regulated marketplace, even in a more transparent place, you're always going to be trying to catch up with that.

Introducing a public component to that, it's kind of a funny notion. It's not like the government is going to compete to make more profits than Blue Cross or WellPoint. It's that the government will be there offering a choice that is the——

Mr. JORDAN. If there is a public option, eventually the public option will dominate. Even Congressman Frank has said that a public option will lead to a single-payer system. This idea that somehow it's not going to do that, I just—I don't think flies. I think most Americans have already figured that out, and that's why they're concerned about this plan.

Ms. POLLITZ. Mr. Jordan, I was on the board for several years of a public program in my State where I ran our State high-risk pool, and it was administered by a private insurance company, and so, you know, they know how to administer claims, and that is definitely its own art and its own skill.

And as the consumer rep on the board, I would ask questions: Why do we have so many denials of preauthorization, for example, for mental health services? That turned out to be one of the biggest services that any of our patients used. Even though that wasn't the major diagnosis, it's very stressful to be sick; people need help. And one of our leading sources of complaints had to do with denials for mental health service.

And so I said, why is that? Why are we denying all this care? Well, it turned out it was paperwork. People were supposed to jump through all these hoops and get preauthorization. They had to do it within a certain number of days, and it was just a load of hoops that they had to jump through.

And I said, well, OK, once they go through all these hoops, how many of them are actually denied—and there were thousands of denials—and they said, seven. And I said really? Then why are you doing this? Why are you making them jump through all these hoops? Oh, they said, this is saving you a lot of money. I said, I don't want you to save us a lot of money. We're here to pay for care. We're a high-risk pool. They're sick. No one else will take care of them. This is our job. This is what the taxpayers have given us tax dollars to do. Let's stop doing that. We did that.

I can't imagine that would happen in the company that Ms. Peeno—Dr. Peeno used to work for. It's just a different incentive. It competes in a different way, and I think we need to create a different standard for covering health care. And if private insurance companies can't compete against that and survive, well, so what? I mean, we took care of the patients who were sick, and isn't that what this has to be about primarily? It seems to me that has to be where we start the discussion.

Mr. KUCINICH. We thank the gentlelady.

I want to thank Mr. Jordan for his participation in this hearing, and thank both the witnesses from the second panel for their participation.

As my friend is leaving the room, I just wanted to comment—and staff can relate this to him—that some—there are some cases, I suppose, where a public option may lead to a single-payer system at some point. I mean, I actually am the coauthor of a bill to create a single-payer system, and I'd like to see a single-payer system. We have 85 Members of the House who have signed on to a bill, H.R. 676, the bill I drafted with Mr. Conyers. That bill, in its fullness, is not likely to have hearings, and whether there might be a vote on it, it needs a movement behind it. That needs a little more strength.

So while some public options may lead to single payer, I would just like to offer the opinion that it's unlikely that the current status of the public option that is suggested in H.R. 3200 would lead to single payer.

The CBO has said in one of its studies that 9 million people at most would be covered by—by any kind of a public option; that the first iteration of that plan was to have 129 million people covered by it. So you have 9 million people, that particular plan may not pose much of a risk or, frankly, a competitive position vis-a-vis the private insurers. I just wanted to mention that since we were talking about public options.

You're much appreciated for the time that you have spent, for your patience, and this committee stands adjourned. I want to remind people that tomorrow we will hear from executives from six of the major health insurance companies so that we can followup and ask them some of the questions that were raised in today's hearing. We're all very appreciative of your presence. The committee stands adjourned.

[Whereupon, at 1:30 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Diane E. Watson and additional information submitted for the hearing record follow:]

Opening Statement

Congresswoman Diane E. Watson

"Between You and Your Doctor: The Bureaucracy of Private Health Insurance- Day One"

Subcommittee on Domestic Policy
Oversight and Government Reform Committee

Wednesday, September16, 2009
2154 Rayburn HOB
10:00 A.M.

Thank you Mr. Chairman for holding today's important and timely hearing on the challenges millions of Americans face when battling for coverage with their private health insurance providers. As President Obama and Congress continue to debate the principles and features of healthcare reform, this hearing provides important insight into a status quo where both the un-insured and under-insured are not receiving the care they need.

The experiences of today's witnesses are prime examples of why reform cannot wait. For instance, Mr. Mark Gendernalik despite being covered by his employer as a teacher with the Los Angeles Unified School District still experienced delays and denials while seeking treatment for his infant daughter. Millions of Americans will face similar circumstances because of the life-threatening and often arbitrary decisions being made about their health by insurers seeking to protect their profit margins.

According to data released yesterday by the Kaiser Family Foundation healthcare premiums have increased by 131 percent over the last ten years, while wages have grown by only 38 percent. The price being paid for healthcare is rising, but the quality of coverage

is not. Too many Americans will be denied the coverage they need because of an endemic culture of rationing for the sake of profits.

It is clear that we need meaningful reform. By eliminating the unfair practices of the private insurance companies, and by increasing the competitiveness and accountability of the system with the introduction of a viable public option we can live up to what President Obama refers to as the "character of our country" and empower all Americans with personal choice and access to affordable high quality healthcare.

I would like to thank today's witnesses for providing us with their testimony at this critical time. Thank you Mr. Chairman and I yield back.

Submissions for the Record from Erinn Ackley

An independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

04/20/2006

WILLIAM ACKLEY
16 KODIAK PATH
ORMOND BEACH FL 32174

RE: Subscriber William Ackley
Subscriber ID 880044926
Patient William Ackley

Subject: Preauthorization for a Matched Unrelated Allogeneic Bone Marrow Transplant

Our Medical Review Staff has evaluated the information received on April 13, 2006, sent by Susan O'Brien at Shands HealthCare at the University of Florida. It has been determined that benefits are not available for the matched unrelated allogeneic bone marrow transplant. A denial results if the proposed service does not meet your policy's definition of "Necessary." Your policy defines Necessary as:

A service provided by a Covered Provider and determined by The Plan to be:

- Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, or injury;
- Provided for the diagnosis or the direct care and treatment of the Member's condition, illness, or injury;
- In accordance with standards of good medical practice;
- Not primarily for the convenience of the Member or the provider; and
- The most appropriate supply or level of service that can safely be provided to the Member. When applied to Inpatient care, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

The proposed service does not meet the above criteria. Our Medical Reviewer states, "Per peer reviewer, this service is investigational for this indication and this patient."

The Member Guide defines investigational/experimental service or clinical trial as:

Investigational/Experimental Service or Clinical Trial

Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of The Plan not recognized as conforming to accepted medical practice or the procedure, drug, or device:

- Has not received the required final approval to market from appropriate government bodies;
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
- Is not demonstrated to be as beneficial as established alternatives;
- Has not been demonstrated to improve the net health outcomes; or

- Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Internal Appeal Process

You have the right to reconsideration of the denial by Blue Cross and Blue Shield of Montana (BCBSMT) within 180 calendar days from the date you receive this notice of denial. Your request should include those reasons you believe the proposed services are necessary and include any additional supporting documentation. BCBSMT has 60 days from the date we receive your request for a reconsideration to review and render a final decision.

Upon request, BCBSMT will provide, at no charge, a copy of the guidelines used and reasonable access to and copies of all documents, records, and other information relevant to the service or supply. Documents may be reviewed at the BCBSMT office between 8 a.m. and 5 p.m., Monday through Friday (excluding holidays), at 560 North Park, Helena, Montana.

Expedited Review

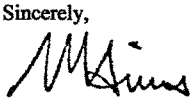
You may also have the right to seek an expedited review of the denial if your health care provider determines that the denial involves a condition that seriously threatens your life or health. To qualify for an expedited reconsideration, your health care provider must certify in writing that your life or health would be seriously threatened by the delay of an internal reconsideration process. Please call me at 1-800-447-7828, Extension 8518, for instructions on initiating a request for an expedited reconsideration.

CONTACTING BCBSMT

- Telephone 1-800-447-7828, Extension 8518, Monday through Friday, 8 a.m. to 5 p.m.
- Mail request to Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604.
- Fax request to (406) 444-8451, Attention: Susan.

If you have any questions concerning the denial or the reconsideration process, please call 1-800-447-7828, Extension 8518.

Sincerely,



Mary Sims, M.D.
Medical Director

0620SYM01.bjf(MM16)
cc: Susan O'Brien, Shands HealthCare

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

May 2, 2006

William G Ackley
16 Kodiak Path
Ormond Beach, FL 32174

Subscriber id: 880044926

This is to notify you of the outcome of the Independent Review process that you requested regarding the Matched Unrelated Allogeneic Bone Marrow Transplant for the diagnosis of CLL.

The review has been completed by the Mountain-Pacific Quality Health Foundation (the Foundation) in Helena, Montana. The Montana Department of Public Health and Human Services has designated the Foundation as the independent review organization that performs independent reviews.

The independent review by the Foundation has upheld the medical necessity denial of this procedure.

This concludes the internal and independent review of this case.

Sincerely,

Mary Sims MD

Mary Sims, MD
Medical Director
Blue Cross Blue Shield of Montana

cc: Jan S Moreb, MD

An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

05/12/2006

WILLIAM ACKLEY
16 KODIAC PATH
ORMOND BEACH FL 32174

RE: Subscriber William Ackley
Subscriber ID 880044926
Patient William Ackley

Subject: Preauthorization for Transplant Using Myeloablative Preparative Regimen

The Medical Review Staff has evaluated the information received on May 4, 2006, sent by Susan O'Brien, Transplant Financial Representative at Shands HealthCare. It has been determined that benefits are not available for the transplant using a myeloablative preparative regimen. A denial results if the proposed service does not meet your policy's definition of "Necessary." Your policy defines Necessary as:

A service provided by a Covered Provider and determined by The Plan to be:

- Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, or injury;
- Provided for the diagnosis or the direct care and treatment of the Member's condition, illness, or injury;
- In accordance with standards of good medical practice;
- Not primarily for the convenience of the Member or the provider; and
- The most appropriate supply or level of service that can safely be provided to the Member. When applied to Inpatient care, this further means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

The proposed service does not meet the above criteria. Our Medical Reviewer states: "Investigational. No bone marrow or stem cell transplant procedure is proven effective for the diagnosis of CLL." Enclosed is a copy of the medical policy from the BlueCross BlueShield Association for your reference.

The Exclusions and Limitations section of your contract states:

> All benefits provided under this member guide are subject to the exclusions and limitations in this section and as stated under the Benefit section of this member guide. Except as otherwise provided in this member guide, the plan will not pay for:
>
> - Any service or supply that is an investigational/experimental service or clinical trial.

The contract defines Investigational/Experimental Service or Clinical Trial as:

> Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in the judgment of the Plan not recognized as conforming to accepted medical practice, or the procedure, drug, or device:

- Has not received required final approval to market from appropriate government bodies;
- Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
- Is not demonstrated to be as beneficial as established alternatives;
- Has not been demonstrated to improve the net health outcomes;
- Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Internal Appeal Process
You have the right to reconsideration of the denial by Blue Cross and Blue Shield of Montana (BCBSMT) within 180 calendar days from the date you receive this notice of denial. Your request should include those reasons you believe the proposed services are necessary and include any additional supporting documentation. BCBSMT has 60 days from the date we receive your request for a reconsideration to review and render a final decision.

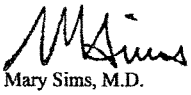
Upon request, BCBSMT will provide, at no charge, a copy of the guidelines used and reasonable access to and copies of all documents, records, and other information relevant to the service or supply. Documents may be reviewed at the BCBSMT office between 8 a.m. and 5 p.m., Monday through Friday (excluding holidays), at 560 North Park, Helena, Montana.

Expedited Review Process
You may also have the right to seek an expedited review of the denial if your health care provider determines that the denial involves a condition that seriously threatens your life or health. To qualify for an expedited reconsideration, your health care provider must certify in writing that your life or health would be seriously threatened by the delay of an internal reconsideration process. Please call 1-800-447-7828, Extension 8518, for instructions on initiating a request for an expedited reconsideration.

Contact BCBSMT by:
- Telephoning: 1-800-447-7828, Extension 8518, Monday through Friday, 8 a.m. to 5 p.m.
- Mailing request to Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604.
- Faxing request to (406) 444-8451, Attention: Susan.

If you have questions concerning the denial or the reconsideration process, please call 1-800-447-7828, Extension 8518.

Sincerely,



Mary Sims, M.D.
Medical Director

0512SYM02.ckh(MM17)
Enclosure
cc: Susan O'Brien, Shands HealthCare

May 26, 2006

Mary Sims, M.D.
Medical Director
Blue Cross Blue Shield of Montana
P.O. Box 4309
Helena, Montana

RE: Subscriber William Ackley
Subscriber ID 8800444926
Subject: Denial of benefits for Transplant Using Myeloablative Preparative Regimen

Dear Dr. Sims,

I am writing this letter to formally request an expedited appeal of your denial of the Bone Marrow Transplant request submitted to you by my physician at Shands Hospital UF, Dr. Jan Moreb. As indicated by Dr. Moreb in his accompanying letter, delaying the process with a standard appeal could be life-threatening.

He disagrees that this procedure is in any sense "investigational or experimental" as you state in your letter of denial dated May 12, 2006. In addition to his letter, I am enclosing a letter from the Office of Patient Advocacy of the National Marrow Donor Program and supporting documents. The NMDP has the most extensive network of related studies and therapies data. The scientific articles they present "illustrate that allogeneic transplant for the diagnosis of CLL is neither investigational nor experimental". I ask you to have a physician who specializes in the treatment of hematological malignancies review this evidence closely.

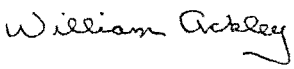
In addition, I personally ask you to look at my case as an individual and not just a subscriber number. My history with CLL is very atypical. I was diagnosed with this disease at the age of 39 (the median age of diagnosis for CLL is 72 years). After 20 years I am still younger than the age when most individuals are first diagnosed. Except for the CLL involvement in my lymph system and bone marrow/blood, I have no other health problems that would be normally associated with a person age 80+ years who would be the typical 20 year survivor of CLL. The extensive physical and mental evaluations conducted at Shands Hospital at the University of Florida (for which BCBS paid) in preparation for the transplant authorization showed that all my major organs and biological systems are in very good condition. A good donor match has been located through the National Marrow Donor Program as a result of the testing also paid for by BCBS. These factors, along with my age, make the likelihood of a successful response to the transplant greater than the average "older" CLL patient.

I have depended on BCBS Montana through the Troy School Dist. group plan to provide my health care coverage for 19 years. During that time, the plan has supported and paid

for those treatments my physicians and other health care specialists deemed necessary for the control and suppression of my disease with the best chance of long-term survival.

That I am a 20 year survivor of CLL is proof of the accuracy of those treatment decisions and the support of them by BCBS Montana. I am asking you not to negate those 20 years of sound judgments with a denial of the treatment I need now.

Sincerely,



William Ackley
16 Kodiak Path
Ormond Beach, FL 32174

386-615-3172
flackley@copper.net

SHANDS
at the University of Florida

May 26, 2006

Bone Marrow
Transplant Program

Mary Sims, MD
Medical Director
BlueCross BlueShield of Montana

RE: William Ackley
Member #880044926
RE: Allogeneic Unrelated Stem Cell Transplant
Request for Expedited Review

Dear Dr. Sims:

I am writing this letter in support of Mr. Ackley's effort to appeal the second denial of his stem cell transplant for chronic lymphocytic leukemia (CLL). Mr. Ackley has suffered from this disease for many years, as you well know, from the history and physical forwarded to you as part of his evaluation. As you also are aware, he had a partial response to his last cycle of chemotherapy. His disease continues to be chemotherapy sensitive; however, it is my opinion that he will soon become refractory to standard dose chemotherapy. For this reason, it is appropriate to offer him high-dose chemotherapy followed by a stem cell transplant at this time. It is truly his only opportunity for a long-term remission and possible cure.

Shands Healthcare has been offering allogeneic stem cell transplants for CLL since 1999. The majority of our patients have BlueCross BlueShield, Medicare or Medicaid. This treatment modality is acceptable to those agencies and we have not had difficulty obtaining authorization for transplant for CLL in the past.

The literature supports the use of stem cell transplantation in situations such as Mr. Ackley's. He has an excellent performance status, despite having fought this disease since 1987. Non-myeloablative transplant still remains the best option for him. Much of the efficacy of allogeneic transplant comes from the graft vs leukemia effect seen with the non-myeloablative regimens. Mr. Ackley has been thoroughly evaluated and from our perspective is a suitable candidate for transplant. Please reconsider your denial. Please handle this appeal in the most expedited fashion based on his risk for progression.

Sincerely,

Jan Moreb, MD
Professor of Medicine
Bone Marrow Transplant Program
University of Florida

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Chief Executive Officer

May 16, 2006

BlueCross BlueShield of Montana
560 N. Park Avenue
Helena, Montana 59604

Member #: 880044926
Member: William G. Ackley
RE: Allogeneic Unrelated Stem Cell Transplant for the Diagonosis of Chronic Lymphocytic Leukemia

To Whom It May Concern:

We are writing this letter on behalf of your member, William G. Ackley, who has been diagnosed with Chronic Lymphocytic Leukemia (CLL). The National Marrow Donor Program Office of Patient Advocacy supports the treatment recommendations outlined by Jan S. Moreb, MD of the Shands Hospital at the University of Florida Bone Marrow Transplant Program.

The National Marrow Donor Program is a research partner within the Center for International Blood and Marrow Transplant Research. As such, much of the data regarding blood and stem cell transplant is collected through these organizations to be utilized for academic publications. The following scientific articles published in peer-reviewed journals illustrate that allogeneic transplant for the diagnosis of CLL is neither investigational nor experimental.

Allogeneic transplantation is the only treatment for CLL which is known to be curative. While other therapies may prolong survival, they can not cure the disease and their usefulness is limited by cumulative toxicity. A patient with CLL who meets the eligibility criteria for transplantation and possesses a matched sibling or closely matched unrelated donor has a clear potential for long term survival.

The following articles are enclosed:

Pavletic SZ, Khouri IF, Haagenson, M, et al."Unrelated Donor Marrow Transplantation for B-Cell Chronic Lymphocytic Leukemia After Using Myeloablative Conditioning: Results from the Center for International Blood and Marrow Transplant Research." (2005). J Clin Oncol 23:5788-5794. *This article demonstrates prolonged disease-free survival among recipients of unrelated donor transplants and concludes, "...allo-HSCT [hematopoietic stem cell transplantation] can induce long lasting remissions in patients with advanced CLL."*

Higher success rates in this setting were limited by transplantation-related mortality, which may be reduced with reduced intensity conditioning regimens.

Sorror ML, Maris MB, Sandmaier BM, et al. "Hematopoietic Cell Transplantation After Nonmyeloablative Conditioning for Advanced Chronic Lymphocytic Leukemia"— et al. 2005 J Clin Oncol 23:3819-3829. *This article illustrates reduced rates of transplantation-related mortality and increased rates of disease-free survival accompanying the use of a reduced intensity conditioning regimen. The authors concluded that, " No other treatment option offers this level of disease response in this patient population. ...Results support the need for prospective phase III studies comparing the different treatment modalities for patients with fludarabine-refractory CLL."*

These studies further support evidence nicely reviewed in the recent American Society of Hematology Education Program Book (Byrd JC, Stilgenbauer S and Flinn IW. "Chronic Lymphocytic Leukemia" (2004). Broudy, Berliner, Larson, Leung, Eds. American Society of Hematology, Washington DC.

We recommend that a physician who specializes in the treatment of hematological malignancies review the request by Shands Hospital at the University of Florida Bone Marrow Transplant Program to cover unrelated allogeneic transplant for Mr. Ackley.

On behalf of Mr. Ackley, I request that you review the information provided and reconsider your denial of coverage for an allogeneic stem cell transplant. These data confirm that transplantation for CLL is not investigational and that transplantation provides the potential for eradication of this disease.

Please do not hesitate to contact the Office of Patient Advocacy at the National Marrow Donor Program at (888) 999-6743 if you would like additional information.

Sincerely,

Stacy Stickney Ferguson, MSW, LICSW
Case Manager
Office of Patient Advocacy
National Marrow Donor Program
Toll-free: (888) 999-6743 ext. 3485
Direct: (612) 362-3485 E-mail:
Facsimile: (612) 627-8195
E-mail: sferguso@nmdp.org

Kate Pederson, MSW
Manager of Patient Services
Office of Patient Advocacy
National Marrow Donor Program
Direct: (612) 627-8126
E-mail: kpederso@nmdp.org

cc: William G. Ackley
Jan S. Moreb, MD, Shands Hospital at the University of Florida Bone Marrow Transplant Program
Margaret Youngblood, RN, MSN, OCN

June 7, 2006

Mary Sims, MD
Blue Cross Blue Shield of Montana
560 No. Park Ave
Helena, MT 59601

Re: Independent Peer Review from second peer for William Ackley

Dear Dr. Sims:

Enclosed please find the peer physician's comments following independent review of this case. Please be aware that these comments represent the peer physician's opinions based on the information provided. The peer physician's review and response along with the medical record and related documents are enclosed. The second peer's review is:

> "I have reviewed the case of Mr. William Ackley, who is a 58-year-old, white male with progressing Rai stage II chronic lymphocytic leukemia and who is requesting approval for high-dose chemotherapy and matched, unrelated donor stem cell transplantation.
>
> Briefly, the patient presented in 1986 with Rai stage II disease. He was asymptomatic initially. He first received treatment with Chlorambucil in 1987. He received intermittent therapy through 2001 with hematologic complete responses. In 2001, he was treated with Fludarabine, Mitoxantrone, Dexamethasone, and Rituxan for 6 cycles with a complete hematologic response. In June of 2005, he developed bulky lymphadenopathy in his neck, axilla, mediastinum, and Fludarabine, Cytoxan, and Rituxan for 4 cycles with stable disease. In January of this year, he developed progressing disease with bulky lymphadenopathy. He was treated with RICE (Rituxan, Ifosfamide, Cytoxan, and Etoposide) with a partial response. His treatment was complicated by the development of an idiopathic pneumonia. Follow-up CT scan recently showed no residual pulmonary infiltrates and partial regression of his lymphadenopathy. He has a normal performance status and is otherwise in good health, without any other major medical problems.
>
> He saw Dr. Jan Moreb of the bone marrow transplant program at the University of Florida. It was recommended that he undergo non-myeloablative transplant using a matched, unrelated donor. Dr. Moreb had earlier recommended treatment with a myeloablative preparative regimen.

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(307) 637-8163 fax

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I believe that a non-myeloablative or myeloablative, matched, unrelated donor transplant is medically necessary. Patients with Fludarabine-resistant disease have an extremely poor prognosis. There are two options for therapy for this particular patient:

Treatment with Alemtuzumab, which produces a 2 year survival of about 40% and extends median survival an additional 12 months compared to historical controls (see Blood 2002, volume 99, pages 3554-3561).

An alternative approach is unrelated donor transplant using myeloablative conditioning, which produces 5 year survivals in the range of 33%. It has treatment-related mortality at 5 years of 38% (see Journal of Clinical Oncology 2005, volume 23, pages 5788-5794). Alternatively, non-myeloablative conditioning with matched, unrelated donor transplant produces a 2 year overall survival of about 75% with 2 year non-relapse-related mortality of 20% (see Journal of Clinical Oncology 2005, volume 23, pages 3819-3829). No randomized clinical trials have compared Alemtuzumab to high-dose chemotherapy in Fludarabine-refractory patients, but a retrospective analysis suggests improved survival with high-dose therapy (see Blood 2001, volume 98, page 42, abstract 2011).

Because Mr. Eckley has an extremely poor prognosis given his extensive prior therapy and because a matched, unrelated donor transplant with non-myeloablative conditioning can lead to prolonged survival, I believe that the approach recommended by Dr. Moreb is medically indicated and would be preferable to treatment with Alemtuzumab."

Therefore, it is the recommendation of Mountain-Pacific Quality Health, based on the second peer's review that the denial be reversed.

The billing for the review of this case will be submitted under a separate copy after all costs have been identified.

Thank you for referring this case to Mountain-Pacific Quality Health.

Sincerely,

John W. McMahon Sr., MD
Corporate Medical Director

William (Bill) Ackley

William (Bill) Ackley, Kodiak Path, Ormond Beach, died Wednesday, January 3, 2007, at Shands Hospital Gainesville following a long battle with leukemia. Funeral service will be held at Church of the Holy Child, 1225 W. Granada Blvd, Ormond Beach, at 5 p.m. Monday, January 8. Born in Richland, Washington June 20, 1947, to Lloyd and Helen Ackley, Bill grew up and graduated from high school in Kennewick, Washington. His love for all sports was formed during these years and continued throughout his life. In 1969, he graduated with a BA in Business Administration from Eastern Washington University where he met his future wife, Marjory Armstrong. Following their marriage in 1970, they settled in Spokane, Washington, moving to Montana in 1972. In 1974 the greatest blessing in their lives arrived, their beautiful daughter, Erinn Colleen. For 31 years Bill dedicated his life to the education of elementary school children in the state of Montana. During this time he taught in Forsyth, Havre and Kremlin, Montana. He obtained his MA in Elementary Education from Northern Montana College in 1976 and subsequently completed the advanced Elementary Administrator course at the University of Montana in 1982. He was Elementary Principal in Nashua, Elementary Superintendent in Somers and finished his career in Troy as principal of Morrison Elementary for 16 years. During these years he touched and enriched the lives of countless students, teachers and parents with his patient, wise counsel and guidance. He loved his time working with K-8 graders both in the classroom and as an administrator. He shared his passion for athletics by coaching many youth basketball, soccer and baseball teams. On an individual level, Bill participated in numerous mid to long distance races including marathons, played shortstop on the 1975 state fastball championship team and honed his golf game during the short Montana playing seasons. In 2003, he retired to Ormond Beach. He worked for 2 years with Publix Supermarkets returning to the occupation that financed his college education over 30 years earlier. For the first time in his life, he was able to indulge his love of golf 12 months out of the year. Spring training baseball and time on the beach were also bonuses of the Florida lifestyle which he embraced. Bill was an active member of Church of the Holy Child in Ormond Beach and the Kairos prison ministry team. His joy in the Lord found true expression in the loving community at Church of the Holy Child. Bill was preceded in death by his parents and a sister, Betty. He is survived by his wife of 36 years, Marjory, at the family home; daughter Erinn and son-in-law, Daniel Seifert, Red Lodge, Montana; two sisters in Washington, Jeanne Kruse, Kirkland and Patricia Morrow, Kennewick; and a brother, Robert Ackley, of Placerville, California. The family requests memorials to The Central Florida Chapter of the Leukemia and Lymphoma Society, 3319 Maguire Blvd., Suite 101, Orlando, FL 32803. Arrangements are under the direction of Haigh-Black Funeral Home and Cremation Service.

Policy Analysis

No. 642 August 6, 2009

Fannie Med?
Why a "Public Option" Is Hazardous to Your Health

by Michael F. Cannon

Executive Summary

President Obama and other leading Democrats have proposed creating a new government health insurance program as an option for Americans under the age of 65, within the context of a new, federally regulated market—typically described as a "National Health Insurance Exchange." Supporters claim that a new government program could deliver higher-quality health care at a lower cost than private insurance, and that competition from a government program would force private insurers to improve.

A full accounting shows that government programs cost more and deliver lower-quality care than private insurance. The central problem with proposals to create a new government program, however, is not that government is less efficient than private insurers, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product.

A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it would reduce competition by driving lower-cost private health plans out of business. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans.

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options.

Congress should reject proposals to create a new government health insurance program—not for the sake of private insurers, who would be subject to unfair competition, but for the sake of American patients, who would be subject to unnecessary morbidity and mortality.

Michael F. Cannon is director of health policy studies at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It.

CATO INSTITUTE

The central problem with proposals to create a new government program is that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product.

Introduction

President Obama,[1] Senate Finance Committee chairman Max Baucus (D-MT),[2] and other leading Democrats have proposed creating a new government health insurance program as an "option" for Americans under the age of 65. This program would operate within the context of a new, federally regulated market—typically described as a "National Health Insurance Exchange." House Speaker Nancy Pelosi (D-CA)[3] and four House caucuses representing more than 100 Democrats[4] have stated that a new government health insurance program modeled on Medicare is the sine qua non of health care reform. Sixteen Democratic senators have signed a letter signaling their support.[5] Senate Health, Education, Labor, and Pensions Committee chairman Edward M. Kennedy (D-MA) has proposed legislation that would create such a program,[6] as have three key House committees.[7]

Others have suggested that Congress should adopt a different model. Senate Budget Committee chairman Kent Conrad (D-ND) and Sen. Charles Schumer (D-NY) have proposed that Congress create one or more health-insurance "cooperatives," although each endorses different structures and different levels of government support. Cooperatives are member-run health plans that already exist in many areas of the country; for instance, Group Health Cooperative already covers 580,000 Americans in the states of Washington and Idaho.[8] Schumer proposes that Congress spend $10 billion to create a single nationwide cooperative, which would be governed by a federal board and endowed with the power to use Medicare-like price controls.[9] Conrad proposes multiple cooperatives[10] with start-up subsidies in the neighborhood of $4 billion.[11]

Advocates of a new government health insurance program claim that government provides coverage more efficiently than the private sector. University of California–Berkeley political scientist Jacob Hacker writes:

> The public Medicare plan's administrative overhead costs (in the range of 3 percent) are well below the overhead costs of large companies that are self-insured (5 to 10 percent of premiums), companies in the small group market (25 to 27 percent of premiums), and individual insurance (40 percent of premiums).[12]

Supporters claim they are willing to put government to the test by having it compete against private plans in the context of a new government-run "exchange." President Obama claims that a new government program "gives consumers more choices, and it helps keep the private sector honest, because there's some competition out there."[13] The House Democrats' legislation would create a "public health insurance option" that would be "self-sustaining and compet[e] on [a] 'level field' with private insurers."[14] Columnist E. J. Dionne writes, "The public-option idea . . . would allow the United States to move gradually toward a government-run system if—*and only if*—a substantial number of consumers freely chose to join such a plan. The market would test the idea's strength."[15]

A full accounting, however, shows that government programs are less efficient than private insurance. Administrative costs are higher in government programs such as Medicare, because they avoid administrative activities that increase efficiency and incur other administrative costs that are purely wasteful. Government programs also suppress innovation, and thereby reduce the quality of care for all patients, whether publicly or privately insured.

The central problem with proposals to create a new government program is not that government is less efficient than private insurers, however, but that government can hide its inefficiencies and draw consumers away from private insurance, despite offering an inferior product. If the government plan's premiums reflected its full costs—and private insurance premiums reflected only their actual costs—there would be no reason not to let the government enter the market. As Dionne suggests, the market would test the idea's

strength. Yet government possesses both the power to hide its true costs (which keeps its premiums artificially low) and to impose costs on its competitors (which unnecessarily pushes private insurance premiums higher). It makes no difference whether a new program adopts a "co-operative" model or any other. The government possesses so many tools for subsidizing its own program and increasing costs for private insurers—and has such a long history of subsidizing and protecting favored enterprises—that unfair advantages are inevitable. This is in no small part because supporters of a new government program *want* it to have unfair advantages.

Literally Ousting Patients from Their Health Plans

In a speech to the American Medical Association, President Obama reiterated a promise that he has made repeatedly since the 2008 presidential campaign:

> No matter how we reform health care, we will keep this promise to the American people. If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what.[16]

After the Congressional Budget Office estimated that as many as 15 million Americans could lose their existing coverage under Senator Kennedy's legislation,[17] the Associated Press reported, "White House officials suggest the president's rhetoric shouldn't be taken literally."[18]

Indeed, a new government program would literally oust millions of Americans from their current health plans and threaten their relationships with their doctors, as employers choose to drop their current employee health plans and as private health plans close down. A Lewin Group analysis estimated that Obama's campaign proposal would move 32 million Americans into a new government-run plan.[19] Lewin subsequently estimated that if Congress used Medicare's price controls and opened the new program to everyone, it could pull 120 million Americans out of private insurance—more than half of the private market.[20] The share of Americans who depend on government for their health care would rise from just over one-quarter to two-thirds.[21] Many of those millions would be involuntarily ousted from their current health plans—much like President Obama suggested ousting 10 million seniors[22] from their private Medicare Advantage plans and forcing them into the traditional Medicare program.[23] Yet even those who voluntarily chose a new government program over their existing coverage would do so not because the government program provides better value for the money, but because the government program would hide some of its cost.

A health insurance "exchange," where consumers choose between private health plans with artificially high premiums and a government program with artificially low premiums, would not increase competition. Instead, it would reduce competition by driving lower-cost private health plans out of business. President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector. In the process, millions of Americans would be ousted from their existing health plans, and all would suffer the consequences of government-run health care.

President Obama's vision of a health insurance exchange is not a market, but a prelude to a government takeover of the health care sector.

Is Government More Efficient?

Supporters of a new government program note that private insurers spend resources on a wide range of administrative costs that government programs do not. These include marketing, underwriting, reviewing claims for legitimacy, and profits. The fact that government avoids these expenditures, however, does not necessarily make it more efficient. Many of the administrative activities that private insurers undertake serve to *increase* the insurers' efficiency. Avoiding those activities would therefore make a health plan less efficient. Existing government health programs also incur

administrative costs that are purely wasteful. In the final analysis, private insurance is more efficient than government insurance.

Administrative Costs

Time magazine's Joe Klein argues that "the profits made by insurance companies are a good part of what makes health care so expensive in the U.S. and that a public option is needed to keep the insurers honest."[24] All else being equal, the fact that a government program would not need to turn a profit suggests that it might enjoy a price advantage over for-profit insurers. If so, that price advantage would be slight. According to the Congressional Budget Office, profits account for less than 3 percent of private health insurance premiums.[25] Furthermore, government's lack of a profit motive may not be an advantage at all. Profits are an important market signal that increase efficiency by encouraging producers to find lower-cost ways of meeting consumers' needs.[26] The lack of a profit motive could lead a government program to be less efficient than private insurance, not more.

Moreover, all else is not equal. Government programs typically keep administrative expenditures low by avoiding activities like utilization or claims review. Yet avoiding those activities increases overall costs. The CBO writes, "The traditional fee-for-service Medicare program does relatively little to manage benefits, which tends to reduce its administrative costs *but may raise its overall spending* relative to a more tightly managed approach."[27] Similarly, the Medicare Payment Advisory Commission writes:

> [The Centers for Medicare & Medicaid Services] estimates that about $9.8 billion in erroneous payments were made in the fee-for-service program in 2007, a figure more than double what CMS spent for claims processing and review activities. In Medicare Advantage, CMS estimates that erroneous payments equaled $6.8 billion in 2006, or approximately 10.6 percent of payments. . . . The significant size of Medicare's erroneous payments suggests that the program's low administrative costs may come at a price.[28]

In the final analysis, private insurance is more efficient than government insurance.

CMS further estimates that it made $10.4 billion in improper payments in the fee-for-service Medicare program in 2008.[29]

Medicare keeps its measured administrative-cost ratio relatively low by avoiding important administrative activities (which shrinks the numerator) and tolerating vast amounts of wasteful and fraudulent claims (which inflates the denominator).[30] That is a vice, yet advocates of a new government program praise it as a virtue.[31]

Medicare also keeps its administrative expenditures down by conducting almost no quality-improvement activities. Journalist Shannon Brownlee and Obama adviser Ezekiel Emanuel write:

> [S]ome administrative costs are not only necessary but beneficial. Following heart-attack or cancer patients to see which interventions work best is an administrative cost, but it's also invaluable if you want to improve care. Tracking the rate of heart attacks from drugs such as Avandia is key to ensuring safe pharmaceuticals.[32]

According to the CBO, private insurers spend nearly 1 percent of premiums on "medical management."[33] The fact that Medicare keeps administrative expenditures low by avoiding such quality-improvement activities may likewise result in higher overall costs—in this case by suppressing the quality of care.

Supporters who praise Medicare's apparently low administrative costs often fail to note that some of those costs are hidden costs that are borne by other federal agencies, and thus fail to appear in the standard 3-percent estimate.[34] These include "parts of salaries for legislators, staff and others working on Medicare, building costs, marketing costs, collection of premiums and taxes, accounting including auditing and fraud issues, etc."[35]

Also, Medicare's administrative costs should be understood to include the deadweight loss from the taxes that fund the pro-

gram. Economists estimate that it can easily cost society $1.30 to raise just $1 in tax revenue, and it may sometimes cost as much as $2.[36] That "excess burden" of taxation is a very real cost of administering (i.e., collecting the taxes for) compulsory health insurance programs like Medicare, even though it appears in no government budgets.

Comparing administrative expenditures in the traditional "fee-for-service" Medicare program to private Medicare Advantage plans can somewhat control for these factors. Hacker cites a CBO estimate that administrative costs are 2 percent of expenditures in traditional Medicare versus 11 percent for Medicare Advantage plans. He writes further: "A recent General Accounting Office report found that in 2006, Medicare Advantage plans spent 83.3 percent of their revenue on medical expenses, with 10.1 percent going to nonmedical expenses and 6.6 percent to profits—a 16.7 percent administrative share."[37]

Yet such comparisons still do not establish that government programs are more efficient than private insurers. The CBO writes of its own estimate: "The higher administrative costs of private plans do not imply that those plans are less efficient than the traditional FFS program. Some of the plans' administrative expenses are for functions such as utilization management and quality improvement that are designed to increase the efficiency of care delivery."[38] Moreover, a portion of the Medicare Advantage plans' administrative costs could reflect factors inherent to government programs rather than private insurance. For example, Congress uses price controls to determine how much to pay Medicare Advantage plans. If Congress sets those prices at supracompetitive levels, as many experts believe is the case,[39] then that may boost Medicare Advantage plans' profitability beyond what they would earn in a competitive market. Those supracompetitive profits would be a product of the forces that would guide a new government program—that is, Congress, the political system, and price controls—rather than any inherent feature of private insurance.

Economists who have tallied the full administrative burden of government health insurance programs conclude that administrative costs are far higher in government programs than in private insurance. In 1992, University of Pennsylvania economist Patricia Danzon estimated that total administrative costs were more than 45 percent of claims in Canada's Medicare system, compared to less than 8 percent of claims for private insurance in the United States.[40] Pacific Research Institute economist Ben Zycher writes that a "realistic assumption" about the size of the deadweight burden puts "the true cost of delivering Medicare benefits [at] about 52 percent of Medicare outlays, or between four and five times the net cost of private health insurance."[41]

Administrative costs can appear quite low if you only count some of them. Medicare hides its higher administrative costs from enrollees and taxpayers, and public-plan supporters rely on the hidden nature of those costs when they argue in favor of a new government program.

Medicare hides its higher administrative costs from enrollees and taxpayers, and public-plan supporters rely on the hidden nature of those costs when they argue in favor of a new government program.

Cost Containment vs. Spending Containment

Advocates of a new government health care program also claim that government contains overall costs better than private insurance. Jacob Hacker writes, "public insurance has a better track record than private insurance when it comes to reining in costs while preserving access. By way of illustration, *between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.*"[42] In fact, looking at a broader period, from 1970 to 2006, shows that per-enrollee spending by private insurance grew just 1 percentage point faster per year than Medicare spending, rather than 2.7 percentage points.[43] That still omits the 1966–1969 period, which saw rapid growth in Medicare spending.

More importantly, Hacker's comparison commits the fallacy of conflating *spending* and *costs*. Even if government contains health care spending better than private insurance (which is not at all clear), it could still impose greater overall costs on enrollees and society than pri-

vate insurance. For example, if a government program refused to pay for lifesaving medical procedures, it would incur considerable nonmonetary costs (i.e., needless suffering and death). Yet it would look better in Hacker's comparison than a private health plan that saved lives by spending money on those services. Medicare's inflexibility also imposes costs on enrollees. Medicare took 30 years longer than private insurance to incorporate prescription drug coverage into its basic benefits package. The taxes that finance Medicare impose costs on society in the range of 30 percent of Medicare spending.[44] In contrast, there is no deadweight loss associated with the voluntary purchase of private health insurance.

Hacker nods in the direction of nonspending costs when he writes, "Medicare has maintained high levels of . . . patient access to care."[45] Yet there are many dimensions of quality other than access to care. It is in those areas that government programs impose their greatest hidden costs, on both publicly and privately insured patients.

Medicare and other government programs uniformly lag private insurers when it comes to quality innovations.

Government Programs Suppress Quality, Cost Lives

Supporters also claim that government programs outperform private health insurance on quality. On the surface, the quality of medical care in government programs tends to be similar to, or worse than, the quality of care under private insurance. This may be largely due to the fact that government programs uniformly lag private insurance in adopting quality innovations. Beneath the surface, however, government programs suppress the quality of care for all patients, whether publicly or privately insured.

Researchers estimate that patients receive high-quality, evidence-based care only about half of the time, regardless of whether they are enrolled in Medicare, Medicaid, or private insurance.[46] A recent Minnesota study found, however, "On eight of the nine statewide measures, performance in achieving high-quality care was significantly lower at both the statewide and medical group levels for [Medicaid and other government programs] compared with [private insurance]."[47] Patients with Medicaid coverage experience more unmet medical needs than similar patients with private insurance.[48] Studies have found that Medicaid patients suffer worse outcomes than similar privately insured patients when it comes to cancer,[49] unstable angina,[50] and coronary artery bypass graft surgery.[51] The Veterans' Health Administration appears to outperform private insurance on some dimensions of quality,[52] but exhibits serious deficiencies in others.[53] President Obama's secretary of Health and Human Services, Kathleen Sebelius, has called the government-run Indian Health Service a "historic failure."[54]

Nevertheless, supporters make the demonstrably false claim that government programs are more innovative than private insurance. Hacker writes, "Medicare has been slow to adopt quality innovations—though generally quicker than private health plans."[55] Peter Harbage and Karen Davenport of the Center for American Progress cite Medicare's policy on "never events"—severe medical errors that should "never" happen—as proof of government's superior ability to promote quality: "Witness steps such as Medicare's refusal to pay medical care providers for 'never events,' where a patient suffers a knowable and catastrophic mistake, such as having the wrong limb removed. This is something other major insurers are now adopting."[56]

In reality, Medicare and other government programs uniformly lag private insurers when it comes to quality innovations. For example, private insurers began experimenting with "pay-for-performance" financial incentives almost an entire decade before Medicare.[57]

"Never events" provide an even clearer illustration. In 2003, an estimated 181,000 severe medical errors occurred in hospitals alone.[58] Throughout its 43-year history, Medicare has actually *encouraged* such errors by financially rewarding health care providers when an error leads to more services, and financially penalizing providers who reduce error rates.[59] In October 2008, Medicare eliminated those perverse incentives for a short list of medical errors called "never events." That policy will

likely discourage *some* medical errors by forcing providers to pay for *some* of the associated costs. Yet the first private health plan to force providers to bear the *full* financial cost of *all* medical errors was offered by the Ross-Loos Clinic in 1929.[60] Kaiser Permanente has done so since the 1940s. Medicare didn't even play a leading role on "never events" among fee-for-service plans, as Harbage and Davenport claim. HealthPartners of Minnesota stopped paying for "never events" in January 2005.[61] Medicare merely followed suit.

Stagnation Costs Lives

Government programs are not merely slow to innovate, they are outright hostile to quality innovations. Government programs inject rigidity into health care markets that suppresses the quality of care for publicly and privately insured patients alike. The result is greater morbidity and mortality.

This can be seen most clearly in the way government suppresses competition between different methods of paying doctors, hospitals, and other health care providers. As noted above, Medicare financially rewards medical errors and penalizes error-reduction efforts because it pays providers on a fee-for-service basis. Fee-for-service payment, as the name suggests, means that providers collect an additional fee for each additional service they provide. Conversely, if providers deliver fewer services, they collect less revenue. Fee-for-service payment thus creates a perverse incentive: if low-quality care (e.g., a medical error, poor coordination between providers, insufficient attention to medical evidence) results in a patient requiring more services, then low-quality providers will receive more revenue than providers who adopt quality innovations. According to the *New York Times*, for example:

> Park Nicollet Health Services, a hospital and clinic system based in St. Louis Park, Minn[esota] . . . started . . . spending as much as $750,000 annually on more nurses and on sophisticated software to track heart failure patients after they left the hospital. It reduced readmissions for such patients to only 1 in 25, down from nearly 1 in 6. But the reduction has been a losing proposition. Although the effort saved Medicare roughly $5 million a year, Park Nicollet is not paid to provide the follow-up care. Meanwhile, fewer returning hospital patients mean lower revenue for Park Nicollet. "We've kept it up out of a sense of moral obligation to these patients, but we're getting killed," said David K. Wessner, chief executive of Park Nicollet. "We will totally run out of gas."[62]

Medicare suppresses countless quality innovations by making them "a losing proposition."

A free market would use competition from different methods of paying providers to keep those perverse incentives in check. Under "prepayment" or "capitation," for example, providers receive a flat fee to provide medical care for a given patient or group of patients. Group Health Cooperative is an example of an integrated, prepaid health plan. Prepayment *rewards* providers for avoiding unnecessary and harmful services: whatever money providers save by avoiding medical errors, for example, the providers get to keep. It is no coincidence that prepaid health plans, like Kaiser Permanente, lead the market in innovations such as coordinated care and electronic medical records, which help avoid unnecessary services. Prepayment also creates its own perverse incentive: providers get to keep whatever money they save by denying access to needed care as well. In a free market, however, competition from fee-for-service providers would force them not to stint on necessary care. By the same token, competition from prepaid plans would force fee-for-service providers to coordinate care, offer electronic medical records, and avoid medical errors.

Government health insurance programs—principally Medicare—block competition between different payment systems, and therefore dramatically reduce the quality of care. As the largest purchaser of medical services in the United States, Medicare accounts for two-

Government programs inject rigidity into health care markets that suppresses the quality of care for publicly and privately insured patients alike. The result is greater morbidity and mortality.

Harbage and Davenport write that a new government program "will create incentives for effective performance just as today's Medicare program promotes quality care alongside cost containment." That is precisely the problem.

thirds to four-fifths of revenues for many hospitals and specialties.[63] Medicare's influence is so vast that hospitals and other providers organize the delivery of medical care around the financial incentives it creates. Providers like Park Nicollet Health Services cannot stay in business by providing high-quality coordinated care, because that means less revenue from Medicare. Because privately insured patients use the same doctors and hospitals, that means Medicare suppresses the quality of care even for privately insured patients.[64]

The main reason that the U.S. health care sector lacks coordinated care, electronic medical records, and comparative-effectiveness research is that government rewards providers who avoid these quality innovations and penalizes providers who adopt them. The main reason that as many as 100,000 Americans die from medical errors each year is that the nation's largest health care purchaser rewards providers who tolerate medical errors and punishes providers who reduce them.

Congress cannot solve this problem by reforming Medicare's payment system, creating a new program that uses a different payment system, or attempting to incorporate such competition into a government program. All methods of paying health care providers create perverse incentives. If Medicare or a new program adopts the payment system used at Group Health Cooperative, Congress will merely trade the perverse incentives of fee-for-service payment (uncoordinated care, medical errors) for those of prepayment (less provider choice, greater rationing). Only competition between different payment systems can hold those perverse incentives in check. Yet government programs like Medicare and Medicaid stifle such competition. Medicare Advantage attempts to allow such competition, yet different health plans with different payment systems constantly lobby Congress for special advantages. Meanwhile, politicians, such as President Obama, propose eliminating such competition entirely.

Harbage and Davenport write that a new government program "will create incentives for effective performance just as today's Medicare program promotes quality care alongside cost containment."[65] That is precisely the problem. A new government program would suppress quality, just as Medicare has, by further stifling competition between payment systems. Sebelius says that making Medicare "a strong and sustainable program depends on our ability to fix what's broken in the rest of the system."[66] Sebelius has it exactly backward: Medicare *is* what's broken in the rest of the system.

We need not look to Canada to find horror stories about government-run health care. Estimates of 100,000 deaths each year in the United States from medical errors should be frightening enough.[67] A new government program, whether modeled on Medicare or not, would further suppress health care quality and cause additional morbidity and mortality.

The Fair-Competition Fantasy

President Obama admits, "I think there can be some legitimate concerns on the part of private insurers that if any public plan is simply being subsidized by taxpayers endlessly, that over time they can't compete with the government just printing money."[68] Nevertheless, supporters claim that Congress can create a new government program that competes with private insurers on a level playing field. The "Blue Dog Coalition" of moderate House Democrats has offered several criteria that a new program would have to satisfy in order to do so.[69] The Blue Dogs insist, for example, that the program would have to be completely self-sustaining (i.e., premium revenue would cover all costs), that the government not leverage its market power to favor the new program, and that government not enact any regulations that favor a new government program over private insurers. Supporters such as Len Nichols and John Bertko of the New America Foundation claim that a new program can satisfy those conditions.[70]

Yet the government need neither subsidize its own program with taxpayer money, nor newly printed money, nor must it do so "end-

lessly," to supplant private insurance with an inferior option. Indeed, government has countless other ways to prevent the true cost of a new program from appearing in its premiums, and to increase the premiums of its competitors. Moreover, government's long history of subsidizing, protecting, and bailing out favored enterprises shows that such special advantages would be inevitable. For example, Amtrak requires repeated taxpayer subsidies to stay afloat.[71] And Congress famously bailed out Fannie Mae and Freddie Mac.

Congress has made Medicare increasingly less self-sustaining over time. When Congress created Medicare in 1965, enrollee premiums covered 50 percent of the cost of physician services. Under pressure from Medicare enrollees, subsequent Congresses gradually reduced that share to 25 percent. The U.S. Postal Service is similarly unable to sustain itself. According to one critic:

> Make no mistake . . . the Postal Service is not self-sufficient. It is kept afloat by a number of hidden taxpayer subsidies. For starters, it has a monopoly on First Class and Standard mail. No private company can deliver a letter for less than $3 or twice what USPS charges, whichever is greater. . . . Meanwhile, USPS is immune from antitrust lawsuits and exempt from taxes on its massive real-estate holdings. . . . It enjoys power of eminent domain. And it doesn't even pay parking tickets.[72]
>
> It calculates the amount of corporate income tax it would owe if it were a private company—and then pays that amount to itself.[73]

Likewise, state governments have repeatedly crowded out private insurance in markets for workers' compensation insurance, crop and flood insurance, and reinsurance for medical malpractice and natural disasters, according to University of Pennsylvania economist Scott Harrington, because "the public sector is supported by various types of subsidies or special rules that allow it to compete with the private sector."[74]

Direct Subsidies

Among the many ways that Congress could favor a new government program is through direct subsidies—that is, real resources provided to the government program, yet withheld from private insurers:

- The federal and state governments finance Medicaid and the State Children's Health Insurance Program almost entirely through tax revenue. As a result, those programs crowd out private insurance among individuals who could otherwise obtain coverage on their own.[75] Likewise, taxpayer subsidies fund nearly 90 percent of Medicare spending, which helps that program almost completely crowd out private health insurance for the elderly.[76]
- Creating a new program around Medicare's existing infrastructure, as some supporters propose, would bestow start-up subsidies not available to new private health plans.[77] Senator Schumer has insisted that a government-sponsored "co-operative" receive $10 billion in start-up subsidies.
- The leading Democratic proposals would create a "risk-adjustment" mechanism that would essentially tax all health plans to compensate those that attract a disproportionate share of high-cost patients and/or that do little to reduce wasteful expenditures.[78] Whether a new government program proves to be more attractive to high-cost patients or does a poorer job of controlling unnecessary expenditures, the risk-adjustment program could easily become a tool for taxing private insurers to subsidize the government plan.
- When estimating Medicare's administrative costs, the federal government does not count the cost of activities undertaken by other federal agencies to support Medicare.[79] If the government fails to include such costs when calculating the premiums for a new program, that would constitute an implicit sub-

Government has countless ways to prevent the true cost of a new program from appearing in its premiums, and to increase the premiums of its competitors.

sidy and enable the new program to set its premiums below its true costs.

To the extent that a new government program receives direct subsidies that are not available to private insurers, its relative cost would also be higher due to the deadweight loss of taxation, yet that added cost likewise would not appear in the government program's premiums.

Indirect Subsidies

To subsidize a new government program, Congress need not hand it bags of cash or use creative accounting when setting premiums. Congress can instead subsidize its program indirectly, whether by granting it special status or increasing its competitors' costs:

- The taxpayer subsidies and other advantages granted to Medicare give the federal government a degree of market power that private insurers cannot match. That market power in turn creates opportunities for Congress to grant other special advantages to a new government program. Many supporters propose that a new program should adopt price controls identical or similar to Medicare's, or that the federal government should require providers to participate in the new program as a condition of Medicare participation.[80] Sen. Jay Rockefeller (D-WV) proposes to let a new program use Medicare's price controls for two years, and to require doctors who participate in Medicare to participate in the new program for three years;[81] yet those time frames could easily be extended to four years, six years, or beyond. Leveraging the special advantages granted to Medicare would enable a new government program to achieve a level of provider participation at a lower cost than private insurers.
- Adopting Medicare-like price controls would also increase the prices that providers charge private insurers. Experts disagree about the exact mechanism that drives prices higher for private insurers.[82] Whatever the case, such price controls would increase the cost of private insurance relative to a new government program.
- Tightening the price controls that Medicaid uses to purchase prescription drugs, or expanding those price controls into either Medicare or a new government program, would likewise increase costs for the new program's private competitors. The price controls that Congress imposes on drug purchases through the Medicaid program have the effect of increasing prices for private insurers by an estimated 15 percent.[83] The Senate Finance Committee has suggested tightening this price control,[84] while House Energy and Commerce Committee chairman Henry Waxman (D-CA) has proposed importing those price controls into Medicare.[85] Either move would further increase costs for private insurers.
- Any new program would come with an implicit guarantee that Congress would bail it out if premiums proved insufficient to cover its costs. Hacker argues for an *explicit* bailout guarantee when he writes that reserve requirements "would not make sense for the public health insurance plan, which has the full faith and credit of the federal government behind it."[86] Even if the bailout guarantee were only implicit, that would enable the new program to set its premiums below costs. According to a 1996 Treasury Department report signed by Larry Summers, who is now President Obama's National Economic Council chairman, a similar implicit guarantee saved Fannie Mae and Freddie Mac an estimated $6 billion per year.[87] Meanwhile, private insurers would effectively face higher reserve requirements than the government program.
- Unlike many private insurers, government programs pay no taxes. The presence of corporate income taxes, invest-

Adopting Medicare-like price controls would increase the prices that providers charge private insurers.

ment taxes, etc., increases the price of private insurance relative to a government program. The CBO estimates that taxes account for 1.2 percent of private health insurance premiums, on average.[88] Government could further advantage its program by raising taxes on private insurers, such as through the special tax on insurance-company profits proposed by Senator Schumer.[89]

- Government can increase the effective cost of private insurance by imposing penalties on consumers who choose it instead of the government plan. Federal regulations penalize seniors who opt out of Medicare to obtain private health insurance by taking away their Social Security benefits, past and future.[90] That penalty exists in spite of a provision in the Medicare statute called, "Option to Individuals to Obtain Other Health Insurance Protection," which reads: "Nothing contained in this title shall be construed to preclude . . . any individual from purchasing or otherwise securing, protection against the cost of any health services."[91]

Even if Congress could create a new government program with no special advantages, a truly level playing field would require a credible guarantee that no future Congress and no future regulator would ever confer any special advantages on that program. Given the bailout craze of 2008–2009, it is not credible to suggest the government would not bail *itself* out if premiums were insufficient to support the new program's outlays. That public perception would itself create an implicit bailout guarantee, and redound to the exclusive benefit of a new government program. Moreover, today's Congress cannot bind future Congresses. Supporters of a new program know this, and they are already contemplating future efforts to secure special advantages for any new program that Congress creates.[92]

Medicare Advantage

Medicare Advantage demonstrates that the playing field between a government program and private insurers could never be level. The Medicare Advantage program allows private insurers to compete with the traditional, government-run Medicare program. The playing field shifts depending on whether the party in power prefers government or private insurance. In 2003, President George W. Bush and a Republican Congress adopted fairly high price controls for the Medicare Advantage plans. More recently, a Democratic Congress has sought stricter price controls. President Obama even proposed to throw private plans out of Medicare entirely, which is not so much a level playing field as it is a cliff.

Nichols and Bertko admit that the playing field isn't level in Medicare Advantage due to congressional interference, and they claim that such interference is "not inherent in public-private competition."[93] Yet when Congress creates a federal health insurance program and a federal bureaucracy to craft and enforce the rules of competition between that program and private plans, nothing is more inherent to such a scheme than Congress and its whims.

If wise philosopher-kings could somehow create a new government health insurance program and (permanently) deny it of any special advantages, *it would cease to be a government program*. It would be just another private insurer. If that is what supporters of a new government program want, there is no need for Congress to act. Supporters can gather investors and launch their own private health plan right now. The only rationale for having Congress construct a new health plan is to create socially harmful competition whose objective is a government takeover of the U.S. health care sector.

The only rationale for having Congress construct a new health plan is to create socially harmful competition whose objective is a government takeover of the U.S. health care sector.

Conclusion

A new government program would supplant private insurance, despite offering inferior care at a higher cost. The program would attract consumers not by virtue of its superior performance, but by government's ability to prevent the full cost of its program from appearing in enrollee premiums and its ability

to increase the cost of private options. As the new program's artificially low premiums crowd out private insurance, the government would exert even greater downward pressure on quality. Any new government health insurance program would shortly lead to a government takeover of health insurance markets—and the entire health care sector.

No one should be surprised. President Obama has repeatedly affirmed his preference for a single-payer, government-run health care system, such as exists in Canada.[94] Many people, including *New York Times* columnist Paul Krugman, support a new government program precisely because they believe it will lead to a single-payer system.[95] Hacker has quipped, "Someone once said to me, 'This is a Trojan Horse for single-payer,' and I said, 'Well, it's not a Trojan Horse—it's right there! I'm telling you: we're going to get there, over time, slowly.'"[96]

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options.

If Congress wants to make health care more efficient and increase competition in health insurance markets, there are far better options. Congress should let consumers—rather than employers or the government—control their health care dollars and choose their health plan. It should convert Medicare into a program that gives seniors a voucher and frees them to purchase any health plan on the market.[97] Reforming the tax treatment of employer-sponsored insurance with "large" health savings accounts would give workers the thousands of dollars of their earnings that employers currently control, and likewise free workers to purchase any health plan on the market.[98] Finally, Congress should expand competition by prohibiting states from denying market entry to health plans and providers licensed by other states—that is, by making clinician and health-insurance licenses portable across state lines.[99] Those reforms would reduce costs, increase innovation, and reduce the number of uninsured—without higher taxes or additional government spending.

Congress should reject proposals to create a new government health insurance program—not for the sake of private insurers, who would be subject to unfair competition, but for the sake of American patients, who would be subject to unnecessary morbidity and mortality.

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