

TERMINATIONS OF HEALTH POLICIES BY INSURANCE COMPANIES: STATE PERSPECTIVES AND LEGISLATIVE SOLUTIONS

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION

—————
JULY 27, 2009
—————

Serial No. 111-58



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

—————
U.S. GOVERNMENT PRINTING OFFICE

74-091

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

HENRY A. WAXMAN, California, *Chairman*

JOHN D. DINGELL, Michigan

Chairman Emeritus

EDWARD J. MARKEY, Massachusetts

RICK BOUCHER, Virginia

FRANK PALLONE, Jr., New Jersey

BART GORDON, Tennessee

BOBBY L. RUSH, Illinois

ANNA G. ESHOO, California

BART STUPAK, Michigan

ELIOT L. ENGEL, New York

GENE GREEN, Texas

DIANA DeGETTE, Colorado

Vice Chairman

LOIS CAPPS, California

MICHAEL F. DOYLE, Pennsylvania

JANE HARMAN, California

TOM ALLEN, Maine

JANICE D. SCHAKOWSKY, Illinois

CHARLES A. GONZALEZ, Texas

JAY INSLEE, Washington

TAMMY BALDWIN, Wisconsin

MIKE ROSS, Arkansas

ANTHONY D. WEINER, New York

JIM MATHESON, Utah

G.K. BUTTERFIELD, North Carolina

CHARLIE MELANCON, Louisiana

JOHN BARROW, Georgia

BARON P. HILL, Indiana

DORIS O. MATSUI, California

DONNA M. CHRISTENSEN, Virgin Islands

KATHY CASTOR, Florida

JOHN P. SARBANES, Maryland

CHRISTOPHER S. MURPHY, Connecticut

ZACHARY T. SPACE, Ohio

JERRY McNERNEY, California

BETTY SUTTON, Ohio

BRUCE BRALEY, Iowa

PETER WELCH, Vermont

JOE BARTON, Texas

Ranking Member

RALPH M. HALL, Texas

FRED UPTON, Michigan

CLIFF STEARNS, Florida

NATHAN DEAL, Georgia

ED WHITFIELD, Kentucky

JOHN SHIMKUS, Illinois

JOHN B. SHADEGG, Arizona

ROY BLUNT, Missouri

STEVE BUYER, Indiana

GEORGE RADANOVICH, California

JOSEPH R. PITTS, Pennsylvania

MARY BONO MACK, California

GREG WALDEN, Oregon

LEE TERRY, Nebraska

MIKE ROGERS, Michigan

SUE WILKINS MYRICK, North Carolina

JOHN SULLIVAN, Oklahoma

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

MARSHA BLACKBURN, Tennessee

PHIL GINGREY, Georgia

STEVE SCALISE, Louisiana

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

BART STUPAK, Michigan, *Chairman*

BRUCE L. BRALEY, Iowa

Vice Chairman

EDWARD J. MARKEY, Massachusetts

DIANA DeGETTE, Colorado

MIKE DOYLE, Pennsylvania

JAN SCHAKOWSKY, Illinois

MIKE ROSS, Arkansas

DONNA M. CHRISTENSEN, Virgin Islands

PETER WELCH, Vermont

GENE GREEN, Texas

BETTY SUTTON, Ohio

JOHN D. DINGELL, Michigan (*ex officio*)

GREG WALDEN, Oregon

Ranking Member

ED WHITFIELD, Kentucky

MIKE FERGUSON, New Jersey

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

CONTENTS

	Page
Hon. Bart Stupak, a Representative in Congress from the State of Michigan, opening statement	1
Hon. Baron P. Hill, a Representative in Congress from the State of Indiana, opening statement	4
Hon. John A. Yarmuth, a Representative in Congress from the Common- wealth of Kentucky, opening statement	5
WITNESSES	
Peggy Raddatz, Relative of Policyholder, La Grange, Illinois	7
Prepared statement	9
Patricia Reilling, Policyholder, Louisville, Kentucky	11
Prepared statement	16
Robin Beaton, Policyholder, Waxahachie, Texas	20
Prepared statement	23
Richard Collins, Chief Executive Officer, Golden Rule Insurance Company, Unitedhealth Group	39
Prepared statement	41
Brian A. Sassi, President And Chief Executive Officer, Consumer Business, Wellpoint, Inc.	44
Prepared statement	47
Carol Cutter, Commissioner, Indiana Department of Insurance	53
Prepared statement	55
Eleanor Kinney, Co-Director, William S. and Christine S. Hall Center for Law and Health, Indiana University School of Law	58
Prepared statement	60
SUBMITTED MATERIAL	
Document binder	85

TERMINATIONS OF HEALTH POLICIES BY INSURANCE COMPANIES: STATE PERSPECTIVES AND LEGISLATIVE SOLUTIONS

MONDAY, JULY 27, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:00 a.m., in the Hoosier Room, University Center North Building at Indiana University Southeast Campus, 4201 Grant Line Road, New Albany, Indiana, the Hon. Bart Stupak [chairman of the subcommittee] presiding.

Member present: Representative Stupak.

Also present: Representatives Hill and Yarmuth.

Staff present: Michael Gordon, Chief Investigative Counsel; Ali Golden, Investigator; Paul Jung, Public Health Investigator; and Sean Hayes, Minority Oversight Counsel.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This meeting will come to order.

Today we have a hearing entitled "Terminations of Health Policies by Insurance Companies: State Perspectives and Legislative Solutions."

Before we begin the hearing, I would like to thank Congressman Hill, a member of the full Energy and Commerce Committee, for housing us today here in Indiana. In addition, I want to welcome Congressman Yarmuth across the river in Kentucky.

It is our general practice at subcommittee hearings that non-members of the subcommittee do not make opening statements or question witnesses. I believe it is appropriate that we deviate from this practice today. I ask unanimous consent that Congressmen Hill and Yarmuth be permitted to make opening statement, if they choose, and to question witnesses during today's hearing. Hearing no objection, that will be the order.

The chair will now be recognized for a five-minute opening statement. Other members of the subcommittee will be recognized for a three-minute opening statement. I will begin.

This hearing of the Subcommittee on Oversight and Investigations has commenced here in Indiana at the request of our friend Congressman Baron Hill. We are pleased to be here for this hearing on abuses in the health insurance industry. I would like to

thank Congressman Hill and his staff for requesting this hearing and housing us here today.

Congressman Hill has been a leader on health care, and I can tell you from firsthand experience that he has been working diligently in Congress and on our Energy and Commerce Committee to look out for the people of Indiana. Thank you for having us here today, Baron.

I would also like to welcome our friend Congressman John Yarmuth, who is from across the river in Kentucky. Congressman Yarmuth has been a key player in many issues in his position on the Ways and Means Committee, and we are delighted that he is here with us today.

Let me also thank Indiana University for hosting us today. It is critical that Congress understand the concerns of local communities as we develop national health care policies, and we do that precisely through field hearings like the one we have here today, where we can go out and hear directly from people on matters of urgent concern.

Today's hearing is about a horrendous practice that some insurance companies engage in called "rescission." Here is how it works. When you apply for health insurance, you fill out an application. The forms ask about all of your preexisting conditions and health history, and sometimes they are extremely complicated. These insurance companies typically require access to all of your health records as well.

The problem is that these insurance companies do not review these applications very carefully when you submit them. They wait. They let you pay your premiums, they let you go along and keep paying for years, creating a false sense of security that you will be covered if something terrible ever happens.

When something does happen, however, when you develop a deadly disease, when you need expensive medical care, or when you have to go to a hospital for critical treatment, these insurance companies don't honor their agreements. Instead, they mobilize a team of investigators to go back through your original application.

They scour years and years of your medical records to find some technicality, some error or omission, some box that wasn't checked when it should have been. And when they find it, they cancel your health insurance. They refuse to pay. And there you are in the hospital left waiting for potentially life-saving medical care that you may never receive.

What is outrageous about this practice is that these insurance companies cancel policies even for people who didn't do anything wrong. The omissions on their applications relate to conditions that their doctors may have never told them about. They relate to conditions that insurance companies' own agents told them not to write down. And many times they relate to conditions that are completely unrelated to the illness or disease they are now seeking treatment for.

Our subcommittee has been conducting a year-long investigation into this abusive practice. We have reviewed more than 116,000 pages. We have reviewed more than 116,000 pages of documents from three of the largest health insurance companies—Assurant, United Health Group, and WellPoint. And we learned that these

three companies retroactively terminated nearly 20,000 policies over the past five years based on omissions on applications that were identified only after people became ill. These rescissions resulted in savings to the companies of more than \$300 million.

Last month we held a hearing in Washington, D.C. with these three companies, and I asked their CEOs to stop canceling health insurance for innocent policyholders. Amazingly, they refused. Let me show you a clip from that hearing. It will take a minute to put up there.

[Video presentation begins.]

Mr. STUPAK. Let me ask each of our CEOs this question, starting with you, Mr. Hamm. Would you commit today that your company will never rescind another policy unless there was intentional fraudulent misrepresentation in the application?

Mr. HAMM. I would not commit to that.

Mr. STUPAK. How about you, Mr. Collins? Would you commit not to rescind any policy unless there is intentional fraudulent misrepresentation?

Mr. COLLINS. No, sir. We follow the State laws and regulations, and we would not stipulate to that. That is not consistent with each State's policies.

Mr. STUPAK. How about you, Mr. Sassi? Would you commit that your company will never rescind another policy unless there was intentional fraudulent misrepresentation?

Mr. SASSI. No, I can't commit to that.

Mr. STUPAK. Each of these three companies simply refused to stop canceling innocent policyholders' contracts. Now, it is one thing to cancel coverage for someone who commits insurance fraud, but it is another thing to cancel coverage for people in the middle of a health care crisis based on innocent mistakes or technicalities. It is simply not fair for insurance companies to collect record profits and award their executives billions of dollars while they are denying innocent people the health insurance they pay for.

Facing with this damning testimony, we concluded that the only way to stop these insurance companies was to change the law. So our Energy and Commerce Committee has drafted health reform legislation that will prohibit this practice of rescission once and for all.

Our bill will protect consumers in a couple of ways. First, we will prohibit insurance companies from rescinding coverage unless there is clear and convincing evidence of fraud during the application process. Second, we guarantee that consumers have an independent and third-party review of any rescission.

We have asked the insurance companies back today to see if they have had a change of heart and to find out what they think of our legislation. We have also invited Indiana's Insurance Commissioner, Carol Cutter, to hear if the State of Indiana supports ending this terrible practice, as well as Professor Eleanor Kinney, the co-director of Indiana Law School's Center for Law and Health.

I also want to extend a personal thanks to both Peggy Raddatz and Robin Beaton, who traveled here today from Illinois and Texas to tell us their stories about how these insurance companies improperly rescinded their health insurance. I also want to thank Pa-

tricia Reilling from Louisville, Kentucky for testifying today about how her policy was recently terminated by her insurance company.

Let me point out that Ms. Beaton's case highlights that this is not a partisan issue. This is not a Democratic or Republican issue. When Ms. Beaton's insurance company canceled her health insurance, she called her local congressman, Joe Barton, who happens to be the ranking Republican member of our committee. To his immense credit, Congressman Barton intervened on Ms. Beaton's behalf, and made sure the insurance committee reinstated her coverage.

Ms. Beaton, I know you regard Mr. Barton as a hero for coming to your rescue. I am not sure if you heard what Congressman Barton said at our hearing in Washington about your case, so let me show you, and here is what he said.

[Video presentation begins.]

Mr. BARTON. I think I speak for every member of the committee on both sides of the aisle that if in fact there is a practice of going in after the fact and canceling policies on technicalities, we have got to do whatever is possible to prevent that. If a citizen acts in good faith, we expect the insurance companies who take their money to act in good faith also.

Mr. STUPAK. I couldn't have said it better myself.

That is the end of my opening statement. Let me next turn to Congressman Baron Hill. Thank you again for hosting us, and you will be recognized for an opening statement, please.

OPENING STATEMENT OF HON. BARON P. HILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. HILL. Thank you, Bart. I want to begin by thanking Congressman Stupak for taking the time to come to the place where God himself was born in Southern Indiana. It is good to have you here in Hoosier State, and we are delighted that you are carrying on these hearings. Hopefully, you will be able to get some results, and people all across our great country will get relief from some of the questionable practices that I have been hearing about.

I also would like you to know that Congressman Stupak is from Michigan, and I am going to be spending a lot of time in your great State, Congressman Stupak, because my youngest daughter this Wednesday travels to Ann Arbor to attend medical school at the University of Michigan. So I am looking forward to that as well.

I have heard Congressman Stupak talk about this issue of post-claims underwriting or health insurance rescission, what transpired at the hearing held on this issue in Washington, D.C. I am very interested to hear what our witnesses have to say today in light of that hearing, and some of the things that they have said that they would not do as a company in response to Congressman Stupak's questions about whether or not they would change their ways of looking at the claims.

And I would also like to thank all of the witnesses for taking the time to participate in this hearing. This hearing could not be more timely. I hope it sheds light on some of the serious ills of our current health care system.

Health care reform is certainly the topic of conversation right now. Today, I am going to be going back to meet with the com-

mittee chairman and the White House and other members of the Energy and Commerce Committee who are dealing with this most important issue, so that we can have health care for all Americans.

So I am glad we are holding such an important hearing right here in New Albany. This issue of health insurance rescission is, quite honestly, shocking. I can't imagine what I would do if this happened to someone in my family, and I think that is how we need to approach health care reform.

Put yourself in other people's shoes. This issue is particularly distressing, because these folks aren't trying to trick the system. They are trying to do the right thing by being covered. And then, to have the rug pulled out from underneath them is not acceptable.

This is also a completely bipartisan issue, as Congressman Stupak has already spoken about. The most vocal critic of this practice is the Republican ranking member of the Energy and Commerce Committee, Congressman Joe Barton.

And I want to repeat what has already been said. In fact, Congressman Barton said this today, this morning, and also said it during the hearing, or not Congressman Barton but Congressman Stupak was quoting Congressman Barton. "I think I speak for every member of the committee on both sides of the aisle that if in fact there is a practice of going in after the fact and canceling policies on technicalities, we have got to do whatever is possible to prevent that."

So I thank everybody for coming today, and I look forward to hearing more testimony from our witnesses. Hopefully, we will be able to get some resolution to this very serious problem.

Thank you.

Mr. STUPAK. Thank you.

Mr. Yarmuth, your opening statement, please. And it is a pleasure to have you here as a member of the Ways and Means Committee. And now you are an honorary member of the Energy and Commerce Committee.

OPENING STATEMENT OF HON. JOHN A. YARMUTH, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. YARMUTH. Thank you very much, Mr. Chairman, and thank you for extending the courtesies of the subcommittee to me. Thank you for holding this hearing.

This hearing is important for a number of reasons. I think the foremost reason it is critical is that as we debate insurance reform and health care reform, we end up talking about a lot of dollars and a lot of abstract theories and a lot of macroeconomic implications. But at its very core, this is a debate about human beings, and this is a debate about humans and their families and their need and their right to have quality health care coverage that they can afford.

So I am very appreciative of the three witnesses—Ms. Beaton, Ms. Raddatz, and Ms. Reilling—for being willing to come here and tell their stories, because unfortunately their stories are not atypical. Their stories are all too common, and we are proud to have them. It is very valuable to have a human face put on the issues that we are discussing today.

Secondly, we will hear a lot about coverage and the uninsured today, and what is important to note is—and I think this hearing is important because it will point out a number of the reasons why people end up uninsured. It is not because they don't want to have insurance. It is because they are put in positions where, through no fault of their own, they are cast in a market where they cannot either afford or even buy at any cost the insurance that they need.

And we will hear a lot of discussion about profits. I know, for instance, that over the last—well, for seven years, from 2000 to 2007, the profits of the 10 largest insurance companies rose over 400 percent. I don't think that the cost of health care rose over 400 percent. I know it didn't. I know salaries didn't rise over 400 percent. And when you connect what we have—the subjects we will hear today, the stories we will hear today, to both issues of profitability and to the inability of Americans to afford insurance, it will be very clear.

And, finally, I think these hearings are important, because as we discuss the need for a public option in health care reform, a public option that will compete with private insurers, as President Obama says “to keep them honest,” I think it will be abundantly clear after these hearings why keeping the insurance companies honest is a mandatory element of what we are trying to do in Congress for the American people right now.

So I applaud the subcommittee for holding this hearing, and I am happy to be a part of it.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Yarmuth.

Let us call our first panel of witnesses forward. On our first panel we have Ms. Robin Beaton, who is a policyholder from Waxahachie, Texas. Ms. Beaton, if you want to come forward. Ms. Peggy Raddatz of LaGrange, Illinois, who is a sister of the late policyholder, Otto Raddatz. And Ms. Patricia Reilling, who is a policyholder from Louisville, Kentucky. If she would come forward, please.

OK. This is a congressional hearing. Our statements, questions, and answers to our questions are recorded and will be part of the official record of the Energy and Commerce Committee. It is the policy of the subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony.

Do any of you wish to be advised by counsel? You are all shaking your head in a no manner, so I figure that is no. OK. Then, I am going to ask you to take the oath.

[Witnesses sworn.]

Let the record reflect that the witnesses have replied in the affirmative. You are now under oath, beginning with your opening statement. We will have an opening statement. You may submit a longer statement for the record, and it will be included in the official transcript.

Ms. Beaton, do you want to start? No. Ms. Raddatz, would you like to start?

STATEMENTS OF PEGGY RADDATZ, RELATIVE OF POLICYHOLDER, LAGRANGE, ILLINOIS; PATRICIA REILLING, POLICYHOLDER, LOUISVILLE, KENTUCKY; AND ROBIN BEATON, POLICYHOLDER, WAXAHACHIE, TEXAS

STATEMENT OF PEGGY RADDATZ

Ms. RADDATZ. I would be happy to, Chairman. Once again, thank you very much for inviting me here today. My name is Peggy Raddatz, and I am appearing here today to testify on behalf of my brother, Otto S. Raddatz. My brother was business owner of a restaurant that he ran with his wife Marie. He purchased a health insurance policy from Fortis Insurance Company in August of 2003, as so many small business owners do in this country.

On the application he indicated he had kidney stones and that he smoked. He also listed all physicians who treated him. Otto's health application with Fortis was accepted, and his coverage began in August of 2003.

A year later, my brother found himself inexplicably losing weight. His wife, Marie Raddatz, urged him to see a doctor. In September of 2004, my 59 year-old brother was diagnosed with Stage 4 Non-Hodgkins-type lymphoma. The very next day he began an intensive course of chemotherapy treatments.

Due to the very aggressive type of cancer that my brother had, a mantel zone lymphoma, he was given six more rounds of chemotherapy by January of 2005. This was a very difficult time for him. Because he was going through intensive chemotherapy, he found it difficult to work, and as a result difficult to continue to manage his business as a restaurant owner.

Otto was referred to a specialist in stem cell transplantation and for high-dose chemotherapy. Otto began more chemotherapy for purposes of preparing him for a stem cell transplant. In the midst of his chemo treatments, Otto received a phone call and letter from Fortis Insurance Company stating his insurance was canceled. He was devastated. I remember the day very well.

My very strong brother who was always together, my older brother, was just totally distraught. And he called me, his sister, who happens to be attorney. He was rescinded all the way back to the acceptance date of August 7, 2004, which meant he basically had no health insurance whatsoever. This meant none of his cancer treatments would be covered at all going all the way back to the beginning when he first got cancer.

Most importantly, he would not be able to receive the stem cell transplant that he needed to save his life. My brother only had a very small window of time in which to receive a stem cell transplant. He needed to be scheduled within the next three to four weeks or else he wasn't going to receive it, because there would be no point to receive it. He would simply worsen and die.

My brother was told he was canceled during what the Fortis Insurance Company called a "routine review" during which they claimed to discover a material failure to disclose on the part of my brother Otto. Apparently, in 2000, his doctor had—his family doctor had done a CT scan which showed an aneurysm and gall stones. My brother was never told of either one of these conditions,

nor was he ever treated for them and he never reported any symptoms whatsoever for these conditions.

After months of preparation, both mentally and physically, the stem cell transplant could not be scheduled. My brother's hopes for being a cancer survivor were totally dashed. His prognosis was only a matter of months without the procedure.

When I called the hospital to see if, as his sister, an attorney, I could schedule the stem cell transplant for him, I was callously told, "Unless your brother brings in cash, he is not going to get the procedure without his insurance any longer."

My brother, who was very, very ill, and was given only a few months to live, was accused by the Fortis Insurance Company of falsely stating his health insurance history, despite the fact that he had no knowledge of ever having any gall stones or aneurysms whatsoever.

Luckily, I am an attorney and was able to aggressively become involved in solving this life-threatening situation for him. I contacted the Illinois Attorney General's office and received immediate and daily assistance from Dr. Babs Waldman, the Medical Director of their Health Insurance Bureau.

During their investigation, they located the doctor who ordered the CT scan. He had no recollection whatsoever of disclosing the information to my brother about an aneurysm and gall stones, or of ever treating him for it. After two appeals by the Illinois Attorney General's office, Fortis Insurance Company overturned their original decision to rescind my brother's coverage, and he was reinstated without any lapse.

Without the help of the Illinois Attorney General's office, this would not have been possible whatsoever. What the Fortis Insurance Company did was unethical. To deny a dying person necessary medical treatment, based upon medical conditions a patient has never had any knowledge of, has never complained about, and has never even been treated for, is cruel.

It is our family's hope that this information will benefit other patients who are in need of life-saving medical treatments, and who do not have knowledge or means necessary to fight against the health insurance companies. It is, further, our desire to expose these practices of the Fortis Insurance Company, so that others who are so deathly ill as my brother was do not suffer as the victims of these insurance companies.

Thank you very much.

[The prepared testimony of Peggy Raddatz follows:]

Statement of Peggy M. Raddatz

My name is Peggy M. Raddatz and I am appearing here today to testify on behalf of my brother, Otto S. Raddatz.

My brother was a business owner of a restaurant that he ran with his wife, Marie. He purchased a health insurance policy from Fortis Insurance Company in August of 2003. On the application he indicated he had kidney stones and smoked. He also listed all physicians who treated him. Otto's health application with Fortis was accepted and his coverage began in August of 2003.

A year later my brother found himself inexplicably losing weight. His wife, Marie Raddatz, urged him to see a doctor. In September of 2004 my 59 year old brother was diagnosed with Stage IV NonHodgkins Lymphoma. The very next day he began an intensive course of chemotherapy treatments.

Due to the aggressive type of cancer Otto had, being mantel zone lymphoma, he was given six more rounds of chemotherapy by January of 2005.

Otto was referred to a specialist in stem cell transplantation and for high dose chemotherapy.

Otto began more chemotherapy for purposes of preparing him for a stem cell transplant. In the midst of his chemo treatments, Otto received a phone call and letter from Fortis Insurance Company stating his insurance was canceled. It was rescinded all the way back to the effective date of August 7, 2004.

This meant none of his cancer treatments would be covered. Most importantly, he would not be able to receive the stem cell transplant need to save his life. My brother only had a very small window of time in which to have the stem cell transplant. He needed to be scheduled within the next 3 to 4 weeks.

My brother was told he was canceled during what they called a "routine review" during which they claimed to discover a "material failure to disclose". Apparently in 2000 his doctor had done a CT scan which showed an aneurysm and gall stones. My brother was never told of either one of these conditions nor was he ever treated for them and he never reported any symptoms for them either.

After months of preparation, the stem cell transplant could not be scheduled. My brother's hope for being a cancer survivor were dashed. His prognosis was only a matter of months without the procedure.

When I called the hospital to see if I could schedule the stem cell transplant for him I was callously told "unless your brother brings in cash, he is not going to get the procedure without insurance."

My brother was accused by Fortis Insurance Company of falsely stating his health insurance history, despite the fact that he had no knowledge of ever having any gall stones or aneurysms.

Luckily, I am an attorney and was able to aggressively become involved in solving this life threatening situation. I contacted the Illinois Attorney General's office and received immediate and daily assistance from Dr. Babs H. Waldman, M. D., the medical Director of their Health Bureau.

During their investigation, they located the doctor who ordered the CT scan. He had no recollection of disclosing the information to my brother or treating him for it.

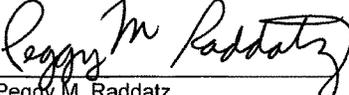
After two appeals by the Illinois Attorney General's Office, Fortis Insurance Company overturned their original decision to rescind my brother's coverage and he was reinstated without any lapse.

Without the help of the office of the Illinois Attorney General, this would not have been possible.

What the Fortis Insurance Company did was unethical. To deny a dying person necessary medical treatment based upon medical conditions a patient has never had knowledge of, never complained about or never been treated for is cruel.

It is our hope that this information will benefit other patients who are in need of life saving medical treatments and who do not have the knowledge or means necessary to fight against the health insurance companies. It is further our desire to expose these practices of Fortis Insurance Company so that others do not suffer as their victims.

Respectfully submitted,


Peggy M. Raddatz

Mr. STUPAK. Thank you, Ms. Raddatz.

Ms. Reilling, would you like to testify? You might want to pull that mic up. Thank you, and thank you for coming.

STATEMENT OF PATRICIA REILLING

Ms. REILLING. Good morning, Mr. Chairman, and members of Congress. My name is Patricia Reilling.

I opened an art gallery in 1987, and in 1990 I took out a group health insurance plan with Anthem through the Kentucky Retail Federation. In 1994, my policy was changed to a one-person group, and I have had the same coverage, with slight changes on occasion, until June 30 of this year. I received a letter from Anthem at the beginning of June informing me that my coverage would end on June 30, 2009, and that was the first time I had heard anything about it.

To be honest, I hadn't even opened that letter for at least four or five days, because I had also received the information I get from my insurance agent every year around this time telling me about the renewal rates for the coming year. And this time the letter was very positive and said there were no change in the rates, I would have the same rates, and that was just great.

And I also received a bill for my July premium, so I had opened those, and so I wasn't really thinking that this letter from Anthem was going to be anything that, you know, was very urgent.

So when I opened that, I was just—I was totally shocked, and it didn't make much sense to me. And I called the agent, and then we started talking about it. But if you don't mind, I would like to back up a little bit and tell you some of the background concerning my health and the reason that it has been so devastating for me.

I have always been really healthy. I hadn't been in a hospital since my son was born, which was several years ago. And I could be in a room full of people that had the flu, I mean there could be hundreds, and I wouldn't even get the sniffles. And I did have a bad back. I mean, I have a bad back, and I at one time had some tests, and I see a pain management doctor about three or four times a year, and I am on prescriptions meds for this. That is the only thing in these actually almost 20 years that I have been with Anthem.

Other than that, I usually describe myself as being healthy as a horse, which is not really flattering, but it is pretty much true, until March of 2008 when I discovered a lump in my breast. After visiting my primary care physician, I went for a mammogram and ultrasound. And when the technician was finished, she said she had to check with the radiologist to see if she had everything she needed.

After a couple of minutes, much to my dismay she was not the one who came back in, but it was the doctor who came in and sat down on the table to explain that they had found lumps in both breasts, and that he was absolutely certain that they weren't cysts, and that I needed to go to a general surgeon right away for biopsies.

So even before the surgeon performed the biopsies, he told me that he was certain that it was cancer, and that he would need to remove both breasts. He did the biopsies, but he had difficulty lo-

cating one of the tumors, and he needed to do one of the biopsies again, so he ordered an MRI.

Well, I very soon, to my amazement, received a letter from Anthem that denied the MRI with the explanation that nothing—something to this effect, that nothing in my health background or my family history indicated that I would be likely to have cancer. And considering the fact that I don't even know anything about my family history, I thought that was really astonishing.

So I ended up having to go through another biopsy, which was really painful, because the doctor ended up having to do a lot of hunting and digging because the point was that he couldn't find it in the first place. So the outcome, of course, was that I did have cancer in both breasts. So April 7, I had the bilateral mastectomies. I made a rather long but full recovery, and on December 2, 2008, I was admitted to Baptist East Hospital again for reconstructive surgery, and I was there for about five days.

And after the last drain was removed at my plastic surgeon's office, and I am probably being a little graphic, but a lot has happened, and if you all don't mind I don't, so it was around January 7 that I returned to her office. And on the 14th—that was when they took the last drain out.

On the 14th, when I went back, it was very obvious that I had a very serious abdominal infection, and she wanted to admit me to the hospital right then. I couldn't, because I had had a little breakfast, so the next morning at 5:00 a.m. I was at the hospital and I was admitted for emergency abdominal surgery for a very invasive case of MRSA staph infection, which I had contracted during the reconstructive surgery in December.

The incision from my December surgery was reopened, and my abdomen was flushed with antibiotic fluid, and the incision was closed. And then, two days later I had another emergency surgery, and, again, the same thing happened, they flushed my abdomen out. But I was so ill and had gone in so ill that they had to give me blood transfusions and potassium, and I was pretty much at death's door.

And this time they actually had to remove the interior part of my navel and sew up my belly button, which this is—I am using really intricate medical terms here, but this is what she—how she described it to me, because this infection had eaten away all of the interior part of my navel. And I remained in the hospital for seven days, and went home, had to stay with a relative for a week because I couldn't take care of myself.

And, basically, I have not regained my strength since that time. It has flared up in a major way about three times since then, every time I go off the antibiotics. Now the area where the abdominal muscles were attached during my reconstruction surgery have all been comprised from this infection, and they no longer support my innards, again using the most sophisticated medical terms. And I really can't stand for more than 15 or 20 minutes. So the infectious disease doctor feels that the infection is deeply embedded in the scar tissue and is going to require surgery in order to clear that up.

So because of the MRSA staph infection, I have never been able to complete my surgeries for my cancer. And now even the surgery

that I had has been compromised, and that is going to have to be redone. And, obviously, with no insurance, that is impossible. So I can't even get rid of this infection, because I don't have any coverage.

I was told that recovery from this reconstructive surgery should be about six weeks. I have been totally out of commission for eight months, have not been able to work, and I work for myself. That, combined with the recovery time for the mastectomies, that has actually—it has been really devastating.

The MRSA was difficult enough to deal with, but when I received notification that my insurance had been canceled with barely a month's notice, the world came crashing down. My medications alone—and this is generic medications—are close to \$2,000 a month.

So they said—I had an appointment—just to give you an example, I had an appointment with an infectious disease doctor to see her again, and when I went to see her at her office they told me that it would cost me \$280, because I didn't have insurance. So they made an appointment with her for me at the clinic, because she is with U of L.

And my appointment was at 9:00. I didn't see her until well after 11:00. I didn't get out of there until after 12:00, and it was not at all the same as when I saw her in her private office.

The reason I mention it is because I have always been a very compassionate person, and I have always tried to put myself in someone else's shoes. But I have certainly been getting an in-depth education in the difference between the haves and the have-nots. This has all been a really eye-opening experience.

You can imagine it is not easy to stand up in front of the world and tell some of the most intimate details of your life, but never in my wildest dreams did I imagine that I would find myself in this situation. I started out with a successful career as a copywriter, I ran a manufacturing company in New York, and then I opened my art gallery, and all it took was for me to get sick to have everything come crashing down.

If I hadn't gotten the staph infection, things would have been a little tight for a while, but life would have gone on. As it is now, I have gone from driving a Mercedes and traveling around the world and going to New York to get my hair done to spending every waking moment calling agency after agency trying to get assistance from pharmaceutical companies to get my prescriptions, trying to find out who can help me pay my utility bills, and who knew that even food stamps are on plastic these days. I used to sell my clothes in consignment stores; now that is where I buy them.

I guess one of the points I would like to make is that it can happen to almost anybody. If you get sick and you lose your insurance, you can be in serious trouble in an amazingly short period of time.

I have had this same policy with Anthem for nearly 20 years. After having that policy, 15 years of which was considered—I was considered a one-person group, and I never missed a payment—I really can't understand how I could receive a letter that gave me less than 30 days after they canceled me.

So I called my agent who told me that Anthem was no longer going to allow one-person groups, which I thought was a little odd

since I have been a one-person group for almost 15 years. So I started calling around. I also thought since I was in the middle of cancer treatment, and this MRSA, I couldn't understand how I could be dropped.

So I called the insurance company, and I finally reached someone who wouldn't give me an answer, never said anything about their policy of canceling one-person groups, but they said that they had sent me a letter in April and that they had sent me a letter in May, and they told me that I would have been given an opportunity to at least dispute this, but they had not heard anything from me. Consequently, I was canceled.

Well, I never got the letter. So I called my agent, and she said, "Oh, yes, I knew about that. But I knew that you wouldn't be able to afford the policy," the conversion policy, which was more than double what I was paying. "So I didn't call you. I didn't let you know about it."

Maybe I wouldn't have been able to afford that. I wouldn't have. But I would have at least had time to try to look for an option. I would have had time to try to get in touch with pharmaceutical companies to get the drugs. And she did forward the letters to me, and they never did send them to me. Those letters were addressed to the agent. They were never addressed to me. They said, "Dear Customer," but the addresses on the letters were both the insurance agent.

And, actually, the information in the letters, that never said anything about canceling one-person groups either. Nowhere in any of these conversations did it say anything about that. So it didn't—it just—she had taken good care of me for almost 20 years, but I don't know what happened through all of this. But the fact that the results of an error like this being so monumentally disastrous and without recourse can obviously be acceptable to the insurance companies seems not only unbelievable but, quite honestly, inexcusable to me.

In my appeal to the insurance company, all I asked was that they continue my coverage until my treatment could be concluded, and their answer said something about—oh, and this came from the president of the company, the president of Anthem. She said that she hoped that my health would improve and that I would regain my previous lifestyle, and she said that there was nothing they could do about their policies.

How they expected me to return to my good health and lifestyle I don't know, but maybe I should have asked to speak to the psychic who knew that my family's health background had predetermined that I wouldn't have cancer. I don't know.

But I just wanted to thank President Obama and all of our Congressmen and their hard-working staff members for their time and efforts to make changes in our system, so that this type of thing will become a bad memory.

Just to add a light note. When I was typing this up the night before last, I got a phone call. And I looked at my caller ID and it said Anthem Blue Cross/Blue Shield. Now this is 26 days after I have been dumped by the company. And it is—for a minute this Pollyana that lives inside me is thinking, "Oh my gosh, they are calling me and they are going to reinstate me."

Then, the realist in me says, "You are an idiot. That isn't possible." And this lovely recording of this woman's voice comes on and says, "Have you had a mammogram lately?" And I am thinking this is really adding insult to injury. And it goes on and asks about other tests and how it is very important for me to do these preventatively and everything. And I thought, if only you were a real person and I could say, "I would love to have these other tests, but I don't have insurance."

So thank you very much.

[The prepared testimony of Patricia Reilling follows:]

Patricia Reilling

July 25, 2009

Good Morning Mr. Chairman and Members of Congress. My name is Patricia Reilling.

I opened my art gallery in 1987 and in 1990 took out a group health insurance plan with Anthem through the KY Retail Federation. In 1994, my policy was changed to a one-person group and I have had that same coverage – with slight changes on occasion – until June 30 of this year. I received a letter from Anthem at the beginning of June, informing me that my coverage would end on June 30, 2009 and that was the first time I had heard anything about it. To be honest, I had not even opened the letter for at least four or five days, because I had also received the information I get from my insurance agent every year around this time telling me about renewal rates for the coming year, as well as my bill for July's premium payment. I had opened those and was planning on calling my agent to ask if I should make any changes or stay with what I had, since it's all Greek to me and I've always followed her advice. When I did open the cancellation letter, I was totally shocked.

But if you don't mind, I'd like to back up a little and tell you some background concerning my health and the reason this has been so devastating for me. I have always been very healthy, hadn't been in a hospital since my son was born, and could be in a room full of people with the flu and wouldn't even get the sniffles. I do have a bad back and at one time had a few tests – and now see a pain management doctor three or four times a year. I have also been on some prescription meds for this condition. Other than that, I've been known to describe myself as being "healthy as a horse," which I guess isn't very flattering, but it is pretty accurate - or was ... until March of 2008, when I discovered a lump in my breast.

After visiting my primary care physician, I went for a mammogram and ultra-sound and when the technician was finished, she said she'd just check with the Radiologist to be sure she had everything she needed. Much to my dismay, it was the doctor who came in and sat down on the table with me to explain they'd found lumps in both breasts, they were definitely *not* cysts and I needed to see a general surgeon for biopsies.

Even before the surgeon performed the biopsies, he told me he was quite certain it was cancer and that he would need to remove both breasts. He did the biopsies, but had difficulty locating one of the tumors and needed to do one of the biopsies again and ordered an MRI. Much to my amazement, I received a letter from Anthem denying the MRI with the explanation that nothing in my health background or family history indicated that I would be likely to have cancer. Considering the fact that even I don't know my family's health history, I found that to be truly astonishing. They did, eventually, approve it but by that time I had already gone through another rather painful

biopsy – which required a bit of hunting and digging – and as expected, I did have cancer in both breasts and had the mastectomies on April 7, 2008.

I made a rather long, but full recovery and on December 2, 2008 was admitted to Baptist East Hospital for reconstructive surgery and was released after five days. The last drain was removed at my plastic surgeon's office around January 7 and when I returned to her office on January 14th it was obvious I had a serious abdominal infection and she wanted to admit me to the hospital that morning but had to wait until the next day because I'd eaten a small breakfast. I was admitted to Baptist East at 5:30 a.m. on the 15th for emergency abdominal surgery for a very invasive case of MRSA, which I contracted during my reconstructive surgery in December. The incision from my December surgery was re-opened and my abdomen was flushed with six liters of antibiotic fluid and the incision was closed. I then had another emergency surgery on the 17th and was so ill and anemic that I required a blood transfusion (I believe a normal hemoglobin count is 13-15, mine was 7 and my potassium level was so low that they had to do a 'fast feed' into my vein right before surgery that was the most painful thing I've ever experienced.) In addition to flushing out my abdomen, this time the surgeon had to remove my entire umbilicus (basically the interior portion of my belly button) and sew up the actual belly button, because the infection had eaten it away. I remained in the hospital for seven days and had to stay with relatives for a week or more before going home because I could not take care of myself. Since that time, I have never regained my strength and the MRSA has flared up in a major way three times, pretty much every time I stop taking the antibiotics.

Now, the area where my abdominal muscles were attached during my reconstruction surgery seems to have been compromised by the MRSA and the muscles are no longer supporting my 'innards' – to use the most sophisticated medical terms – and it is very painful to stand for more than 15 or 20 minutes. My infectious disease doctor feels that the infection is deeply imbedded in the scar tissue and will require surgery to clear it up. Because of the MRSA, I was never able to complete the second stage of my reconstruction surgery and now a large portion of my original surgery has been compromised and will need to be repaired. Obviously, with no insurance coverage this will be impossible.

I was told that recovery time for this TRAM flap procedure was approximately six weeks. I have been totally out of commission for eight months. That, combined with the recovery time from my mastectomies without work has been devastating. The MRSA was difficult enough to deal with, but when I received notification that my insurance was being cancelled – with barely a month's notice, the world came crashing down. My medications alone – and this is generics – come to nearly \$2,000.00/month. I recently had an appointment with my infectious disease doctor, but when I told them my insurance had been cancelled, they told me it would cost \$280.00 to see her. They said

I could see her at the clinic, but it would be another 2 ½ weeks. I made the appointment for 9 a.m., didn't get to see her until after 11 and to be honest, things just weren't the same. I've always been a very compassionate person and have tried to put myself in another's shoes. But I have certainly been getting an in-depth education in the difference between the haves and the have-nots recently and it's truly eye-opening.

As you can probably imagine, it's not easy to virtually stand up in front of the world and tell some of the most intimate details of your life. But then, I never in my wildest dreams imagined I would find myself in this situation. I started out with a successful career as a Copywriter for some of Louisville's top agencies then became a freelance writer. I ran a manufacturing company in New York, then opened my art gallery, which was an instant success and have remained working in art, interior design and organization ... until I got sick. Had I not gotten the staph infection, things would have been a little tight for a while, but life would have rolled on. As it is now, I've gone from driving a Mercedes convertible, with a mini-van for the gallery; travelling around the world; getting my hair done in New York; paying all my bills and being able to help anyone who needed it (which was my greatest joy) ... to spending every waking moment calling agency after agency for assistance and pharmaceutical companies for free medications and trying to find freelance writing jobs again (which I love, but no longer have my connections) because that's work I can do lying down. Who knew that even food stamps are on plastic these days? I used to *sell* my clothes at consignment stores, now I *buy* them there, but I'm not complaining, there are beautiful things to be found ... and I'm not proud.

I guess one of the points I'd like to make is that it can happen to almost anyone. If you get sick and you lose your insurance, you can be in serious trouble in an amazingly short period of time. With all the laws that have been passed protecting women with breast cancer and assuring they will get proper treatment, I never imagined I could end up in this situation ... with no way to repair my initial surgery and complete my reconstruction. After having been a policy holder with Anthem for nearly twenty years, almost fifteen of which I was considered a one-person group and never missed a payment, I couldn't understand how I could receive a letter dated June 1, 2009 saying my coverage would end June 30, 2009!

I called my agent, who told me that Anthem was no longer going to allow one-person groups. I still couldn't understand how they could drop me with so little notice and with my cancer reconstruction surgery not completed. So I began writing and calling everyone I could think of. I finally reached someone who told me I had been sent a letter telling me they were discontinuing my coverage (no mention of one-person groups) in April and another in May that I could respond to. I never received those. They told me the letters were also sent to my agent and when I called and asked, she said she had received a letter, but said that they were offering a conversion plan that

was way too expensive and she knew I wouldn't be able to afford it and said she had sent it on to me. She did send it on, but that was after I had received the cancellation notice. Had I known something in April, I could have at least had a head start on finding some alternative coverage and certainly could have gotten in touch with the pharmaceutical companies for my prescriptions.

I'm sure this was an oversight or mistake of some kind, because for nearly twenty years she has provided me with excellent service. But the fact that the results of an error like this being so monumentally disastrous and without recourse seems unbelievable and quite honestly inexcusable on the part of the insurance company. In my appeal, all I asked was that they continue my coverage until my treatment could be concluded. Their answer said something about hoping my health improved and that I regained my previous lifestyle. How they expected that to happen I don't know. Maybe I should have asked to speak to the psychic who knew that my family's health background had pre-determined that I couldn't possibly have cancer.

I just want to thank President Obama and all our congressmen and their hardworking staff members for their time and efforts to make changes in our system so this type of thing will become a bad memory. I know that my time can certainly be better spent than making endless calls, writing countless letters and waiting on never ending lines merely in an attempt to restore some semblance of normalcy and a lesser degree of panic to my life.

Mr. STUPAK. Thank you for your testimony.
 Ms. Beaton, your testimony, please.

STATEMENT OF ROBIN BEATON

Ms. BEATON. Mr. Chairman, members of the committee—

Mr. STUPAK. Can you just pull that mic up? It is hard to hear you. I know you have a soft voice.

Ms. BEATON. Is that good?

Mr. STUPAK. That is better. Thank you.

Ms. BEATON. Mr. Chairman, members of the committee, I am very honored to be here today to share my story. My name is Robin Beaton. I was registered nurse for 30 years. I had group insurance and was in very good health. I retired from nursing and opened a small antique business. My father always taught our family how very important insurance was. So at my 87 year-old Dad's insistence, I obtained an individual health policy with Blue Cross and Blue Shield in December 2007.

In May of 2008, I went to a dermatologist for pimples. A word was written on my chart, which was interpreted incorrectly as meaning precancerous. In June 2008, I was diagnosed with invasive HER-2 genetic breast cancer. This is a very aggressive form of breast cancer. In the beginning, I was told I needed immediate surgery. The doctor said my tumor was two centimeters. Two centimeters is like probably that big. The doctor said that he would perform a lumpectomy. When you don't have a large tumor, you get to have a lumpectomy. In the beginning, I was going to have a lumpectomy.

Blue Cross and Blue Shield precertified me for the surgery and for the hospital stay. The Friday before the Monday I was to have my surgery, Blue Cross and Blue Shield called me on the telephone and they told me that my chart was red-flagged. What does "red-flagged" mean? That means that they are going to investigate you. They were doing it due to the dermatologist's report, due to the pimple report.

My dermatologist called Blue Cross directly to report that this was only pimples, it was nothing related to cancer. He asked Blue Cross and Blue Shield to please not hold up my cancer surgery. Blue Cross and Blue Shield the next day stated that they were launching a five-year medical investigation into my medical history. This would take approximately two to three months.

I was frantic. I was totally alone as my family lives in Jacksonville, Florida. The hospital wanted a \$30,000 deposit, and I knew I could not pay for surgery myself. I had no idea what to do. I had no idea where to turn or exactly what to do to get surgery. I met a lady who told me, she said, "You need to call your congressman, Joe Barton, for help."

I called Joe Barton's office and told him of my situation. Joe Barton's office went to work immediately to help me. The next day I received a letter from Blue Cross and Blue Shield permanently canceling my insurance, stating that my insurance was canceled back to the date that it began.

Can you imagine having to walk around for months with cancer growing inside your body and having no insurance? Joe Barton and Christy Townsend worked non-stop every day calling Blue Cross

and Blue Shield trying to get my insurance reinstated, so that I could have my cancer surgery. They had no success at this point.

I began going everywhere looking for help—county hospitals, agencies, foundations, anywhere that I could go where people would listen to me tell my story and see if I could get help. I was placed on a waiting list. When you have aggressive invasive breast cancer, you don't have time for waiting. My medical records were lost three times at the county hospital. The process was unending, searching for help.

The sad thing is Blue Cross and Blue Shield took my high premiums, and the very, very first time that I ever filed a claim with them, the very first time, and was suspected of having cancer, they took action against me, searching high and low for a reason to cancel my policy, so they would not have to pay for my cancer.

A nurse who attends my church, her main job is eight hours a day she reads medical charts, and what she does is she looks for reasons for Blue Cross and Blue Shield to cancel insurance. When she heard about my story, what they had done to me, she came to me and she said, "I am so sorry this happened to you." She said, "I am just so sorry."

Blue Cross and Blue Shield has control over life and over death. People have to be able to count on what they pay for. Blue Cross and Blue Shield will do anything to get out of paying for cancer—anything. The sad fact is anyone with a catastrophic illness not part of a group stands a much higher chance of being canceled and left out in the cold without insurance.

I go to a cancer support group every week, and have since I very first found out I had cancer. Four of the girls in my group had their insurance canceled. Two of them have had to declare bankruptcy. It is very difficult to speak out, because I live in fear every day that my insurance will be canceled again.

I looked everywhere for help, and no one—no one—would help me. No help was found until Joe Barton and Christy Townsend, after working a very, very long time, got my insurance reinstated. After being diagnosed in June 2008 with aggressive invasive breast cancer, I was placed back on the surgeon's waiting list to get my cancer surgery. My tumor grew from two to seven centimeters. Instead of having a small lumpectomy, I had to have a radical double mastectomy, and I had to have all of my lymph nodes taken out, every one of them.

Delaying cancer treatment only worsens the condition, costing more to treat, treatment much more intensive, and treatment not being as effective. Also, the outcome is not as good. Once you have cancer, you always have cancer. It is a never-ending battle.

I go to chemotherapy every three weeks, and I will do this for the next year. Last week I had my second surgery, a two and a half hour surgery, which was very hard, to be cut on again. I had that just last week.

Cancer is expensive, and no one wants to pay for it. This is America. People who purchase individual policies and pay their premiums on time, they deserve to receive what they have paid for. I pray with all my heart that no one has go through the sheer agony that I have endured for this last year. I did not deserve to have my insurance canceled. Blue Cross set out to get rid of me.

They searched high and they searched low until they found enough to cancel me.

I owe my life to Joe Barton and his staff. I gave up. I completely gave up. But they never gave up. They never gave up on helping me. Only because of them was I able to get help. That was the only reason I got help. If it wasn't for them, I would be dead today.

I pray that you will listen to my story and help people like me who are powerless against big insurance companies.

And I thank you so much for what you all are doing. I just admire you all so much, and I thank you for listening to me.

Thank you.

[The prepared testimony of Robin Beaton follows:]

Testimony of Robin Beaton

My name is Robin Beaton. I am 59 years old. I was a Registered Nurse for 30 years, worked in a hospital. I had group insurance and was in good health. I retired from nursing and opened my own small antique business. My father always taught our family how very important insurance was. So at my Dad's insistence I obtained an individual policy with Blue Cross and Blue Shield in December 2007.

In May 2008 I went to a dermatologist for acne. A word was written on my chart and interpreted incorrectly as meaning precancerous.

In June 2008 I was diagnosed with invasive HER-2 genetic breast cancer, this is a very aggressive form of breast cancer. In the beginning, I was told I needed immediate surgery. The doctor told me you have a lumpectomy if the tumor is small enough. In the beginning the doctor said the tumor was 2 centimeters.

When the surgeons scheduled my surgery I was pre-certified for two days hospitalization and surgery. The Friday before the Monday I was scheduled to have my surgery Blue Cross red flagged my chart due to dermatologist chart. The dermatologist called Blue Cross directly to report that I only had acne (pimples) and to please not hold up my cancer surgery. Blue Cross called me on the Friday before I was to have cancer surgery on Monday and informed me that they were launching a 5 year medical investigation into my medical history and this would take approximately 3 months.

I was frantic. I was totally alone as my family lives in Jacksonville Florida. The hospital wanted a \$30,000 deposit, and I knew I could not pay this or for the surgery myself. I had no idea what to do or where to turn. I met a lady who told me you need to call your congressman Joe Barton for help.

I called Joe Barton's office and told them my situation. Joe Barton's office went to work immediately to help me. The next day I received a letter from Blue Cross completely cancelling my insurance back to the first date it was issued. Joe Barton and Christy Townsend worked non-stop everyday calling Blue Cross Blue Shield to try to get my insurance reinstated so I could have my cancer surgery. No success at this point.

I began going everywhere looking for help, county hospitals, Foundations, agencies. Everywhere I went I was placed on a waiting list. When you have aggressive invasive cancer you have no time to wait as the cancer grows everyday. I went back to the county hospital where they lost my medical records three times. The process was unending searching for help for cancer. I did everything to get help. Everywhere you go takes time. No help was found until Joe Barton and his staff, after working a very long time, got Blue Cross to reinstate my insurance after being diagnosed with aggressive invasive breast cancer in June 2008. I was then placed back on the surgeons list to receive my cancer surgery. I finally was operated on October 2, 2008. My tumor grew from 2 centimeters all the way to 7 centimeters. Also, I had to have both breasts removed and all my lymph nodes due to waiting from June to October for treatment.

Delaying treatment for cancer only worsens the condition, costing more to treat and treatment much more intensive. Also the outcome is not as good.

This is America and people who purchase individual policies and pay their premiums deserve to receive what they have paid for. The sad thing is Blue Cross gladly took my high premiums and the very first time I filed a claim and was suspected of

having cancer I was cancelled. Blue Cross searched high and low looking for a reason to cancel me when I needed insurance the most.

There is a nurse in my church who works fulltime for Blue Cross. Her sole job is to go through medical records searching for reasons to cancel people's policies. After she heard what happened to me she came to me and told me how very sorry she was.

Blue Cross will do anything to get out of paying for cancer. Another sad fact is anyone who has a catastrophic illness who is not part of a group stands a greater chance of being cancelled, left out in the cold without insurance.

Since last June I go to a cancer support group. Four of the women in my group had individual policies and had their insurance cancelled due to cancer. Two of the four women had to declare bankruptcy.

I live in fear everyday of my insurance being cancelled again. Blue Cross has control over life and over death.

I go to chemotherapy every 3 weeks for 1 year. Last week I had my second 2 ½ hour breast reconstruction surgery. Once you have cancer you always have it. It is a never ending battle. I pray no one has to go through the sheer agony I have endured for one year. I did not deserve to have my insurance cancelled.

I owe my life to Joe Barton and his staff. I gave up and they never gave up on helping me. Only because of them was I able to get help.

I pray that you will listen to my story and help people like me who are powerless against big insurance companies.

Thank you.
Robin Beaton
July 23, 2009

Mr. STUPAK. Thank you, Ms. Beaton.

We are going to go to questions for this panel. Let me begin.

Ms. Beaton, when your insurance policy was rescinded, you needed a mastectomy to save your life, is that correct?

Ms. BEATON. I needed first a lumpectomy in the very beginning. I forgot to say that. When I went to Washington, truly honestly I was only going to have to have a lumpectomy, which is where they go in and remove the small tumor. But due to the waiting, I had to go from a lumpectomy to a double radical mastectomy and the lymph nodes. So that is how much my cancer spread.

Mr. STUPAK. So in that delay, you were going for a lumpectomy, you ended up having a double mastectomy.

Ms. BEATON. Yes. Everything.

Mr. STUPAK. What would have happened if Congressman Barton was not able to get your insurance reinstated? What would you have done? Would you have had the surgery?

Ms. BEATON. I went to the county hospital, and they placed me on their waiting list to get a mastectomy, to get a lumpectomy at first and then it turned into a mastectomy. But anyway, at the county hospital you have to wait. And to be honest with you, they lost my records three times, and they never called me back. In other words, I kept calling, and I kept calling.

Mr. STUPAK. So you don't know how long you would have had to wait for the county hospital—

Ms. BEATON. I had to wait—I probably would have waited a long time, a lot longer, to get my—I probably wouldn't have lived.

Mr. STUPAK. You also stated in your opening statement four of the women in your cancer support group had their insurance canceled because of cancer. Two of the four had to declare bankruptcy.

Ms. BEATON. Yes.

Mr. STUPAK. Without using any names here, can you tell us any details about their specific interactions with their insurance companies?

Ms. BEATON. Yes. Both of them had individual policies, and both of them had paid their premiums. One girl had her insurance for almost six years, and the other girl had her insurance for three years. And just the moment that she put in the first claim for cancer, they started doing an investigation. It was almost like repeating my story over.

And they did an investigation into her history, and they found a little tiny thing she forgot to write down on her application. And they rescinded her insurance, canceled her, you know. She had to go apply for the Safe Health—both of them were on Safe Health.

So that is the sad thing—when private insurance gets rid of people, eventually they will get help, but the taxpayer is going to have to pay for it. And that is exactly what happened. Both of them were on disability and on I guess you would call it Medicaid or Medicare. And I have to listen to—every week I hear them talking about the terrible time they are having, and they have both lost their house, they have lost their home.

Mr. STUPAK. To be on Medicaid, if you are under 65, as all of us know up here because we deal with it all the time, you either have to spend down and have very little assets or you have to be at least disabled for two years before you can even qualify for Medicare. If

you had to wait two years and become disabled in order to qualify for Medicare to pay for your surgery, you probably wouldn't be here today.

Ms. BEATON. No. One of the girls has brain cancer, and the other has breast cancer, which spread to her lungs. So, you know, if I went around the room and told you all the people in my cancer group and the stories, those are just the four most significant ones. But every one of them has had trouble with their insurance companies, getting them to pay for stuff, not wanting to pay for scans, and just the cost of cancer is just overwhelming.

Mr. STUPAK. Well, you were a nurse, Ms. Raddatz is an attorney, Ms. Reilling is a professional person, who is obviously quite successful. We have a rather sophisticated panel here, and it seems like each of you had to intervene in a certain way to—probably more acuity or more knowledge on how the system works in order to get your insurance or get some form of coverage.

Ms. Raddatz, if you may, that binder right in front of you, the brown one, Tab Number 5, I want to ask you a question about your brother. Tab 5 is a letter your brother sent to the Illinois Attorney General after his health insurance was rescinded, and this was right before he was supposed to have the bone marrow transplant, correct?

Ms. RADDATZ. That is correct. It was a stem cell transplant, yes.

Mr. STUPAK. In there he writes, "I have been through chemotherapy, and I am being prepared for a stem cell transplant within three or four weeks. This is an urgent matter. Please help me so I can have my transplant as scheduled. Any delay could threaten my life."

So in your brother's case he needed this transplant to save his life, is that correct?

Ms. RADDATZ. That is correct.

Mr. STUPAK. And if the rescission stood, in other words if his policy was not reinstated, would he have been able to get that transplant?

Ms. RADDATZ. No.

Mr. STUPAK. So the insurance company's decision was literally a matter of life and death for him?

Ms. RADDATZ. It absolutely was, because there was a very small window of opportunity for him to have it. And he couldn't just go shopping for another method of having it. At the last hearing, someone brought that up. "Well, how come you didn't try to get some alternative means of treatment?" Well, this is a stem cell transplant. There are only certain doctors that do this, and, first of all, you prepare for this for months with a very specific protocol. It is a very sophisticated procedure. It is a life-saving procedure; thank goodness that it exists and that it is saving people's lives.

But you have to do it within that window of opportunity. If you don't do it, he would have died.

Mr. STUPAK. So, then, you intervened with the Attorney General, and the Attorney General wrote a couple of letters. And finally, after the second or third letter, they reinstated his policy, because he was denied for something he had no knowledge of, correct?

Ms. RADDATZ. That is absolutely correct.

Mr. STUPAK. OK. And your brother, unfortunately, died. But did the stem cell transplant extend his life?

Ms. RADDATZ. It certainly did. If he didn't receive the stem cell transplant, after, like I said, he was told he wasn't—I mean, imagine you are told that you are dying, that you only have a few months to live, but there is a doctor who can give you a stem cell transplant and help you, and he is preparing you for it.

And so you are somewhat hopeful that your life will be extended, and now all of a sudden, no insurance, no stem cell transplant. Yes, he had the stem cell transplant eventually, and it extended his life approximately three and a half years, which, you know, he did pass away just 12 hours short of his 64th birthday on January 6 of this year.

But those three and a half years, to myself and our family, were precious. We spent the last 30 days with him in the hospital every day, and those last 30 days, for anyone who has ever been in that situation, every month—every year, every month, every day, every hour is precious, for your loved one and for your family. And it was successful. And as a matter of fact, he was preparing to have a second stem cell transplant when he did pass away.

Mr. STUPAK. Thank you.

Ms. Reilling, you were with Anthem insurance for 20 years?

Ms. REILLING. Yes.

Mr. STUPAK. And Anthem is really—is our ballpoint insurance company?

Ms. REILLING. Yes. I think they were fairly recent with—

Mr. STUPAK. And of those approximately 20 years, 15 you were in this single-person group policy?

Ms. REILLING. Yes.

Mr. STUPAK. Did they ever tell you this single-person group policy was coming to an end, they were changing their policies on single-person group policies?

Ms. REILLING. No. As I said, supposedly, these letters that were supposedly sent to me in April and May, but when I did see those, which were sent to me in June after the fact from my agent, they never said anything about them either.

Mr. STUPAK. Well, were those letters addressed to your agent or to you?

Ms. REILLING. To the agent. They referred to me, but they were never sent to me. And they did not say anything about that either.

Mr. STUPAK. So you weren't rescinded. They failed to renew your policy.

Ms. REILLING. Oh, no, they canceled me.

Mr. STUPAK. Right.

Ms. REILLING. They said, "You will be canceled as of June 30."

Mr. STUPAK. And then, they offered you a single, individual policy, correct?

Ms. REILLING. Well, yes, because we applied for another policy that was—my agent applied for something that would have been a reasonable policy, knowing that they were—she knew that they would not allow me to have that, because I was going to try to get a State policy, which is like a high-risk pool.

Mr. STUPAK. Sure.

Ms. REILLING. So they—but they didn't allow—they did deny me that.

Mr. STUPAK. So that you—

Ms. REILLING. But they didn't tell me why.

Mr. STUPAK. Did you submit an application for an individual policy?

Ms. REILLING. Yes.

Mr. STUPAK. And you were denied?

Ms. REILLING. They said, "We would love to give you insurance. We are pleased to give you insurance. However, we will not give you the insurance that you applied for, the policy that you applied for. However, we would be glad to give you this other policy," which is close to \$1,300—well, one that was close to \$1,200 a month and one that was close to \$1,300 a month, which is—with a \$2,500 deductible, which is totally out of my reach.

And the reasons that they gave for denying me the policy that I applied for make no sense whatsoever, and they actually didn't tell me.

Mr. STUPAK. Do you believe they failed to renew your policy because they are closing this single-person group policy status they had, or do you believe it is because you were sick?

Ms. REILLING. That makes no sense. I had it for almost 15 years. The only thing that—to me, I almost never made any claims. I mean, the only thing was is I had this ongoing treatment for my back that, as I said, I only went to the doctor every three to four months, and that was because I had to do that to get my medications renewed. And other than that, I haven't been sick for as long as I can remember.

Mr. STUPAK. So you didn't cost them any money until the last year.

Ms. REILLING. No. And I totaled it up, and I know that I have spent well over \$200,000 on my premiums. And even with my surgeries, they are still way ahead.

And I did want to mention something that had to do with what Ms. Beaton said. When she was talking about the fact that if—the insurance companies would approve some of these things that are asked for, it would save them money. There was a test that my oncologist had me go for, and it actually allowed them—the results of that test allowed me to not have chemotherapy, which was a wonderful, wonderful thing for me. It is a new test. It is a relatively new test. It is expensive. It is \$2,000-something.

However, it saved the company, because had I not had that test, I was definitely going to have to have chemotherapy and possibly radiation. They would not—no, it was close to \$3,000. The insurance company denied payment for it, and we are still fighting it, and this goes back to 2008. They are still denying it. They paid something like \$750, and they will not pay any more, and we have had, you know, time after time we are trying to—

Mr. STUPAK. Sure.

Ms. REILLING [continuing]. Go through that. So when you talked about the cost effectiveness, somebody is not paying attention, because, yes, that is an expensive test, but it is preventing much more expensive treatment. So it doesn't make any sense.

And the other thing is is the infection that I have now, that is—I can't see my son, because he is diabetic, and he has an insulin pump, which has a needle going into his stomach. So this staph infection is threatening to him, so I can't be around my son. I have a grandson, who is so afraid of the swine flu, that now when he hears about this I can't see him.

And I can't go on with my life, because I can't treat this infection. So it is just—it is crazy that you can't go on with your life if you do not have your insurance. And I am being—you know, I never—I didn't do anything wrong.

Mr. STUPAK. Sure. So it is not just a financial, but as we have seen from each of you, the emotional toll it takes on families is tremendous. And each of you brought forth a form of cancer that your brother had or you had personally.

And in documents obtained by the committee—I said we have looked at over 116,000 documents, and it shows that cancer is one of the conditions that automatically triggers an investigation by these insurance companies, whether it is Assurant or WellPoint or any of these. In fact, here is a list of Assurant's. There is about 1,400 different codes they use. So once you apply for it, it then triggers it in their computers. Then, they go through and scour and try to find some reason to deny you, because of an expense. And you have 1,400 by one company, 2,000 codes by another, so that—

Ms. REILLING. The wording of—

Mr. STUPAK [continuing]. Pretty much means you have—

Ms. REILLING. The wording of why they denied me this new policy that I tried to apply for, they said “ongoing treatment for” and then—

Mr. STUPAK. They list it.

Ms. REILLING [continuing]. They used—well, no, they wouldn't say what it was. They mentioned my back, but of course they have been treating me for that for over 20 years. Then, they said—I don't remember the word, it is in papers that I gave you all, but conditions, something like “unnamed conditions.”

Well, the only other condition is the MRSA staph, which I got when I was in the hospital—

Mr. STUPAK. Right.

Ms. REILLING [continuing]. And cancer. It seems that it is not right for them to deny me that. And the MRSA, the thing that is frightening to me, is this has already been eating away at my insides. I mean, they have done emergency surgeries for that. You know, so the longer I go not being able to have a surgery that is supposed to help get rid of that, the longer I am at risk of it going ahead and just munching its way through to my insides. And it is very frightening, not to mention the fact that I can't do anything, and I can't work and I can't make a living.

So, you know, with just the strike of a pen, they can totally ruin people's lives.

Mr. STUPAK. Thank you.

Mr. Hill, questions, please.

Mr. HILL. Thank you, Mr. Chairman. And, again, I want to thank the chairman for coming to Indiana to hold these hearings to try to get to the bottom of the problems that we are having in health care.

I am going to have to leave around noon, which is a little earlier than when the committee is going to have to adjourn, because I am traveling back to Washington today, as a member of the Energy and Commerce Committee, to carry on discussions about what we should be doing with this bill that is before us.

One of the things that is a given is the fact that when we pass health care—and I believe that we will, although it is going to be a struggle to do it. The legislative process grinds slowly. But one of the things that we will be addressing is preexisting conditions. So when we pass health care, we will no longer have to have meetings like we are having, committee meetings right now, because your situation will not be relevant anymore, because preexisting conditions will no longer be an issue.

And that is one of the most important reasons why we need to pass health care legislation this year. Everybody has a story to tell. I have my own story. My youngest daughter, Libby, has a blood disorder. She is 22 years of age, and she is heading off to Michigan Medical School. And she very soon is going to be on her own. She is on our policy now.

What will happen to her now that she has this preexisting condition when she has to buy her own insurance policy? We are all very nervous about it. And so unless we get a company or somebody that accepts preexisting conditions, she is going to be out of luck. And so we all—the three of us here, and the members of Congress, realize the importance of passing legislation that is going to correct this inequity.

Now, having said that, I do have a few questions. Ms. Beaton, you say that you obtained an individual policy with Blue Cross and Blue Shield in December of 2007. And then, in May 2008, which is approximately five months later, you were diagnosed with acne, which was precancerous.

Ms. BEATON. But it wasn't precancerous. It was just a misinterpretation of a word. But what it did to them is it red-flagged my chart. In other words, it brought suspicion on me, because the word. The doctor—he was the nicest man. He called Blue Cross and Blue Shield directly, and he begged them, he said, "Please," he said, "this is a misunderstanding." He said, "This lady came to see me for pimples or acne." He said, "She doesn't have anything related to cancer."

Mr. HILL. And who said that?

Ms. BEATON. Dr. Kent Afergutten.

Mr. HILL. This is your dermatologist?

Ms. BEATON. Yes, sir.

Mr. HILL. OK. And then, the insurance company told you on the Friday before you were to have cancer surgery that "They were launching a five-year medical investigation into my medical history, and this would take approximately three months."

Ms. BEATON. Yes.

Mr. HILL. Did that delay your surgery?

Ms. BEATON. Absolutely. It delayed it from June until October 2, because what I had to do is I had to provide them every doctor, every hospital, every pharmacy, anything I had that was related to my medical history for the last five years. And can you imagine having to go back in your medical history for five years? You know,

you don't remember things. Because they said if I forgot one thing, if there was one thing that I forgot, that I didn't disclose, that I would automatically be canceled.

So I searched, and, I mean, I went through all of my records. It took me like weeks to do that. And I gave them every pharmacy I had ever been to, because I don't use always the same pharmacy, I go to different pharmacies. I had to give them every pharmacy, every doctor, every hospital, every emergency room I had ever been to. And then, what they do is they write—they have to get permission from you to get it. They get your medical records, and they go through with a fine-tooth comb those medical records.

So, yes, it took from June when I was supposed to have my surgery, June, July, August, September, October 2 I had my surgery. And just like I said, the most significant thing is, if you can look on a picture how big two centimeters is, how small it is, to know that I was going to have to have a lumpectomy, and then to have to have both of your breasts removed and all of the lymph nodes, I will never be able to do anything with this arm again, like have blood drawn, have IVs, or anything out of this arm for the rest of my life. So, yes, it affected me with all of my heart.

My tumor grew, it spread, and, you know, you never know, but if they could have done my surgery really quickly, perhaps none of that would have happened.

Mr. HILL. OK. Who made the decision to delay your surgery?

Ms. BEATON. Blue Cross and Blue Shield.

Mr. HILL. Did the hospital not want to, or the doctors not want to, perform the surgery because it was in doubt whether or not you had coverage or not?

Ms. BEATON. Yes. They said that I would have to pay a \$30,000 deposit, and I didn't have that kind of money, and neither did my mother and father. So they wanted a big deposit, and I didn't have it.

Mr. HILL. So the matter got worse, and then you had to call upon Joe Barton to help you get it fixed and he did.

Ms. BEATON. He did. If you only knew how hard he worked every day. He went all the way to the president of Blue Cross and Blue Shield. He called them every day on the speakerphone and talked to them, and every time they called he would call me and say, "No luck. We haven't had any luck, but we are still trying. We are not giving up." They gave me a report every day, so I wouldn't give up.

To be honest with you, I did give up. I gave up. I went to the county hospital. I applied to Susan G. Komen Breast Foundation. I applied at Promise House. I applied anywhere I could to get help, and their funds are limited everywhere you go, because there are so many people who have breast cancer these days. So I was very limited in the help that I could receive.

Mr. HILL. OK.

Ms. BEATON. I was on different waiting lists.

Mr. HILL. Ms. Raddatz, your brother's cancer treatment, was it delayed at all?

Ms. RADDATZ. It was not delayed, no.

Mr. HILL. OK. But you had to go through several hoops in order to get—make sure that he was going to have coverage.

Ms. RADDATZ. Oh, yes. I mean, when we got the news that it was canceled, we were just horrified. I can't even tell you how upsetting that was, because it was all scheduled. I mean, it was ready to be scheduled—excuse me—but he had done all of the protocols, he was ready to go. And so I literally was not working at my law practice for weeks. I was at my office, but daily I was working on solving my brother's health insurance rescission problem. And I was—I am attorney, and I still didn't know how to solve it straight up.

Mr. HILL. Right.

Ms. RADDATZ. It took me several weeks, and many, many phone calls to other attorneys, judges, experts, and finally we made it to our Attorney General's office. And I understand in Illinois we are very lucky to have the Health Services Section in our Attorney General's office, Lisa Madigan's office. There are many states that do not have those services available for citizens to go to.

And even if it is available, most people, when they get that type of news, they don't know what to do. They are sick. Their spirits are low. A lot of them are not working. They don't know what to do, and they don't know where to turn. And many of these people just give up.

Mr. HILL. OK. Ms. Reilling, in reading through your testimony and listening to your testimony, I am making the assumption that Anthem did pay for some of your treatment.

Ms. REILLING. Yes.

Mr. HILL. And that somewhere midway through all of your treatments they decided to cancel you.

Ms. REILLING. Yes.

Mr. HILL. And the reason that they gave for canceling you is that the policy was not going to be offered anymore.

Ms. REILLING. Well, to my knowledge, I was not given any reason, because I never received the letters that they supposedly sent. So I just suddenly got a letter on around June 1 that said, "Your policy will be ending—we will be canceling your policy as of June 30."

Mr. HILL. OK.

Ms. REILLING. I had no explanation.

Mr. HILL. Do you have insurance now?

Ms. REILLING. No.

Mr. HILL. None at all.

Ms. REILLING. No.

Mr. HILL. Do all three of you feel like that the insurance companies were manipulating the reasons as to deny coverage to you all?

Ms. BEATON. Absolutely.

Mr. HILL. Now, that is an opinion of course.

Ms. BEATON. Absolutely.

Mr. HILL. But you all three feel that way. And, Ms. Beaton, do you have any insurance coverage now?

Ms. BEATON. I only have insurance because of one reason.

Mr. HILL. Joe Barton.

Ms. BEATON. That is the only reason.

Mr. HILL. OK. Thank you.

Ms. BEATON. They didn't want to give me back my insurance. He told me that—I had never met Mr. Barton. I met him for the very first time in Washington. He helped me not even knowing who I

was, just because I was a constituent in his area. And the first time I met him I just broke down and said, "I could never thank you enough for helping me." But he went all the way to the top and he told me, he said, "They did not want to reinstate you." He said, "I really had to fight them." He told me that.

Ms. RADDATZ. May I respond?

Mr. HILL. Sure, Ms. Raddatz.

Ms. RADDATZ. Yes. Not only—we also know after our last hearing in Washington that now, knowing all of this information, they still agree that they will continue their practices of rescinding. So it didn't really matter that we already—Ms. Beaton and myself told these stories, and many other stories were told to them in person in Washington, D.C. last month, they still admitted that they would just continue those practices.

So, you know, until Congress stops them from doing it, they are just going to keep going on, because they know it is legal right now for them to do that. It is legal for them to rescind people who are dying and take away their insurance policies after good American citizens have paid their hard-working dollars. In my brother's case, he was paying \$900 a month for his policy. And it is OK for them to do that.

And not only have they done it, but they came right out in Congress and in front of the whole world on C-SPAN and said, "We are just going to keep doing it." So they are basically saying, "Look, Congress, either stop us from doing it or we are just going to keep doing it, because that is what we do. We make our—that is how we make our living. We make our livings by rescinding people and making more money."

Mr. STUPAK. That is a good point.

And as Congressman Hill indicated, he is going to have to leave a little early here, because he has got to go back. We are trying to do health insurance—or I should say health coverage for all Americans through our Energy and Commerce Committee.

Congressman Yarmuth, who is going to be going back, is going to ask questions next. They already passed it through Ways and Means Committee, but the Energy and Commerce Committee is the main policy, health policy for the Congress, and we have been working on this.

We were actually supposed to do one of these hearings last week, as you know, Ms. Raddatz, in Chicago. We had to cancel because of health care meetings. We thought about canceling this one, but I couldn't do that twice to you, so we kept this hearing going. I will stay and keep this hearing going. I know Mr. Hill is going to go back and protect our interest, and we have a lot of questions.

If my memory serves me correct, it is Section 162 which would prevent rescissions without an independent third-party review. But I think after this hearing, and after our next panel, I think we have to go even further and put a time limit as to when that review would take place, so many days, and a few other things. So these hearings not only helps us, but, unfortunately, it is a very busy time for all of us with health care.

And, Congressman Hill, by the end of the year I think you will see at least enactment of a national health insurance plan to cover all Americans, where preexisting injuries would not be a condition

to eliminate people's coverage, and will do something with this rescission.

But with that, let me turn it to Congressman Yarmuth for questions, please.

Mr. YARMUTH. Thanks, Mr. Chairman. I am just going to ask a couple of brief questions.

Ms. Beaton, you talked about your cancer support group and the four women who are with you in that, and two of them have gone bankrupt and they had had their coverage canceled. Were the situations similar? Were these all cases of rescission as far as you know?

Ms. BEATON. Yes, every one of them was.

Mr. YARMUTH. Were they able to—are they currently insured at all? They are not insured?

Ms. BEATON. Not at all. They all are on state assistance, every one of them. Every one of—the one girl lost her house, and now she is living in government-subsidized housing. She had a nice house, and she lost her house. She lost everything and has to live in government housing now.

Mr. YARMUTH. Did they receive their treatment in any way, or were they—did they rely on charitable care or something?

Ms. BEATON. They relied on charitable care, which is like mine. They didn't get immediate care; they had to wait. And when you go through a county hospital around Dallas, there are so many people there, you wouldn't even believe. Every time you go to a clinic appointment it is the whole day. You go—no matter if you have an 8:00 appointment, you wait all day long with a room just like this big just full of people. You can't even imagine how long you have to wait.

And then, when you get in a room, you finally think you are going to get to see the doctor, well, guess what, you wait another couple of hours. So it is an all-day thing. There is no way you can work. There is no way you can keep a regular job or do regular things, because your whole time is going to waiting to see a doctor. It is a very bad situation.

Mr. YARMUTH. Congressman Barton was able to keep your coverage in force. Has there been a change in your premium rates since then?

Ms. BEATON. Yes, they went up quite a bit. They went up. They said it wasn't anything related to that. They said that they were going up on everybody's policy, but they sent me a letter, and, yes, they went up. Right away they went up.

Mr. YARMUTH. How much did they go up, do you remember?

Ms. BEATON. It was like \$200 a month. And it was already a real high premium, because of my age. I am 59.

Mr. YARMUTH. Right.

Ms. BEATON. So to me it was a lot of money. It was all I could do. And to be honest with you, I never would have—when Mr. Barton called and told me my insurance was reinstated, you know what I told him? I said, "I don't want it. I don't want it back." I said, "I have lost my trust."

And by that time, I had applied to a state program, and I had gotten accepted for the state program where they pay 100 percent for women with breast and cervical cancer, and I told him, I said,

“I don’t want Blue Cross and Blue Shield back.” I said, “Why should I want them back? What they did to me, what they cost me.” But he told me, he said, “You will never be able to have insurance again. You will be uninsurable because of the cancer.” He said, “Take it back.” He said, “It is your last chance in your life to get regular insurance.”

So because of his great wisdom, I only took it back because of him, because I lost every bit of my trust. I hated them.

Mr. YARMUTH. Ms. Reilling, we have a copy of a letter that you received on July 1 of this year, just a few weeks ago, offering you the alternative individual coverage, and stipulating the reasons that you were denied coverage and denied your application, which I assume was to resume your one-person group insurance coverage, is that right?

Ms. REILLING. No. Actually, my agent, she just kind of ignored that whole thing and acted like—she is the one who told me that Anthem was discontinuing one-person groups. I never heard it—I have never heard it from the company, so she applied—

Mr. YARMUTH. For an individual policy.

Ms. REILLING [continuing]. For an individual policy, but one that was close to what I was paying, and that was what they denied.

Mr. YARMUTH. And they denied that.

Ms. REILLING. And they offered me one that was—

Mr. YARMUTH. One that was more expensive and mentioned—

Ms. REILLING. A whole lot more expensive.

Mr. YARMUTH [continuing]. The preexisting conditions and your treatment for protected health information, it says in the letter—

Ms. REILLING. Yes.

Mr. YARMUTH [continuing]. Under Tab 23. I understand why they didn’t want to put it in the letter, because that—it is your personal information, even though to you it might have not been a congressional—

Ms. REILLING. But the only—

Mr. YARMUTH [continuing]. So they want to protect you.

Ms. REILLING [continuing]. Thing it could be, though, is the cancer and the MRSA.

Mr. YARMUTH. Right.

Ms. REILLING. Because that is the only thing I have been treated for.

Mr. YARMUTH. Right. Do you know if this offer—the offer that they made, whether there would be any exclusions as to coverage?

Ms. REILLING. No, because, as I said, I didn’t even—

Mr. YARMUTH. Couldn’t afford it anyway.

Ms. REILLING. I didn’t know about any of this, and my agent just turned it down. And, actually, she was only applying for it as a means to getting me to apply for Kentucky Access, which required—it wasn’t enough for me to just have been dropped by the insurance company, I had to have applied and been denied, which is why I have gone so long without insurance.

However, when I found out what the rates are for Kentucky Access, I can’t afford those either. It is \$800 a month, and that is a public—I mean, a State program.

Mr. YARMUTH. Right. OK. Thank you very much.

Thanks to all of you for telling your stories. They were, again, very important in putting a face on the types of situations that we are trying to correct and on efforts to reform health care delivery and insurance in the country. Appreciate it.

I yield back. Thanks, Mr. Chairman.

Mr. STUPAK. Thanks, Mr. Yarmuth.

We had asked Assurant Health Insurance to come. They refused. I do not want to use the subpoena power, even though this committee has it. But, Ms. Raddatz, that was your brother's health insurance, but I want to ask a question anyway, if I could.

Your brother's individual health policy was Fortis, which is really Assurant Health. Is that right?

Ms. RADDATZ. Yes, that is correct.

Mr. STUPAK. OK. I would like to play a television ad that Assurant is running across the country right now and get your reaction to it. Would you show us that ad, please?

[Video presentation begins.]

"Female Speaker: My employer doesn't offer medical insurance. So we needed an affordable health plan that fit our family's needs.

Female Speaker: When I started my own business, I didn't think I could afford health insurance. I just wanted to be able to see my personal doctor once a year.

Male Speaker: When I retired, we were years away from Medicare.

Female Speaker: But we still needed protection. What if something serious happened?

Female Speaker: So a friend recommended Assurant Health. We were able to protect our entire family. They even have a dental plan.

Female Speaker: I saved hundreds of dollars by only paying for benefits I want. I even got a 50 percent discount just for being healthy.

Male Speaker: We have got \$6 million in medical coverage, and can even see the specialist we choose.

Female Speaker: Without a referral.

Male Speaker: For over 100 years, Assurant Health has been meeting the needs of individuals like you. Plans start under \$100 per month.

Male Speaker: Call now and speak with your local agent, Carl Heath, Jr., for your no obligation quote. Call 1-410-288-0772 now."

Mr. STUPAK. In this ad, it shows people who might need insurance, as they say in the ad, "like you," a family, small business owner, retiree, and they all look relatively healthy. But what the ad never mentions is that Assurant will not provide insurance to people with preexisting conditions, because these people get too expensive and it would reduce their profits.

So let me ask you, from your experience, does this company have an interest in keeping sick policyholders on its rolls? Ms. Raddatz?

Ms. RADDATZ. In keeping sick policyholders?

Mr. STUPAK. Yes.

Ms. RADDATZ. Absolutely not. All they want are healthy people, so that they can collect insurance premiums and not have to pay out any claims. They don't want sick people. When you become

sick, they cancel and rescind your policy. And so as they state in the commercial, how dare they? What if something serious happens? Something did serious happen to my brother, and they rescinded him.

Mr. STUPAK. Let me show you another clip on another Assurant TV ad.

[Video presentation begins.]

“Male Speaker: Unlike other health insurance companies that focus on corporations and treat everyone the same, Assurant Health is there for the individual. So if you need health insurance, call the number on your screen, visit our Web site, or contact your local agent.

Male Speaker: Call now to find out”——

Mr. STUPAK. They say they are not treating everyone the same, and they are there for the individual. Were they there for your brother Otto?

Ms. RADDATZ. Absolutely not.

Mr. STUPAK. Do you find these ads misleading about how Assurant covers individuals?

Ms. RADDATZ. I would say they are misleading, they are upsetting. I would say to people, “Run, do not buy insurance with a company that doesn’t stand behind the people that need them.”

Mr. STUPAK. And as I said, there is 1,400 reasons or excuses why they cancel you once you become sick.

Let me ask you, Mr. Baron, Hill, do you have any further questions?

Ms. BEATON. Can I say something real quick?

Mr. STUPAK. One minute.

Mr. Hill, questions?

Mr. HILL. The only question I might have is—maybe this is for the representatives from the insurance companies, but my guess is that once you are denied insurance coverage, it is almost impossible for another insurance company to pick you up. I don’t know if you have had that experience or not, Ms. Beaton. I know you——

Ms. BEATON. They never pick you up. Never. Never.

Mr. HILL. There is just like a zero chance for you being able to get coverage.

Ms. BEATON. Right. Have you ever been refused insurance? They ask that on the questionnaire. It is one of the questions they ask you. If you have ever been refused insurance or canceled, they just kick you right out.

Mr. HILL. OK.

Ms. BEATON. All I wanted to say is I admire you so much for getting those commercials. I wish you would have brought the Texas Blue Skies Blue Cross/Blue Shield commercial that has been airing every day, about 15 times a day. I want to just puke every time I hear it. They have you humming a little tune, you know, about America and blue skies and everything is wonderful, “We will always be here for you,” and every time I listen to that commercial on TV, how they are spending millions of dollars for those commercials, I just say—I want to say, “You are lying. You are liars.”

You know, they are spending all that money on Blue Skies commercials. Sometime you can get one of those Blue Skies’ commer-

cial for Blue Cross/Blue Shield and it will make you sick to your stomach.

Mr. STUPAK. Well, there is no doubt the—from 2000 to 2007, according to SEC filings, the profits for insurance companies has gone from \$2.4 billion to \$12.9 billion. That is a 428 percent increase during the last seven years. And we see it on the backs of people like you, and so hopefully we do get national health care, so we don't have to worry about that.

Let me, once again, thank this panel for your heartfelt testimony. Thank you for traveling here at your expense to be with us.

Ms. Beaton, have a safe trip back to Texas; Ms. Raddatz, back to Illinois; and, Ms. Reilling, back to Kentucky. Thank you very much for being here.

Ms. RADDATZ. Thank you all for caring enough to do this. Thank you so much.

Mr. STUPAK. Thank you. We will dismiss this panel.

Ms. REILLING. Thank you.

Ms. BEATON. Thank you.

Mr. STUPAK. I would now like to call our second panel of witnesses. On our second panel we have Mr. Richard Collins, who is the Chief Executive Officer at Golden Rule Insurance Company, which is owned by UnitedHealth Group; Mr. Brian Sassi, who is Chief Executive Officer for Consumer Business at WellPoint, Incorporated; Ms. Carol Cutter, who is the Commissioner of the Indiana Department of Insurance; Professor Eleanor Kinney, who is a Professor of Law at Indiana University in Indianapolis.

Thank each and every one of you for coming and for adding to today's hearing. As I told the last panel, it is the policy of this Committee to take all testimony under oath. Please be advised you have the right under the rules of the House to be advised by counsel during your testimony. If you wish to be represented by counsel?

[Witness responses.]

Mr. STUPAK. Let the record reflect each indicated they did not wish to be represented by counsel at this time. If at any time during your testimony you wish to consult with counsel, you can. Counsel cannot testify, but you can consult with them before answering a question.

Since you are all standing, please raise your right hand and take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative. You are now under oath. We will now hear your 5-minute opening statement. You may submit a longer statement, extra documents, for inclusion in the official hearing record.

Mr. Collins, if you don't mind, we will start with you, go from my left to right.

Mr. COLLINS. Yes, sir. Thank you, sir.

Mr. STUPAK. Thank you.

STATEMENTS OF RICHARD COLLINS, CHIEF EXECUTIVE OFFICER, GOLDEN RULE INSURANCE COMPANY, UNITEDHEALTH GROUP; BRIAN A. SASSI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CONSUMER BUSINESS, WELLPOINT, INC.; CAROL CUTTER, COMMISSIONER, INDIANA DEPARTMENT OF INSURANCE; AND ELEANOR KINNEY, CO-DIRECTOR, WILLIAM S. AND CHRISTINE S. HALL CENTER FOR LAW AND HEALTH, INDIANA UNIVERSITY SCHOOL OF LAW

STATEMENT OF RICHARD COLLINS

Mr. COLLINS. Chairman Stupak, Congressman Hill, Congressman Yarmuth, and members of the Subcommittee, thank you for inviting me today as we continue our dialogue on individual health insurance.

My name is Richard Collins. And I am the CEO of Golden Rule Insurance Company, a UnitedHealth Group business that provides health insurance policies to individuals and their families. Golden Rule is headquartered in Indianapolis and employs 750 individuals in the State of Indiana. It has been offering this important coverage option for more than 60 years.

As part of our continuing commitment to the outstanding workforce of the State of Indiana, we recently completed the initial phase of a new 24,000-square foot, state-of-the-art customer care center in Vincennes. The center currently employs 90 individuals with the capacity for 300 additional full or part-time jobs.

Our company mission is to improve the health and well-being of all Americans. In the individual insurance market, we accomplish this by offering innovative and affordable products that meet the diverse health care and financial needs of our customers.

We also have a responsibility to treat all of our customers fairly, and I can assure you we take this responsibility very seriously. In our current system of health care delivery, the individual insurance market operates primarily for families who do not have access to group coverage or to government health benefit plans, such as Medicare.

Unfortunately and for a variety of reasons, some individuals choose not to purchase private health insurance until they have a significant health event. This decision not only has an enormous physical and financial impact on these individuals and their families but raises the cost of health care for everyone.

We have long advocated that this country needs comprehensive health insurance reform that includes modernizing the delivery system, tackling the fundamental drivers of health care cost growth, strengthening employer-based coverage, and providing well-targeted support for low and middle-income families.

To be effective, we believe modernization of the individual insurance market needs to contain all of the following elements. First, individuals must be required to obtain and maintain health insurance coverage so that everyone participates in both the benefits and the costs of the system.

Second, insurers should be able to set rates within the limited parameters of age, geography, family size, and benefit design just as they do in the group insurance market. However, let me emphasize this point. Rates should not vary based on health status, and

coverage should be guaranteed, regardless of preexisting conditions for those that maintain continuous coverage.

Third, low and middle-income families should receive some form of subsidy to ensure that they have access to the same care as all Americans.

Fourth, insurers should be able to offer a wide spectrum of plan designs to allow American families the flexibility to choose a plan that fits their budget. And, lastly, the tax treatment for individual insurance premiums should be on par with employer-sponsored coverage.

Until comprehensive reform is achieved, we believe that the medical underwriting of individual insurance policies will continue to be necessary. If these changes are instituted, most of the reasons for individual medical underwriting of individual health insurance as well as most of the reasons that individual policies are rescinded or terminated would cease to exist.

As you know, the practice of rescission has been recognized by the laws of virtually every state. Rescission is an unfortunate but necessary recourse in the event of a material and at times intentional or fraudulent misstatement or omission on an insurance application.

Our use of rescission is rare. Less than one-half of 1 percent of all of individual insurance contracts in 2008 were terminated or rescinded. And in each case the affected customer was afforded the right to appeal. Our practice is to rescind coverage only in the event an applicant made a knowing material misrepresentation or omission on the application for insurance.

In the event that we determine it is necessary to rescind coverage after a thorough investigation of the facts and in compliance with existing state laws and regulations, we follow practices and procedures designed to ensure a fair and transparent process for the individual.

Under our current system, failure to act on these cases would be fundamentally unfair to individuals and working families that play by the rules, and it would further limit our ability to provide quality and affordable health care for every American. And affordability is by far the biggest barrier to access.

We look forward to working with the Subcommittee and the Congress and state and federal regulators on ways to continue to expand access to affordable health insurance coverage in the individual market. Thank you.

[The prepared statement of Richard Collins follows:]

**TESTIMONY OF RICHARD A. COLLINS
BEFORE THE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
NEW ALBANY, INDIANA
JULY 27, 2009**

Chairman Stupak, Ranking Member Walden, Congressman Hill and members of the subcommittee, thank you for inviting me to testify today as we continue our dialogue on the individual insurance market. My name is Richard Collins, and I am the CEO of Golden Rule Insurance Company, a UnitedHealth Group business that provides health insurance policies to individuals and their families.

Golden Rule, which is headquartered in Indianapolis and employs 750 individuals in the state of Indiana, has been offering this important coverage option for more than 60 years. Reflective of our continuing commitment to the state, we recently completed the initial phase of a new 24,000-square foot, state-of-the-art customer care center in Vincennes. The center currently employs 90 individuals with the capacity for 400 full- and part-time employees.

Our company mission is to improve the health and well being of all Americans. In the individual insurance market we accomplish this mission by offering innovative and affordable products that meet the diverse health care and financial needs of our customers. We also have a responsibility to treat all of our members fairly and I can assure you we take this responsibility very seriously.

In our current system of health care delivery, the individual insurance market operates primarily for families who do not have access to group coverage or to government health benefit plans. Unfortunately, for a variety of reasons some individuals choose not to purchase private health insurance until they have a significant health event. This decision

not only has an enormous physical and financial impact on these individuals and their families, but raises the cost of health care for everyone.

We have long advocated that our country needs comprehensive health reform that includes modernizing our delivery system, tackling the fundamental drivers of health care cost growth, strengthening employer-based coverage, and providing well-targeted support for low-income families. Further, these fundamental elements of reform should be pursued alongside the constructive changes to the individual insurance market that we, along with our industry partners, have proposed.

To be effective, we believe modernization of the individual insurance market needs to contain all of the following elements.

- First, individuals must be required to obtain and maintain health coverage so that everyone participates in both the benefits and the costs of the system.
- Second, insurers should be able to set rates within the limited parameters of age, geography, family size, and benefit design – just as they do in the group insurance market. Similarly, individuals should be permitted to take advantage of lower rates if they make healthy lifestyle choices. However, rates should not vary based on health status, and coverage should be guaranteed, regardless of pre-existing medical conditions for those that maintain continuous coverage.
- Third, low- and middle-income families should receive some form of subsidy to ensure that they have access to the same care as all other Americans.
- Fourth, insurers should be able to offer a wide spectrum of plan designs to allow American families the flexibility to choose a plan that fits their budget.
- And lastly, the tax treatment of individual insurance premiums should be on par with that for employer-sponsored coverage.

Until comprehensive reform is achieved, we believe that the medical underwriting of individual insurance policies will continue to be necessary. If these changes are instituted, most of the reasons for individual medical underwriting of health insurance –

as well as most of the reasons that individual policies are rescinded or terminated – would cease to exist.

As you know, the practice of rescission has long been recognized by the laws of virtually every state. Rescission is an unfortunate but necessary recourse in the event of a material – and at times intentional or fraudulent – misstatement or omission in an insurance application. Under our current system, failure to act on these cases would be fundamentally unfair to individuals and working families that play by the rules and it would further limit our ability to provide quality and affordable health care for every American.

In the event that we determine it is necessary to rescind coverage after a thorough investigation of the facts and in compliance with existing state laws and regulations, we follow practices and procedures designed to ensure a fair and transparent process for the individual. Our practice is to rescind coverage only in the event an applicant made a knowing material misrepresentation or omission on the application for insurance.

Our use of rescission is rare. Less than one half of one percent of all of our individual insurance contracts in 2008 were terminated or rescinded. And in each case the affected customer was afforded the right to appeal.

We look forward to working with this subcommittee, the Congress and state and federal regulators on ways to continue to expand access to affordable health insurance coverage in the individual market. Thank you.

Mr. STUPAK. Thank you.

Mr. Sassi, your opening statement, please, sir?

STATEMENT OF BRIAN SASSI

Mr. SASSI. Thank you Chairman Stupak and members of the Committee for inviting me to testify before you today. I am Brian Sassi. And I am President and CEO of the Consumer Division of WellPoint.

There seems to be a lot of confusion about why an insurance company might rescind a policy. Some have said that insurers rescind policies because they don't feel like paying when someone gets sick. This is simply not true. The decision is about controlling corporate fraud and material misrepresentations that contribute to spiraling health care costs.

At WellPoint, we do not rescind a policy coverage just because someone on the policy gets sick. My company employs over 42,000 people nationwide: 4,500 here in Indiana and 1,300 across the river in Kentucky. For anyone to suggest that I or my fellow associates, each of us with our own personal experiences with illness, would rescind a person's coverage just because he or she got sick is an unfair accusation. I hope, Mr. Chairman, that as you complete your inquiry, you will be able to help correct this misperception.

We take contract rescissions very seriously because we understand the impact these decisions can have on families and individuals. We have put in place a thorough process with multiple steps to ensure that we are as fair and as accurate as we can be in making these difficult decisions. And to be clear, we do not rescind policies based on a condition for which the policyholder was unaware at the time that he or she had applied for coverage.

I want to emphasize that rescission is about controlling fraud and material misrepresentations that contribute to spiraling health care costs. By some estimates, health care fraud in the U.S. exceeds \$100 billion per year, an amount large enough to pay for covering nearly half of the 47 million uninsured in this country.

Rescission is one tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the costs for those who do not. The bottom line is that rescission is about combating costs driven by these issues.

If we fail to address fraud and material misrepresentation, the cost of coverage would increase, making coverage less affordable for existing and future individual policyholders. I would like to put this issue in context.

While most people in this country who are under the age of 65 receive coverage through their employers, 15 million Americans purchase coverage in the voluntary individual market. In a market where individuals can choose to purchase insurance at any time, health insurers must medically underwrite applicants for current health risk.

If an individual buys health coverage only when he or she needs health care services, the system cannot be sustained. While we understand and appreciate that this is a critical personal issue, individual market rescission impacts an extremely small share of the individual market membership.

In our experience, we believe that more than 99 percent of all applicants for individual coverage provide accurate and complete information. In fact, as a percentage of new individual market enrollment during 2008, we rescinded only one-tenth of 1 percent of the policies that year.

Here in Indiana, the issue of rescission in health insurance also affects an extremely small number of individuals. In 2008, we enrolled over 66,000 new individual market members but rescinded only 116 individuals.

Rescission is a longstanding insurance contract remedy in America. The concerns regarding rescission surfaced in the California media in 2006, generating the public concern which we are discussing here today. Our main point today is the same as it was then. A voluntary insurance market for health insurance requires that we protect our members from costs associated with fraud and material misrepresentations. Otherwise the market cannot be sustained.

In response to the public concern over the practice of rescissions, WellPoint in 2006 undertook a thorough review of our policies and procedures. Following that review, WellPoint was the first insurer to announce the establishment of a variety of robust consumer protections that ensure rescissions are handled as accurately and as appropriately as possible.

These protections include: creating an application review committee, which includes a physician that makes rescission decisions; two, establishing a single point of contact for members undergoing a rescission investigation; and, three, establishing an appeal process for applicants who disagree with our original determination which includes a review by an application review committee not involved in the initial decision. And in 2008, WellPoint was the first in the industry to offer a binding, external, independent third party review process for rescissions. We have put all of these protections in place with multiple steps because we cover millions of Americans and want to be as fair and as accurate as we can be.

In response to policy-maker interest in enacting consumer protections related to rescission, WellPoint is proposing a set of rescission regulations with new consumer protections. I have outlined these in my written testimony.

In addition, the health insurance industry has proposed a set of comprehensive and interrelated reforms to the individual health insurance market as a whole. The centerpiece of this proposal is the elimination of medical underwriting combined with an effective and enforceable personal coverage requirement. This would render the practice of rescission unnecessary.

We appreciate that the health care reform bills under consideration in the House envision such a system. However, unless Congress creates a strong and effective personal coverage requirement and allows younger individuals to receive sufficient discounts, many only buy coverage when they need services, which will dramatically drive up the costs for everyone.

As currently written, the health care legislation under consideration in the House does not accomplish this. We would welcome the opportunity to work with you to find common ground on this issue to make certain that these insurance market reforms achieve the

object so that we can make quality, affordable health coverage available for all Americans.

Thank you for the opportunity to discuss this issue and these proposals with you. I look forward to your questions.

[The prepared statement of Brian Sassi follows:]

47

Testimony of Brian A. Sassi
President and C.E.O., Consumer Business
WellPoint, Inc.

United States House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
New Albany, IN Field Hearing

July 27, 2009
(Written Submission)

Thank you Chairman Stupak, and Congressman Hill for inviting me to testify before you today.

There seems to be a lot of confusion about why an insurance company might rescind a policy. I recently heard a legislator say insurers rescind policies "because they don't feel like paying for your illness." Mr. Chairman, that is simply not true.

At WellPoint, we do not rescind a policyholder's coverage just because someone on the policy gets sick. Mr. Chairman, my company employs over 42,000 people nationwide – 4,500 here in Indiana, and 1,300 across the river in Kentucky. For anyone to suggest that I or my fellow associates – each of us with our own personal experiences with illness – would rescind a person's coverage just because he or she got sick is an unfounded and unfair accusation. And I hope, Mr. Chairman, that as you complete your inquiry, you'll be able to help correct this misperception.

We take contract rescissions very seriously because we understand the impact these decisions can have on individuals and families. We have put in place a thorough process with multiple steps to ensure that we are as fair and as accurate as we can be in making these difficult decisions. And to be clear, we do not rescind policies based on a condition of which the policyholder was unaware at the time he or she applied for coverage.

I want to emphasize that rescission is about stopping fraud and material misrepresentations that contribute to spiraling health care costs. By some estimates, health care fraud in the U.S. exceeds \$100 billion per year,¹ an amount large enough to pay for covering nearly half of the 47 million uninsured. Rescission is one tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the costs for those who do not. The bottom line is that rescission is about combating cost driven by these issues. If we fail to address fraud and material misrepresentation, the cost of coverage would increase, making coverage less affordable for existing and future individual policyholders.

I would like to put this issue in context. While most people who are under the age of 65 receive coverage through their employers, some 15 million Americans purchase coverage in the

¹ Sparrow, Malcolm. *License to Steal*.

voluntary individual market. In a market where individuals can choose to purchase insurance at any time, health insurers must medically underwrite applicants for current health risk. If an individual buys health coverage only when he or she needs health care services, the system cannot be sustained.

While we understand and appreciate that this is a critical personal issue, individual market rescission impacts an extremely small share of the individual market membership. In our experience, we believe that more than 99 percent of all applicants for individual coverage provide accurate and complete information. In fact, as a percentage of new individual market enrollment during 2008, we rescinded only one-tenth of one percent of the policies that year.

- During 2008, we enrolled approximately 873,000 new individual market members and rescinded 1,275 contracts, approximately one tenth of a percent of the new enrollment (.001).
- During the first four months of 2009, we enrolled approximately 283,000 new individual market members and rescinded 303 contracts, again approximately one tenth of a percent of new enrollment (.001).

Here in Indiana, the issue of rescission in health insurance also affects an extremely small number of individuals. For example, in 2008, we enrolled over 66,000 new individual market members, but rescinded only 116 individuals.

Rescission is a longstanding insurance contract remedy in America. The concerns regarding rescission surfaced in the California media in 2006, generating the public concern we are discussing here today. Our main point today is the same as it was then: a voluntary market for health insurance *requires* that we protect our members from costs associated with fraud and material misrepresentations. Otherwise the market cannot be sustained.

In response to public concern over the practice of rescissions, WellPoint in 2006 undertook a thorough review of our policies and procedures. Following that review, WellPoint was the first insurer to announce the establishment of a variety of robust consumer protections that ensure rescissions are handled as accurately and appropriately as possible. These protections include: 1) creating a new Application Review Committee which includes a physician that makes rescission

decisions, 2) establishing a single point of contact for members undergoing a rescission investigation, and 3) establishing an appeal process for applicants who disagree with our original determination which includes a review by an Application Review Committee not involved in the initial decision. And in 2008, WellPoint was the first in the industry to offer a binding, external, independent third-party review process for rescissions.

We have put all of these protections in place with multiple steps because we cover millions of Americans and want to be as fair and accurate as we can be.

Some have asserted that health insurers provide a systematic “reward” or job performance recognition for employees regarding rescissions. This is absolutely not the case at WellPoint. While we did respond to the Committee’s request by providing rare references to rescissions contained in performance reviews for two California employees from 2003, this does not reflect any policy, and I want to assure the Committee that there is no WellPoint policy to factor either the number of rescissions or the value of claims not paid in the evaluation of employee performance or when calculating employee salary or bonuses. Late last year when these reviews were discovered, the company undertook a review of performance records for other California associates who handled rescission investigations, numbering over 100 individuals. No other references to savings were found in any of these reviews. In the cases of these two employee reviews, there were two references to “retro savings” among a wide variety of other factors. Pointing to the same information, one employee received a rating of “3” and the other received a rating of “5”, demonstrating that this reference was not a significant factor in the evaluation of the performance for these two employees in 2003. The individuals reviewed did not receive extra salary or bonus as a result but received the same level of bonus as other similarly situated associates.

In response to policymaker interest in enacting consumer protections related to rescission, WellPoint is proposing a set of rescission regulations with new consumer protections, which include the following:

- Establishing an independent third-party review process for rescission disputes.
- A requirement that all insurers provide an opportunity for new enrollees to review the application for coverage.

- A new regulator “health question bank” that insurers must draw upon to develop their health history questionnaire.
- A requirement that rescissions impact only the individual for which incorrect information was provided, not the entire family.
- A requirement that insurers complete a rescission investigation within 90 calendar days of receiving all information requested during the investigation process from the individual and third parties.
- A prohibition against rescinding contracts that have been in place for more than two years.
- A requirement that every insurer’s rescission review process include a physician.
- A requirement that every insurer’s rescission review process include an opportunity for an expedient appeal that involves a review by an internal committee that was not involved in the original decision to rescind and that includes a physician.
- A requirement that every insurer establish a liaison that provides a single point-of-contact for an individual going through a rescission investigation.
- A requirement that allows an individual to purchase a policy he or she would have been eligible for had he or she included the appropriate information on the application.

In addition, the health insurance industry has proposed a set of comprehensive and interrelated reforms to the individual health insurance market as a whole. The centerpiece of this proposal is the elimination of medical underwriting combined with an effective and enforceable personal coverage requirement.

Under this system of shared responsibility where everyone participates in the insurance pool by purchasing coverage, insurers would not need the ability to rescind coverage to protect our other policyholders. We appreciate that the health care reform bills under consideration in the House envision such a system.

However, for these reforms to work properly and not increase costs significantly, Congress must design a personal coverage requirement that applies to everyone with strong financial

disincentives to ensure that younger and healthier individuals join and stay in the insurance pool and do not wait to get coverage until they need services. And to further increase its effectiveness, younger individuals need to be allowed to receive sufficient discounts for participating in the system. As currently written, the health care reform bills under consideration in the House do not meet these tests.

Unless Congress creates a strong, effective personal coverage requirement and allows younger individuals to receive sufficient discounts, many will purchase coverage only when they need services, which will dramatically drive up costs for everyone else in the pool. We would welcome the opportunity to work with you to make certain that these insurance market reforms achieve the objectives we share and can be sustained over time.

These proposals are examples of how we are working to find common ground on these issues so that we can make quality, affordable health coverage available for all Americans. Thank you for the opportunity to discuss this issue and these proposals with you. I look forward to your questions.

Mr. STUPAK. Thank you, Mr. Sassi.
 Ms. Cutter, your opening statement, please?

STATEMENT OF CAROL CUTTER

Ms. CUTTER. Thank you, Mr. Chairman.

Chairman Stupak, Representative Hill, Representative Yarmuth, thank you for the opportunity for the Indiana Department of Insurance to make comments today in terms of procedures we follow that are set up according to State legislature rules and law, also through our HIPAA process that was passed by the federal government back in 1996.

As you know, individual health policies are legal contracts that contain certain provisions. And all insurers who write policies in Indiana must include those particular provisions in their form filings and are submitted to our department for review before that contract or policy is allowed to be sold or offered to any consumer residing in Indiana.

These provisions have been adopted over the years by our State legislature and tend to be fairly consistent among the 50 states. The National Association of Insurance Commissioners, which is a trade association for insurance commissioners throughout the State, also helps state departments of insurance develop language for statutes and regulations or models for the language that may be used for guidance as well.

There are thirteen provisions currently in Indiana code. They are the entire contract, time limit on certain defenses or incontestability, grace period, reinstatement, notice of claim, claim forms, proofs of loss, time of payment of claims, the actual payment of claims, physical examinations and autopsy, legal actions, change of beneficiary, and guaranteed renewability provisions.

Of these provisions, the second one, which is that time limit on certain defenses or incontestability, is the provision that prohibits an insurer from denying a claim or voiding coverage once the policy has been in effect for 2 years or more from the date of issue, unless fraud has occurred.

Thus, an insurer is allowed to rescind coverage only within the 2-year window following issuance of that policy for any misstatement or preexisting condition that wasn't indicated on the application for coverage.

HIPAA supports this very same action within the "guaranteed renewability of individual health coverage" wherein it states that an insurer may non-renew or discontinue coverage due to non-payment of premium, fraud or intentional misrepresentation of material fact, or withdrawal of the insurer from the marketplace, if the insured moves outside the service network, or there is a termination of membership in the association that offered the insurance. So in Indiana, we follow not only the laws under the State legislature that have been given to us but also under the federal HIPAA law.

There are no provisions in Indiana code which disallow the rescission or specify the procedures under which that event is to function. However, Indiana does have two alternatives that allow insurers to offer individual policies that do contain exclusions for specific conditions, called waivers, if the applicant chooses to accept

it. This allows people who would normally be declined for coverage or refuse coverage the ability to pick a policy that may have a waiver for a health condition that that applicant does not believe would be recurring in the future.

A second safety net that Indiana offers is the Indiana Comprehensive Health Insurance Association, which is our State risk pool, which does open its doors to anyone who is refused coverage by an insurer in the State of Indiana or have a condition that is considered uninsurable by an individual carrier.

Our policy analysts within the department also review the language contained in any applications that are used by insurers to issue health policies to make certain that there are no all-inclusive, have you ever, or other questions using medical terminology too complex for the average consumer to understand. No insurer may use an application without our stamped approval of that form.

Indiana's statutes do not require insurers to report the number of policies rescinded as part of their annual statements. So our involvement with rescissions begins when the insured files a complaint with our Consumer Protection Area.

We then investigate the actions surrounding the rescission to see if there has been any inappropriate behavior on the part of the insurer. Last year in Indiana, of the 6,000 complaints we investigated, 14 of those complaints were for rescission of individual health policies. Of those 14 rescissions, 2 of them were for a medical condition for which the claim that had occurred was not related to that particular angle mentioned.

And so alternative arrangements were made for the insurer to provide coverage for that person, instead of actually rescinding the coverage. Generally, the rescission complaints we have reviewed over the last few years were most always based upon the same medical condition for which the insured had submitted a claim but, for some reason, had not revealed that information on the application of coverage.

As noted in prior testimony before this Subcommittee, insurers have established outside review procedures when a rescission occurs, which does give the policyholder the opportunity to question those actions and retain coverage or receive a waiver rider for that condition. The department's Consumer Protection Unit is specifically described and used for a safety net for consumers who fall into these sorts of categories.

Another concept, which Mr. Collins just referred to and I believe the Subcommittee is considering, would be the change on an individual health contract to a guarantee issue basis, with an accompanying coverage, mandate for coverage, which would eliminate the need for medical histories for applicants under any circumstances.

We believe that the insurers currently have the legal ability to perform medical reviews within that 2-year contestability period to protect the other policyholders from fraudulent claims payments or higher premiums. We are always open to discussions for any improvements that could be made in the rescission process itself.

Thank you for your time.

[The prepared statement of Carol Cutter follows:]

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
July 27, 2009

Testimony of Carol Cutter, Commissioner
Indiana Department of Insurance

Chairman Stupak, Ranking Member Walden, Chairman Waxman and Ranking Member Barton, Indiana appreciates the opportunity to discuss rescission of individual health policies in our state.

As you may know, all individual insurance contracts contain certain required provisions that all insurers must include in their form filings submitted to our Department for review, before that contract or policy is allowed to be offered or sold to any consumer residing in Indiana. These provisions have been adopted over the years through our state legislature and tend to be relatively consistent among most all of the 50 states. The National Association of Insurance Commissioners, a trade association that helps state departments of insurance develop language for statutes and regulations, has generated models that states may use for guidance as well.

There are thirteen (13) such provisions in Indiana code. They are 1) entire contract, 2) time limit on certain defenses or incontestability, 3) grace period, 4) reinstatement, 5) notice of claim, 6) claim forms, 7) proofs of loss, 8) time of payment of claims, 9) payment of claims, 10) physical

examinations and autopsy, 11) legal actions, 12) change of beneficiary, 13) guaranteed renewability. Of these provisions, it is the second one that prohibits an insurer from denying a claim or voiding coverage once the policy has been in effect for two years from the date of issue, unless fraud has occurred. This provision, thus, allows an insurer to rescind coverage within the two (2) year window following issuance of the policy for misstatements or pre-existing conditions not indicated on the application for coverage. HIPAA supports this action within the 'guaranteed renewability of individual health coverage' (42 USC 300gg-42) wherein it states an insurer may nonrenew or discontinue coverage due to 1) non-payment of premium, 2) fraud or intentional misrepresentation of material fact, 3) withdrawal of the insurer from writing individual contracts in the marketplace, 4) if the insured moves outside the network service area, and 5) termination of membership in the association that offered the insurance.

There are no provisions in Indiana code specific to 'rescission' or the procedures under which that event is to function. However, Indiana does have a 'waiver' law that allows insurers to offer individual policies that contain exclusions for specific conditions, if the applicant chooses to accept it. Only two (2) waivers per covered person are allowed under the contract, and the exclusion of that condition may not last beyond a maximum of 10 years. This provides an opportunity for more consumers to be approved for individual policies than if the insurers simply declined the applications.

Our policy analysts also review the language contained in any applications used for individual health policies to make certain there are no 'all-inclusive', 'have you ever', or other questions using medical terminology too complex for the average consumer to understand, included. No insurer may use an application without our stamped approval of that form.

Indiana's insurance statutes do not require insurers to report the number of policies rescinded as part of their annual statements. Our involvement with rescissions begins when the insured files a complaint with our Consumer Protection Area and we then investigate the actions surrounding the rescission. Generally, the rescission complaints we've reviewed over the last few years were based upon the same medical condition for which the

insured submitted a claim, but had not revealed that information on the application for coverage. Those insureds who have incurred a rescission may acquire coverage through Indiana's state risk pool, that accepts all applicants who've been refused coverage. The risk pool is subsidized by the insurers and the state.

As noted in prior testimony before this Subcommittee, insurers have established outside review procedures when a rescission occurs, which give the policyholder the opportunity to question those actions, and retain coverage or receive a waiver rider for that condition.

Another concept introduced by the industry has been the change on individual health contracts to a 'guarantee issue' basis, with an accompanying coverage mandate, which would eliminate the need for medical histories for applicants.

Indiana does believe that insurers need to have the ability to perform medical reviews within the two year contestability period so as to protect the majority of policyholders from fraudulent claims payments and higher premiums. We are, certainly, open to discussions as to any improvements that could be made in the rescission process itself.

Thank you for your time. I'll gladly answer any questions you may have.

Mr. STUPAK. Thank you.
And, Professor Kinney, your statement, please.

STATEMENT OF ELEANOR KINNEY

Ms. KINNEY. Thank you. Thank you, Chairman Stupak, Mr. Hill, Mr. Yarmuth. It is an honor for me to be here to testify today. And I will try to be a little bit briefer than my statement, which has already been submitted for the record.

I was asked by Mr. Gordon to kind of look at Indiana and the situation generally. In Indiana, the task force at Indiana University while the Indiana University Health Reform Faculty Study Group did do an in-depth study of the situation in Indiana with respect to health coverage.

I fear that the situation with requiring people to rely on the private market is increasingly—specifically, I think there are situations where we are losing health insurance coverage through employment. And, in particular, we have witnessed a fairly precipitous drop of insurer-sponsored coverage over the years. And we find that employers compared to other states offer less insurance.

Also, with the economic times, people are losing jobs in Indiana, like other states. And, thus, they have to rely on the private individual insurance market for their health insurance. And this puts people with serious conditions or health problems in a difficult position when it comes to getting adequate health insurance coverage. And I think it is one reason why we need comprehensive health reform, which I think all of us uniformly believe is the case.

One would say, “Well, somebody with a health problem creating an existing condition can go to the Indiana Comprehensive Health Insurance Association.” And, indeed, they can, but on page 3 of my testimony, I have put together a chart of what that would cost for somebody in Marion County, which is Indianapolis; and Vanderburgh County, which is down in Evansville on the coast.

I don’t know about your all’s financial circumstances, but I would find that having to pay some of these premiums prohibitively expensive. And then if you look at the information on the plans which were available on the Web site, you get health insurance coverage that is pretty skimpy in terms of the co-insurance involved. In other words, there is lots of money that would have to be paid out of pocket before benefits chip in. So it is questionable in my judgment whether this is really a sufficient answer to the problem of people with serious health insurance problems.

We have also done work in the Center for Law and Health in the past that shows that these kinds of practices with insurance companies have occurred and people with serious illness have experienced cancellation of insurance policies. And I have got that research on page 4 of my testimony.

It is clear that HIPAA, which I think, in part, was designed to address the problem of non-renewal and cancellation, really hasn’t done the job when it comes for revision.

I think that strategies for reform, which I was also asked to address, must address the unfair aspects of the process of rescission and post-claims underwriting.

In review, in getting ready to come here today, I looked at the National Association of Insurance Commissioners’ principles on

health reform. And one of their principles on health reform quoted on page 6 of my testimony is addressing adverse selection. And I think it is very important to appreciate that adverse selection is an important problem in the private health insurance market. And it is not realistic for us to assume that that is not an important problem for insurers. It will be addressed if we have comprehensive health insurance with individual mandate.

And, finally, I would commend the Committee, not only for H.R. 3600 and the provisions in that bill intended to address rescission practices and post-claim underwriting, but for the tremendous job in laying out issues associated with this very, very difficult condition.

I think that you have done a good job with increasing the evidentiary standard that would be applied in making a rescission decision as well as require external review. I am interested to see that insurers that have testified here today have also talked about external review.

Another provision you might want to think about that I see has been bantered around in the NAIC model of long-term care, health insurance regulations of long-term care, insurance regulations, is a prohibition against post-claims underwriting. It seems to me that if an insurance company has the chart for a specific period of time, it might be closer than a shorter period of 2 years, then they ought to be able to look at the chart, see if they want to provide a policy and let the policyholder know that they are not going to be able to be there for them in the event of another serious illness.

Thank you. I will take your questions.

[The prepared statement of Eleanor Kinney follows:]

**CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
111th Cong., 1st Sess.**

**COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

**Testimony of Eleanor D Kinney, JD, MPH
Hall Render Professor of Law & Co-Director
Hall Center for Law and Health
Indiana University School of Law – Indianapolis**

July 27, 2009

Mr. Chairman:

Thank you for the opportunity to testify before your committee today about a very important aspect of the conduct of the market for private insurance in Indiana and the United States. I am Co-Director of the William S. and Christine S. Hall Center for Law and Health at the law school and also Co-Director of the Consortium for Health Policy, Law and Bioethics, an IUPUI Signature Center. Both the Hall Center and the Consortium are engaged in research, scholarship and education on health law and policy.

It is clear that the United States health care sector is in trouble. The major means of financing health care products and services – health insurance – is broken. The percentage of Americans whose health insurance is provided through employment has dropped precipitously in recent years from 80 percent of workers in 1982 to 73 percent by 1998.¹ The United States Census reports that the number of the percentage of the population covered by employer-sponsored private health insurance is 59.3 percent in 2007.² And just last Friday, The Commonwealth Fund issued a report on how the individual health insurance market was failing Americans.³

¹ J. Gruber & R. McKnight, Why did Employee Health Insurance Contributions Rise? *J. Health Economics* (2003);22:1085.

² C. DeNavas-Walt, B.D. Proctor & J. C. Smith, Income, Poverty, and Health Insurance Coverage in the United States: 2007 (Current Population Reports, Aug 2008), available at <http://www.census.gov/prod/2008pubs/p60-235.pdf> (visited Jul. 23, 2009).

³ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009, available at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jul/Failure-to-Protect.aspx> (visited Jul. 24, 2009).

From 2006-2008, the Indiana University Health Reform Faculty Study Group,⁴ with funding from the State of Indiana, analyzed Indiana's health care sector and developed proposals for reform.⁵ The information on Indiana presented in this testimony was developed by this Study Group from published national and Indiana data. I served as Co-Director of this Study Group.

The Crisis Today in Indiana and the United States

The situation with private health insurance coverage in Indiana is not unlike other states. Indiana's uninsured population is composed principally of working adults and its ranks are growing.⁶ On any given day, Indiana has approximately 561,000 uninsured residents. This number has expanded faster than the national rate each year since 2000. Sixty-two percent of the uninsured are between 18 and 64 with incomes below 200 percent of the federal poverty level (i.e., \$40,000 for a family of four). Of note, Indiana has higher per capita expenditures compared to other states and an age-adjusted mortality rate 6.2 percent higher than the national average, with notably excess mortality in diabetes and cancer.⁷ Further, Indiana falls way below other states in important public health status measures like obesity and tobacco use.⁸

Between 2001 and 2005, Indiana experienced an 8.8 percent drop in employer sponsored coverage – one of the sharpest declines among all states.⁹ In 2006, only 34 percent of Indiana firms with fewer than 50 employees offered health insurance to their workers, lower than the 43 percent who did so nationally. Firms that do offer coverage are shifting an increasing portion of costs to their employees.

⁴ Indiana University, Indiana University Health Reform Faculty Study Group, available at <http://www.healthcarereform.iupui.edu/> (visited Jul. 24, 2009).

⁵ E. Wright & M. Foddrill, A Framework for Health Reform in Indiana: Draft for Public Discussion (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2009), available at <http://policyinstitute.iu.edu/PubsPDFs/framework%20recommendations.pdf> (visited Jul. 23, 2009).

⁶ P.J. Seward, A. Holmes & E. Wright, *The Uninsured: Indiana's Rising Healthcare Dilemma* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2009), available at <http://policyinstitute.iu.edu/PubsPDFs/Uninsured.pdf> (visited Jul. 24, 2009). (Data in this paragraph are from the cited source. Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

⁷ A. Holmes & E. Wright, *The Rising Tide of Health Care Costs in Indiana* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2008), available at <http://policyinstitute.iu.edu/PubsPDFs/The%20Rising%20Tide%20of%20Healthcare%20Costs%20in%20Indiana.pdf> (visited Jul. 24, 2009). (Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

⁸ H. McCabe, G. Steele, E.D. Kinney et al., *Public Health Programs Key to Healthy Population, Lower Healthcare Costs* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2008), available at <http://policyinstitute.iu.edu/PubsPDFs/PublicHealthProg.pdf> (visited Jul. 24, 2009).

⁹ A. Holmes & E. Wright, *The Rising Tide of Health Care Costs in Indiana*, *supra* note 7. (Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

Individual private health insurance is one of the few options for health coverage for individuals and families who are not otherwise eligible for public health insurance programs like Medicare and Medicaid. We have reason to believe that the situation with private coverage in Indiana is not unlike the situation that The Commonwealth Fund reported nationally.¹⁰ According to this report:

Over the last three years, nearly three-quarters of people who tried to buy coverage in this market never actually purchased a plan, either because they could not find one that fit their needs or that they could afford, or because they were turned down due to a preexisting condition.¹¹

Indiana does have a high-risk pool for individuals who are medically uninsurable. The Indiana Comprehensive Health Insurance Association (ICHIA) offers four plans. The cost and benefits of these plans are summarized in the table below.¹² ICHIA policies have a pre-existing condition of three months unless waived. As demonstrated in the table, ICHIA policies are expensive and have high levels of cost sharing.

Monthly Premiums for ICHIA Insurance Plans in Rate Area 5: Marion (Indianapolis) and Vanderburgh (Evansville) Counties July 2009								
	Plan 1 Deductible: \$500 Coinsurance: 80% / 20% In-Network (no more than \$1000) 60% / 40% Out-of-Network Out-of-Pocket Maximum: \$1,500 (including deductible)		Plan 3A Deductible: \$1,000 Coinsurance: 80%/20% In-Network (no more than \$2000) 60% / 40% Out-of-Network Out-of-Pocket maximum: \$3,000 (including deductible)		Plan 3B Deductible: \$1,500 Coinsurance: 80% / 20% In-Network (no more than \$2500) 60% / 40% Out-of-Network Out-of-Pocket maximum: \$4,000 (including deductible)		Plan 4 Summary not available	
Ages	Male	Female	Male	Female	Male	Female	Male	Female
Child	\$266.59	\$304.68	\$218.72	\$249.49	\$168.55	\$191.53	\$143.04	\$162.53
19 – 24	335.54	667.72	288.93	574.27	266.83	527.23	226.43	447.41
25 – 29	343.83	667.72	298.06	574.27	275.60	527.23	233.88	447.41
30 – 34	374.96	667.72	325.46	574.27	300.76	527.23	255.22	447.41
35 – 39	420.06	667.72	363.65	574.27	334.06	527.23	283.48	447.41
40 – 44	500.66	667.72	459.27	612.87	420.49	559.98	350.52	466.79
45 – 49	616.76	733.11	567.72	671.02	520.31	611.12	433.73	509.43
50 – 54	763.07	838.32	705.43	767.06	648.25	697.62	540.37	581.54
55 – 59	957.66	971.88	888.57	890.74	818.57	811.56	682.36	676.50
60 – 64	1,159.83	1,149.36	1,076.07	1,054.35	990.31	961.41	825.51	801.42
65 +	1,347.05	1,328.77	1,243.81	1,213.78	1,138.82	1,101.91	949.31	918.54

¹⁰ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect, *supra* note 3.

¹¹ *Id.*

¹² Indiana Comprehensive Health Insurance Association, On-Line Health Plan.Com, available at <http://www.onlinehealthplan.com/> (visited Jul. 24, 2009).

Indiana families are really feeling the strain of costly health insurance and health care services.¹³ By 2001, average personal spending on healthcare for Indiana families exceeded the expenditures that they spent on food, housing, or transportation. About a quarter of nonelderly families spend at least 10 percent of their pretax income on health care. Nearly half of all personal bankruptcies in Indiana are due to medical expenses.

Insurer practices of rescission or post claim underwriting that are the subject of this hearing can be particularly devastating for Indiana consumers. Consumers are virtually uninsurable after the rescission of a health insurance contract as indicated in insurer testimony at the June 16th hearing. Their only recourse is to obtain insurance through employment, which may be out of the picture if they are ill. Or they can enroll in one of the ICHIA plans that are quite expensive as indicated above. They are only eligible for Medicare if they are determined to be disabled and exhaust a two year waiting period. They are only eligible for Medicaid if they spend down to Medicaid income and resource levels, which are quite low in Indiana. (Of note, Indiana does not have a Medicaid Medically Needy program.) They are only eligible for Indiana's Healthy Indiana Plan if they meet that program's restrictive eligibility requirements, including participation in a medical savings account program.

Historically, Indiana residents have been subject to insurer practices of rescission, post claim underwriting and other practices that have ultimately denied private health insurance to seriously ill individuals. In the 1990s, with funding from The Robert Wood Johnson Foundation and the National Multiple Sclerosis Society, we at the Hall Center and colleagues at Indiana University documented the extensive problems that Indiana residents had with all types of private health insurance coverage.¹⁴ In another study of the working poor's attitudes toward health insurance coverage in Indiana, focus groups of the working poor clearly indicated that private coverage with high cost-sharing provisions and lack of coverage of prescription drugs among other items was not worth purchasing given their limited resources.¹⁵

¹³ A. Holmes & E. Wright, *The Rising Tide of Health Care Costs in Indiana*, *supra* note 7. (Data in this paragraph are from the cited source. Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

¹⁴ See N. Swigonski, E. Kinney, D. Freund & T. Kniesner, *Unfinished Business: Inadequate Health Coverage for Privately Insured Seriously Ill Children*, *Children's Health Care* (2001);30(4):219; K. Stroupe, E. Kinney & T. Kniesner, *Chronic Illness and Health Insurance-Related Job Lock*, *Journal of Policy Analysis and Management* (2001); 20(3):525; K. Stroupe, E. Kinney & T. Kniesner, *Is There Evidence for Health Insurance-Related Job Lock When a Family Member is Chronically Ill?* *Journal of Health Policy, Politics and Law* (2000);25(2): 309; E. Kinney, D. Freund, M. Camp, K. Jordan & C. Mayfield, *Serious Illness and Private Health Coverage: A Unique Problem Calling for Unique Solutions*, *Journal of Law, Medicine & Ethics* 190 (1997); 25(2-3):190; E. Kinney & S. Steinmetz, *Notes from the Insurance Underground: How the Chronically Ill Cope*, *Journal of Health Politics, Policy and Law* (1994);19(3):633.

¹⁵E. Kinney, M. Tai-Seale, J. Greene, R. Murray & W. Tierney, *Three Political Realities in Expanding Coverage for the Working Poor: One State=s Experience*, *Health Affairs*, (1999); 18(4):188.

Strategies for Reform

As noted in the Supplemental Memorandum that was prepared following the hearing before this committee on June 16, 2009, there is considerable controversy over the legality of the practices of rescission and post claim underwriting. The Supplemental Memorandum presents information on statutes and court cases across the states that address insurer rescission of individual health insurance contracts.

Ostensibly, as the Supplemental Memorandum points out, the Health Insurance Portability and Accountability Act (HIPAA) prohibits insurance companies from rescinding or otherwise discontinuing individual insurance coverage unless there has been fraud or intentional misrepresentation of a material fact by the applicant or policyholder. HIPAA states that a “health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual” except if “the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.”¹⁶

However, as explained in the Supplemental Memorandum, insurance companies do not necessarily follow the above quoted HIPAA provision in rescission situations. Rather, they could correctly maintain that rescission of a policy is different than non-renewal. In contract law, the consequence of rescission is that the rescinded contract never existed in the first place.¹⁷ Cancellation and non-renewal apply to an existing contract.

The Problem of Adverse Selection. Rescission and post claims underwriting are one way that an insurer can address adverse selection that exists in a voluntary individual private health insurance market. Insurers in this market suspect that the people are purchasing individual private health insurance policies on a voluntary basis only because they are sick or have reason to believe that they will become sick. The problem of adverse selection could be solved with a legal mandate that all people get insurance. The joint health reform that the three House Committees just reported out does have such mandates.¹⁸ Nevertheless, it is important to address problem of rescission and post claims underwriting in the interim.

The National Association of Insurance Commissioners, comprised of state insurance regulators, has developed principles of health reform that include a mandate for health insurance coverage. These principles also require that health reform address the problem of adverse selection:

¹⁶ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1998 (codified as amended, Public Health Service Act § 2742, 42 U.S.C. § 300gg-42).

¹⁷ H.R. 3200, America’s Affordable Health Choices Act, 111th Cong., 1 Sess. (2009).

¹⁸ See J.W. Stempel, *Law of Insurance Contract Disputes* (1998 & Supp. 2002); E.A. Farnsworth, *Contracts* § 9.3 (3rd Ed. 1999).

Avoid Adverse Selection. Any program that grants consumers the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. Likewise, setting different rules for different plans within the pool or allowing consumers to wait until they get sick to purchase insurance, without penalty, can have adverse consequences on the pool. Any reforms must be carefully constructed to ensure the long-term health of the market. *We can support guaranteed issue and elimination of preexisting condition exclusions for individuals to the extent that these reforms are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable* [Emphasis supplied].¹⁹

H.R. 3600, America's Affordable Health Choices Act. In my view, H.R. 3600 does much to address current problems with individual private health insurance coverage, with long term and genuine health reform.

However, H.R. 3600 could do more in the interim. Specifically, H.R. 3600 treats rescission of the insurance contract as a non-renewal of the contract. As explained above, rescission and nonrenewal are not the same legal concepts. Rescission voids the insurance contract altogether and from the start, while cancellation and non-renewal terminate an existing contract.

To be effective, H.R. 3600 should explicitly address the practices of practices of rescission and post claim underwriting for individual health insurance contracts. Possible reforms would be the imposition of time limits on which insurers could rescind an insurance contract. Other reforms, included in H.R. 3600, are a higher evidentiary standard for intentional misrepresentation and mandated external review of decisions to rescind. Another reform would be to prohibit the practice of post claims underwriting altogether or after a brief time period.

Thank you.

¹⁹ National Association of Insurance Commissioners and the Center for Insurance Policy and Research, *Principles of Health Reform* (2009), available at http://www.naic.org/topics/topic_health_care_reform_principles.htm (visited Jul. 24, 2009).

Mr. STUPAK. Well, thank you, Professor.

And before I turn to my two colleagues, let me just ask one quick question. Mr. Collins, on behalf of Golden Rule Insurance Company and UnitedHealth Group, would you commit today that your company will never rescind another policy unless there is a potential fraud misrepresentation in the application?

Mr. COLLINS. We would commit that we will not rescind a policy if there is a knowing and material misrepresentation or omission on a health insurance policy.

Mr. STUPAK. So, in other words, your answer is no?

Mr. COLLINS. No, sir. There is quite a bit of overlap in those two standards between knowing and intending. The standard that we follow is a knowing material omission, misstatement or——

Mr. STUPAK. So if I just forget to check a box, I can be rescinded, right?

Mr. COLLINS. Well, our——

Mr. STUPAK. That is an omission.

Mr. COLLINS. Well, sir, our applications are designed to elicit relevant information needed to underwrite a policy form.

Mr. STUPAK. Anyone who went through applications in Washington could explain it, the terms.

Mr. COLLINS. Sir, I can explain the terms of ours. I believe you are referring to somebody else who testified.

Mr. STUPAK. So to my question of intentional fraud, unless there is intentional fraud, you reserve the right to rescind an application for whatever reason your policy states?

Mr. COLLINS. We follow state laws.

Mr. STUPAK. Every state is a little different.

Mr. COLLINS. And we have an obligation to our policyholders to honestly fill out the application, to fill out the application completely. Our people made it up. We have a condition excluded from coverage or some who are even designed to treat them the same as people who did not fill out an application completely or remain during this representation in the application.

Mr. STUPAK. My concern is that your definition of knowing is you assume you know everything in your medical records for the last 5 years. Lay people really don't.

So let me go to Mr. Sassi. Are you willing to commit that WellPoint today that your company will never rescind another policy unless there is intentional fraud, misrepresentation in the application?

Mr. SASSI. Like Mr. Collins, WellPoint follows state law. In the vast majority of states in this country——

Mr. STUPAK. It is a very simple——

Mr. SASSI. No, it isn't, sir.

Mr. STUPAK [continuing]. "Yes" or "No" answer.

Mr. SASSI. Well, it is not a simple question because with the misrepresentations of the law. And so in most states, it is a no-win standard. And if someone knowingly misrepresents their health status and it is material to whether we could offer a policy, then we will rescind that but only if it is material in the interim and it is not just——

Mr. STUPAK. Even if it is unintentional, just because they knowingly missed something, you could rescind them, right?

Mr. SASSI. If it is material, then it would have not already covered—

Mr. STUPAK. Sure. If they knowingly—

Mr. SASSI. If someone has been unaware of their medical condition—

Mr. STUPAK. Sure.

Mr. SASSI [continuing]. Then we would not rescind.

Mr. STUPAK. You have 1,400 codes to trip up people, right? These are your codes. Don't you have 1,400 codes which trigger a review of an application post-underwriting, as the professor said?

Mr. SASSI. I would contend that we do not participate in post-claim underwriting.

Mr. STUPAK. You have 1,400 codes that trigger a review of policies, right? You have 1,400 and Assured has 2,000 different codes. Once you trigger one of those codes, there is an automatic review to try to get out and rescind that policy?

Mr. SASSI. Not necessarily, only if it is—

Mr. STUPAK. But there are 1,400 codes, right? Can you say "Yes" or "No" to that?

Mr. SASSI. Yes. And there are—

Mr. STUPAK. OK.

Mr. SASSI [continuing]. Tens of thousands of medical conditions.

Mr. STUPAK. Mr. Hill for a question, please?

Mr. HILL. Thank you, Mr. Chairman. I have got a few questions for you particularly, Mr. Sassi, but I also have a general question I want to ask.

Do either one of you offer incentives to your employees when they are able to find some reason they need to file this rescission?

Mr. COLLINS. Absolutely not, Congressman.

Mr. SASSI. WellPoint does not have a policy to offer incentives or a pay/borrow system to employees.

Mr. HILL. How would you respond to the one woman who said that she had a friend of hers in church whose job it was to find reasons we cancel policies? Any explanation of that? She gave her testimony under oath. So it has to be an accurate statement.

Mr. COLLINS. Well, sir, I really can't explain Ms. Beaton's testimony about the practices of Health Care Services Corporation, which is a Chicago-based Blue Cross/Blue Shield parent company with Blue Cross in Texas.

Mr. HILL. You don't have anybody on staff to look at this kind of thing, do you?

Mr. COLLINS. Well, sir, we have processes, as all insurance companies do, including group insurance companies, to monitor for pre-existing conditions that may or may not be covered under our policies.

Mr. HILL. Well, let me ask the question a different way, then. That person sends in a claim, whatever it might be, heart surgery, cancer, whatever it is. When they send in that claim, is there a person in your company that begins a review of that person's medical records before they pay that claim?

Mr. COLLINS. There is not a person that starts an investigation based on a single item that comes into the company. No, sir.

Mr. HILL. Mr. Sassi.

Mr. SASSI. We do have people that look for fraud and situations that—

Mr. HILL. After a claim is filed?

Mr. SASSI. Well, we do not have departments of people that just review claims to determine fraud. In the individual market, we do exclude coverage for certain preexisting conditions if those conditions exist. So we do have checks and balances.

Mr. HILL. I think your answer is yes, you do do an investigation of that person's medical records after a claim is filed?

Mr. SASSI. Yes. An investigation does not turn into a rescission in the individual market. Over 92 percent of rescission investigations are closed with no action.

Mr. HILL. And, Mr. Collins, that is not your policy? Is that what you are saying?

Mr. COLLINS. Well, my point was, sir, that based on a single data point, we are not doing investigations. We clearly will review claims for applicability to the policy, whether they are covered in the policy.

There are extensive computerized claim reviews that happen. Throughout the industry, whether it is group insurance, whether it is individual insurance, there are—every claim goes through a computerized system that reviews the appropriateness of the claim and whether the claim is eligible, whether the person is eligible, the provider is eligible who is submitting the claim.

Mr. HILL. Let me ask the question in a third way. Does a claim trigger an investigation?

Mr. COLLINS. There are many ways that rescission investigations could start. Sometimes rescissions are started with a call from a provider, a precertification call. Sometimes it is because a claim is submitted, but there are multiple ways, multiple routes in which we get intelligence that there is a claim that may have been preexisting, which may or may not have been disclosed on an application.

Mr. HILL. And is a claim one of those triggers?

Mr. COLLINS. There are multiple aspects that we look at, but a claim—

Mr. HILL. Is a claim one of them?

Mr. COLLINS. Yes, sir.

Mr. HILL. Mr. Sassi, you are the CEO of WellPoint's consumer business. And your company has provided the Committee with thousands of pages of documents relating to policies you rescinded. I would like to ask about several policies you rescinded here in Indiana.

In the case you identified as case number 59-71-7, WellPoint rescinded an Indiana resident's health insurance because he failed to disclose a condition called chronic obstructive pulmonary disease, or COPD. Are you aware of this claim?

Mr. SASSI. I am not aware of the specific case.

Mr. HILL. Mr. Sassi, these are documents you provided to the Committee. These are from your own files. Our staff has been going back and forth with your team about this case for weeks. Are you now saying you don't know anything about it?

Mr. SASSI. I am aware that WellPoint has provided the requested documents to the Committee. I have personally not reviewed those documents. I am aware that there is a high level of—

Mr. HILL. Let me ask you this. The doctor in this case proved that WellPoint made a mistake. Why did the policyholder have to go out and hire a lawyer to convince you to reinstate the policy? Why didn't you believe the doctor?

Mr. SASSI. Again, I know nothing about the details of the case.

Mr. HILL. OK. Well, you know, I wish I could stay and ask questions. It is obvious that the claims procedure does trigger investigations. And you had people that are going through the very small details of a person's medical history in order to find a way of denying that claim. I think it is rather obvious.

Mr. Chairman, let me thank you for coming to Indiana to hold this hearing. It is very important that we get to the root of a lot of reasons that have been offered here as to why claims are denied.

We appreciate your leadership in this particular issue. Again, we appreciate you coming here to Indiana.

Mr. STUPAK. Thank you, Congressman. And we look forward to seeing you back later today.

Mr. Yarmuth.

Mr. YARMUTH. Thank you, Chairman Stupak.

Let's just ask. Chairman Stupak showed you and you acknowledged it, that there are 1,400 diagnostic codes that would prompt a retroactive review of the insured. And you said there were 20,000 diagnostic codes?

Mr. SASSI. There are thousands.

Mr. YARMUTH. Thousands more than the 1,400. What would distinguish the 1,400 codes that prompt a review from the rest of them? Is there a common distinction?

Mr. SASSI. I would say they are codes. And this is particularly in the individual insurance market, where we receive information after a policy is issued. And our claims system would if a claim was received—it could be a pharmacy claim, a \$20 pharmacy claim—that pertained to either a chronic condition that a member might have or some type of ongoing condition that would prompt us to investigate whether it was a preexisting condition or not and whether that was disclosed to us or not on the application.

Mr. YARMUTH. Would it be fair to say—and if not, would you correct me?—that the distinction would be that these are diagnoses that would require relatively expensive and long-term payments?

Mr. SASSI. I would say not in all cases because many pharmacy claims that come in for meds are for—

Mr. YARMUTH. I'm talking about the condition itself, not the actual individual claim. What we were talking about here—and Jim Stupak has a list. I have a list of Blue Cross in California, for instance. And it is individual plans, table of diagnoses, subject to re-orientation review.

And it is not a list of 1,400. It is a list of two pages long. I am sure there is a third, three pages long. And it is things like diabetes, neoplasms, or cancers, schizophrenic disorders, asthma, rheumatoid arthritis, emphysema, chronic renal failure, not anything like chicken pox. These are things reading across this list that would require lengthy, expensive treatment.

Would you say that is true? I mean, would a diagnosis in a child of chicken pox prompt a retroactive view of the claim or the medical history?

Mr. SASSI. Most likely not, but from looking at that list, I would say not every condition is necessarily an expensive condition. Many people have these conditions and for very little cost.

Mr. YARMUTH. I am not sure it has been said at this hearing, but I know that it came out at a hearing in Washington that over the past 5 years, there have been approximately 20,000 rescission cases that saved according to insurance company data \$300 million. That averages out. My math is \$15 a case.

If you were to have a situation like some of the ones we heard here today—we had two cases of breast cancer on the panel before us, before you. Sir, could you give us an estimate, either one, Mr. Collins, Mr. Sassi, of what the average expenditure for treatment of the cases that you heard today might be?

Mr. COLLINS. Not off the top of my head, Congressman. No, sir.

Mr. YARMUTH. Could you give me a range?

Mr. COLLINS. The range, sir, is like—I really couldn't, sir, give you a reasonable estimate.

Mr. YARMUTH. Would you think that \$15,000 is probably as little as in the case of breast cancer the cost of a double mastectomy and the ensuing chemotherapy and in some cases reconstructive surgery? Would you say that those situations would cost substantially more than \$15,000?

Mr. COLLINS. For all of those conditions together, yes, sir.

Mr. YARMUTH. So the odds are that if there were 20,000 rescission cases over the last 5 years, the actual savings to the insurance companies, even though they might not be able to calculate it because a lot of it is prospective, could be substantially more than \$300 million. In fact, it could be in the billions of dollars.

I will ask it another way. Is it unusual for a cancer regimen, a treatment regimen, to be in the hundreds of thousands of dollars?

Mr. COLLINS. No, sir.

Mr. YARMUTH. Right. I think the problem that a lot of us have is we look at the insurance company profits over the last few years in light of the rest of the indicators in the economy, we see WellPoint's profits having increased in 7 years by something like 1,300 percent from 200 and some million to 3. something billion and United HealthCare's profits increasing over 500 percent in the same period of time. And we hear cases of rescission in which we know that literally hundreds of thousands of dollars per case could have been saved.

And we question whether this is a policy that is being implemented, Mr. Sassi, as you said, to be shared to those people who don't knowingly misrepresent the policies and whether it is strictly a financial consideration.

And, I mean, we know that the premium increases of 100 percent in the individual market over that same period of time do not particularly relate to costs in the economy. They don't relate to salary increases.

So I would say that we are trying to decide what to do. You know, I am very pleased to see that we have a pretty good con-

sensus of the fact that we need to do many of the things that we are talking about doing in Congress.

I would basically say, to what can we attribute these incredible profit margins when we are trying to deal with making sure that individuals such as the ones we saw here are given the care that they need and that they contracted for?

Mr. SASSI. Well, I can't speak to the numbers because I haven't seen the numbers, but going back 7 years, I think the large increase in profit numbers is not comparing necessarily apples to apples.

Seven years ago, WellPoint was a much, much smaller company. The last 7 years, we have merged with several other companies. And so I think that would account for much of which you—in fact, the last 7 years, our profit margins have not been going that well.

Mr. YARMUTH. Mr. Collins, would you like to comment on that as well?

Mr. COLLINS. Yes, sir. UnitedHealth Group has grown via acquisition, much as WellPoint has. And I think that the point that Mr. Sassi made around the comparability of numbers over time is one of those things.

UnitedHealth Group is one of the largest health care organizations in the United States. We touch 70 million American consumers. And we grow value to the system. And people pay us for the value that we add to the system.

We help pull down costs. We help organize the care, the delivery of care. We are involved in just about every aspect of delivery. And most of the innovation that has come forward in the past 30 or 40 years around health care delivery has been financed by and facilitated by the health insurance industry.

So I think that as one of America's largest businesses, we are entitled to a healthy profit margin. And we have been very prudent about our investments through this financial turmoil that we have had. And the company has got a good, sound balance sheet. It is in good shape to take care of the customers that meet its commitments. And we don't apologize for that.

Mr. YARMUTH. Let me just ask two quick questions, Mr. Chairman. And then I will yield back my time.

In light of what you have said, you indicated that there has been a fairly substantial concentration going on in the insurance market over the last decade. Is that a fair characterization of what you said?

So that when opponents of what we are trying to do in Congress say, "Well, there is already substantial competition out there in the market," what you are saying is that competition has diminished over the last decade. Is that true?

Mr. SASSI. I would say that there has been a fair amount of consolidation within the health insurance industry, but, as the Nation's largest health insurer, insurance company, we still have on average only 30 percent market share. In the vast majority of our markets, there is healthy competition amongst literally tens, sometimes hundreds of—

Mr. YARMUTH. You have 30 percent of the market share in the country. And UnitedHealth has how much?

Mr. COLLINS. I don't know off the top of my head.

Mr. YARMUTH. A substantial amount, right? And this represents substantial competition in your minds? I think your company in Kentucky controls 59 percent of the market. Do you consider that a healthy, competitive environment or are you just good at it?

Mr. COLLINS. One of our toughest competitors is located right here in Louisville: Humana.

Mr. YARMUTH. Thank you for that shout-out, yes.

Mr. COLLINS. On the front lines, sir, I mean, there is quite a bit of competition. In fact, there has been a large number of new entrants into the individual health insurance market.

And I would urge the members of the Committee if they had a moment just to go to ehealthinsurance.com and put in your Zip code and see what pops up. You will find that there is a wide variety of carriers. There is great transparency in the individual market in terms of price and product. And there is a lot of competition in this marketplace. We have had a lot of new entrants.

Mr. YARMUTH. I would be interested, and I will do that.

One final question. When you have somebody who has been in your individual market for 10 years and they have been paying premiums for 10 years and they end up like one of our former panelists and they have a serious illness and their policy ends up being subject to rescission, how is that handled? How do you handle all the premiums they have been paying you for all of those years?

Mr. SASSI. WellPoint would not rescind the policy after 2 years. So if someone had been paying a premium for 10 years, we would not look at that, irregardless of—

Mr. YARMUTH. They were not the subject of rescission. OK. What if they fell within the 2-year period, if they have been paying for 2 years? What would you do with their premiums?

Mr. SASSI. Well, as I outlined in my testimony, we have a very thorough process where we review. We reach out to the members to see if there is any additional information the member could provide. We share the information that we have. It goes to a committee that is established with the doctor that makes the decision and multiple appeal processes, including binding third party appeal and a third party review.

Mr. YARMUTH. That is all wonderful. What I am saying is if you decide to rescind their policy, they have been paying for 20 months and then you rescind their policy, what happens to the premiums they have been paying?

Mr. SASSI. The premiums would be refunded less any claims that were paid.

Mr. YARMUTH. OK. Is that the same policy you would have, Mr. Collins?

Mr. COLLINS. We refund 100 percent of the premiums on the policy.

Mr. YARMUTH. OK. That is all I had, Mr. Chairman. Thank you.

Mr. STUPAK. Thank you, Mr. Yarmuth. Thanks again for joining us. Thanks.

Well, let me ask this question just on competition. You say there is so much competition between you, between the insurance companies. Isn't it true that the insurance companies are not subject to antitrust laws?

Mr. COLLINS. I am not prepared to answer that question, sir.

Mr. STUPAK. Maybe Mr. Sassi?

Mr. SASSI. I am not an attorney.

Mr. STUPAK. So when the Energy and Commerce Committee does the markup of H.R. 3200, the national health care bill, when I offer my amendment to take away the antitrust exemption for insurance companies, you have no objection to that?

Mr. COLLINS. Sir, my testimony was I am not prepared to testify on that. And I am really not an expert in antitrust matters in any way, shape, or form.

Mr. STUPAK. It is only the insurance industry and Major League Baseball that are not subject to antitrust laws. Therefore, you can set the profits wherever you want. And we would have no recourse.

Competition. The average health insurance premium for Indiana employers and employees went from \$6,628 in 2000 to over \$12,153 in 2007. In that group, 116 percent were individuals and 75 percent for employers. Doesn't that account for the huge profits you had?

Mr. SASSI. I think that probably accounts for an increase in health care costs.

Mr. STUPAK. Well, accounting for the increase in health care costs has been why would your profits according to SEC go from 2.4 billion to 12.9 billion?

And if you take WellPoint, Mr. Sassi, your profits increased from 226 million in 2000 to 3.45 billion? To me, that is a 1,380 percent increase. So it can't be health care costs. It has got to be the record premiums you are charging people.

Mr. SASSI. Well, as I have previously testified, looking back at the starting points, WellPoint was a much different company. And we have grown dramatically through acquisitions of other companies.

Mr. STUPAK. Sure.

Mr. SASSI. So I don't think it is an apples to apples comparison.

Mr. STUPAK. Sure, but you said that the reason why premiums went up is because health care costs so much nowadays, costs so much to deliver health care. Then if that is the case, you would be paying out more money, and your profits would be less. You wouldn't be having a 1,380 percent increase.

Mr. SASSI. Chairman, the point that I was trying to make is that 7 years ago, we were a company of a million members. And now we are a company that insures over 35 million members—

Mr. STUPAK. Sure.

Mr. SASSI [continuing]. With a combination of many companies.

Mr. STUPAK. Sure. But you said the reason why you had to charge, you went from \$6,600 to \$12,000, was because health care costs went up. But, of course, corresponding is the fact that your profits also went up 1,380 percent when the cost of health care basically went up 116 percent. There is quite a disparity there, no matter how many people you cover. If you cover more people, you would have more costs.

Let me ask you this question. The American Insurance Plans wrote us a letter. Are you both a member of AHIP, America's Health Insurance Plan?

Mr. COLLINS. Yes.

Mr. SASSI. Yes.

Mr. STUPAK. I want to ask a question about no longer doing rescissions without intentional fraud. You know, I know today you sort of danced around it. After I asked a question in Washington, the AHIP wrote a letter, said, "Well, the companies focused their responses on specific legal standard referenced in the question. They will not rescind an individual's coverage on the basis of a pre-existing medical condition which the policyholder was unaware of at the time he or she applied for coverage."

So will you commit today that you will not rescind an individual's coverage on the basis of a preexisting medical condition which the policyholder was unaware of? Will you commit to that today, Mr. Sassi?

Mr. SASSI. Yes. I previously testified to that this morning.

Mr. STUPAK. You, too, Mr. Collins?

Mr. COLLINS. Yes, sir. That is the knowing standard I was testifying to earlier.

Mr. STUPAK. OK. Then it goes on to say, "And are you committing that you will only rescind the policy to the policyholder as materially misrepresenting their knowledge, health status or history?"; so a material misrepresentation. Is that correct? You do that?

Mr. COLLINS. Yes, sir, material misrepresentation or omission on the application.

Mr. STUPAK. Is that your standard, too?

Mr. SASSI. Yes, that is our standard.

Mr. STUPAK. OK. So we are making some progress. Let me ask you this. Mr. Sassi, Mr. Hill asked you a number of questions about victims here in Indiana.

And our Committee also asked you questions and asked for your cooperation so we could contact them. In fact, last week we sent you a letter listing four cases here in Indiana. And they were case number 59-717-60, number 65-86, number 67-20, and number 65-83. And we asked you to send these people a letter and ask them to contact the Committee. And you refused, saying that you could not do that.

Why did you refuse to contact these policyholders?

Mr. SASSI. It is our understanding that the request being asked of us would have violated HIPAA.

Mr. STUPAK. How would it violate HIPAA when the insurance company is contacting their policyholder?

Mr. SASSI. Again, I am not an attorney. And I believe that our attorneys were working closely with the Committee staff to determine if and how we could comply with your request.

Mr. STUPAK. Well, we checked with CRS and everyone else that under privacy laws, your company, WellPoint, clearly falls within the definition of a covered entity. And you are permitted to use or disclose an individual's protected health information to the individual. It was up to the individual to contact us.

So would you contact those folks and have them contact our Committee?

Mr. SASSI. I will take that under advisement and speak with our legal team.

Mr. STUPAK. OK. Maybe we will have to use our—let me ask you this, then. The Reilling case, Ms. Reilling who was here, why did

you cancel her out? Do you still offer these one-group policies, these one-person group policies?

Mr. SASSI. Chairman, Ms. Reilling's case, here today was the first that I had heard of that case. While she was testifying, we did do some research. And Ms. Reilling was covered under an employee policy issued by Kentucky Retail Federation.

Mr. STUPAK. Correct.

Mr. SASSI. So it was an employer plan. And apparently the eligibility rules of that employer plan indicate that groups must have two members. And so it is my understanding that the association, Kentucky Retail Federation, does not insure groups of one.

Mr. STUPAK. Are you saying Kentucky Retail Federation told you to cancel Ms. Reilling's?

Mr. SASSI. They are the policyholder.

Mr. STUPAK. Really? So for the last 15 years when you allowed Ms. Reilling to have this policy, did Kentucky Retail Federation pay that premium?

Mr. SASSI. Chairman, again, this is the first I am hearing about this. We would be happy to investigate the situation—

Mr. STUPAK. Mr. Sassi.

Mr. SASSI [continuing]. And provide something for the record.

Mr. STUPAK. You are under oath.

Mr. SASSI. Yes.

Mr. STUPAK. You are not here telling us that Kentucky Retail Federation was responsible for providing Ms. Reilling a policy. You were. You didn't go through Kentucky Retail Federation to provide a policy or even to contact Ms. Reilling on her policy.

Everything, every document you have had, everything you have seen—and if you did your due diligence, everything is between your insurance company and Ms. Reilling or your insurance company and Ms. Reilling's agent. There is no Kentucky Federation.

Mr. SASSI. Chairman, again, based on my limited understanding of the situation, my understanding is that Ms. Reilling was covered under a policy issued—

Mr. STUPAK. Do you still write single-person group policies?

Mr. SASSI. I believe other associations. Associations do have that option.

Mr. STUPAK. So you still write single-person policy coverage?

Mr. SASSI. I can't definitively say. Again, I would be happy to research the matter and provide a response for the record.

Mr. STUPAK. Well, you did for her for 15 years. So why was she canceled? Was it because she was sick in the last year?

Mr. SASSI. Chairman, unfortunately, you have exhausted my knowledge of the situation. Again, I would be happy to research it and provide a response for the record.

Mr. STUPAK. OK. You said federal privacy laws prevented you from contacting your own policyholders to contact our Committee if they so choose. Under Ms. Reilling's case, federal law, HIPAA, prevents you from canceling a contract that is in effect. You can't go back and cancel it under HIPAA law.

So why did you cancel it? It seems like you rely on federal law when it is in your best interest, but when it is not in your interest, you don't follow federal law.

Mr. SASSI. Again, my understanding is that Ms. Reilling was covered under an employer contract.

Mr. STUPAK. For 15 years.

Mr. SASSI. It has eligibility requirements. And, again, I would be happy to research it. I don't know if—

Mr. STUPAK. So, Professor, under HIPAA, could they cancel Ms. Reilling's policy?

Ms. KINNEY. I would be reluctant to answer without all of the facts, but the purpose of HIPAA is to enable people to maintain their policy.

Mr. STUPAK. And then HIPAA says you can't cancel unless you have—

Ms. KINNEY. Unless you have the statutory standard that is included in your excellent supplemental report and basically intentional misrepresentation or failure to pay the premium.

Mr. STUPAK. Right. And she was able to. In fact, they even sent Ms. Reilling a renewal. They sent her a renewal, and then they sent her a rescission, all in the same month. But HIPAA prohibits insurance companies from rescinding or otherwise discontinuing individual insurance coverage unless there's been a fraud or intentional misrepresentation of a material fact by the applicant.

Ms. KINNEY. The problem with HIPAA is that I think it doesn't go far enough. It does not address rescissions. A rescission is when you have the contract that existed in the first place.

Mr. STUPAK. Sure.

Ms. KINNEY. It is like an annulment versus a divorce.

Mr. STUPAK. She wasn't rescinded. She was just failed to renew. And HIPAA goes on to state that "A health insurance issuer that provides individual health insurance coverage to an individual shall"—it is mandatory—

Ms. KINNEY. Right, but HIPAA—

Mr. STUPAK [continuing]. "Renew or continue in force such coverage at the option of the individual," Ms. Reilling.

Ms. KINNEY. Right.

Mr. STUPAK. So under HIPAA, the failure to renew here since they did it for 15 years straight puts you in violation of law.

Ms. KINNEY. It would be my view that they are in violation of the law having seen what is before us before.

Mr. STUPAK. Let me ask you this, Professor, if I may. In your chart, page 3—

Ms. KINNEY. Yes.

Mr. STUPAK [continuing]. It is interesting when I was looking at it. It looks like basically from a child until age 60, the premiums for women are always higher until you hit 60. Then finally the men have a higher premium. Now, I understand there are child-bearing years in there, but is there any reason for that or is that just coincidence?

Ms. KINNEY. I would really have to give that to underwriting and actuarial science, which always is a mysterious process. And I think that these are determined based on the experiences that the insurance industry generally has with people in this age, sex, and so forth.

Mr. STUPAK. You agree with me, though, these four plans laid out until age 60, women pay higher premiums than men?

Ms. KINNEY. Right. I saw that, too. I mean, I was putting this together basically Thursday, Friday. And I was kind of struck by that observation, too.

Mr. STUPAK. Well, let me go back to Mr. Collins and Mr. Sassi since our first panel was all women. I am not trying to come to conclusions here, but do you charge women more? Do they have greater health risks than men as a general rule, Mr. Collins?

Mr. COLLINS. In Golden Rule's actuarial duties, the individual policies that we sell, if you stacked up the policyholders through age 65, men would pay slightly more than women over the course of a lifetime if you took 1 policyholder for each age and laid them out.

Mr. STUPAK. Right. But of the 60, women pay higher according to the professor's chart. Is there a reason for that?

Mr. COLLINS. Well, that is the Indiana high-risk pool that you are looking at. I don't think it—

Ms. CUTTER. Yes.

Mr. STUPAK. Yes, you are right.

Ms. CUTTER. Mr. Chairman, if I may?

Mr. STUPAK. Sure.

Ms. CUTTER. That is from the Indiana Comprehensive Health Insurance Association. Those actuarial bases are established by a national firm called Millimen.

Mr. STUPAK. Right.

Ms. CUTTER. And they use data from multiple areas to determine what the prices should be for individual contracts in Indiana based on geography, age, gender, that sort of thing.

Mr. STUPAK. Surely. Didn't it strike you as funny as the Insurance Commissioner that up to age 60, women pay more than men?

Ms. CUTTER. Women generally pay more for health insurance during those child-bearing years from about 20 up until about 50. And then it starts to more even out, as you have noticed, that by age 60, then, the men are tending to catch up.

The other thing that—

Mr. STUPAK. Well, I guess I would agree with that up to maybe 19 to 40–45, but even as a child, it seems like it is the boys who are jumping off roofs. It is not young girls. Why would they pay more or why between 50 and 60, they would pay more?

Ms. CUTTER. I would have to look at the actuarial data that Millimen has collected in order to generate those pricings. But most of the time, women tend to be more careful about their health than men tend to be until they get into those upper ages, when, unfortunately, our bodies just don't work as well as they had 20 or 30 years previously. And I think that is the point at which men's health starts to catch up in terms of cost with women's health.

We would be glad to get that information from Millimen, Mr. Chairman, if you would like to have that.

Mr. STUPAK. Let me ask you this question, if I may. I want to make sure I understood this right. So if I write an insurance policy in Indiana, an individual policy, after 2 years, I can't rescind it, no matter what?

Ms. CUTTER. That is correct. The incontestability clause only addresses the first 2 years of a policy. I believe Mr. Sassi made a comment earlier in his testimony where you asked him if somebody

had paid a premium for 10 years and, all of a sudden, you found out there was something wrong with the policy, you couldn't cancel it. His answer to that was no.

Mr. STUPAK. OK. So there is no rescission after 2 years. Have you investigated rescission practices here in Indiana?

Ms. CUTTER. We have. We have had 14 of those investigated for the year 2008.

Mr. STUPAK. So 14. And what were those reasons for rescinding those 14?

Ms. CUTTER. There are multiple reasons. Generally speaking, as I said earlier, they were for a claim that was related to a critical condition that had not been revealed on the application by the applicant.

Mr. STUPAK. So intentionally not renewed or unintentionally? It made no difference?

Ms. CUTTER. There were about three or four of those cases where we concluded similar circumstances to Ms. Raddatz's testimony, where there was information that the doctor had indicated in medical records that the patient was completely unaware of. And, therefore, in those circumstances, rescission was withdrawn or other terms are transforming with that at the 10-4 coverage with the weight for a particular provision.

Mr. STUPAK. Let me ask you this. In your testimony, you said, "Our policy analysts also review the language contained in any applications used for individual health policies to make certain that there are no all-inclusive or have you ever or questions using medical terminology too complex for the average consumer to understand. No insurer may use an application without our stamped approval on that form." Is that correct?

Ms. CUTTER. Yes, sir, it is.

Mr. STUPAK. The binder right there, the red book right there, would you take a look at it in tab number 18? That is actually tab number 18 is actually AMBIEN's individual application kit. And if you go to page—I believe it is page—let me find it here—page 8, start with question, it looks like, 16 there on that form. It says, "In the last 5 years, have you had an illness, physical injury persisting or new physical and/or health problems not mentioned elsewhere in this application that you have not been evaluated for that you plan to have evaluated by a licensed health practitioner?"

It sounds like this sort of question is sort of an all-inclusive, "Have you ever?" type question.

Ms. CUTTER. Well, it is limited to a time element of 5 years looking back.

Mr. STUPAK. OK. So it is everything you had in 5 years.

Ms. CUTTER. Exactly. We don't like questions that say, "Have you ever?" just as you had stated.

Mr. STUPAK. OK. So you don't like that question, but they do have that in there, right?

Ms. CUTTER. Well, giving a time limit that we will allow them to say, "In the last 5 years, has anything else happened to you that hasn't been previously asked?"

Mr. STUPAK. So if you ever had a common cold, you should put that down, too, in the last 5 years? I am not trying to be flippant, but—

Ms. CUTTER. No. I totally understand.

Mr. STUPAK. OK. Well, then, another question—and here is where I am on page 16 because you have got to help me out with this one.

Ms. CUTTER. On page 16?

Mr. STUPAK. I am sorry. Question 16 on page 8.

Ms. CUTTER. All right.

Mr. STUPAK. “Within 5 years, have you ever been diagnosed with or treated for any of the following?” and “Kelosi’s enditis, Oucher’s disease, pneumocystic carinii pneumonia, and sploridia”? What are those?

Ms. CUTTER. Those are diseases that if you had had a diagnosis for, you were going to know that disease.

Mr. STUPAK. Sure. Can you tell me what they are? I mean, I might have it and no one ever told me.

Ms. CUTTER. I can tell you what several of them are. I can’t tell you what every single one of them is.

Mr. STUPAK. Well, what is Kelosi’s enditis?

Ms. CUTTER. You would ask the one that I don’t know.

Mr. STUPAK. Well, you don’t even know what the common name of it is? Is it like tendinitis? I don’t know.

Ms. CUTTER. No. I think—

Mr. STUPAK. Do we know what—

Ms. CUTTER. I think it is much more serious than—

Mr. STUPAK. OK. How about Oucher’s disease? What is that?

Ms. CUTTER. I don’t know that one either. Hemophilia I know, muscular dystrophy, multiple sclerosis.

Mr. STUPAK. Oh, yes. Yes. I think we all know those.

Ms. CUTTER. Right, right.

Mr. STUPAK. But there are about six terms there I have no idea. But isn’t your job to weed these out to make sure it is a common understanding so we don’t make a misrepresentation on the application forms, we don’t get behind?

Ms. CUTTER. Absolutely it is our job and my—

Mr. STUPAK. Can you go back and look at this application and see if there is something we should do to improve upon it?

Ms. CUTTER. My point would be that those specific conditions that are listed are so unusual that you are not going to have one of those without a doctor having made a diagnosis about that particular condition because they are relatively serious conditions.

Mr. STUPAK. Sure. So you are saying because one of those words is on there, someone might have said that to me, I should know it, right? And I should know what the illness is?

Ms. CUTTER. I would say if you have been given a diagnosis by a physician for one of those conditions, you would be well-aware of that condition.

Mr. STUPAK. I see. OK. Do you support on rescission the Connecticut approach, which basically prohibits post-claims, underwriting? Companies must do their underwriting up front. Do you support that idea?

Ms. CUTTER. I would certainly entertain that idea. Our concern would be what kind of time line that would involve because I have to tell you very honestly that most physicians’ offices—and not that

I blame them for this—insurance papers are the last thing that they will deal with in a physician office.

Mr. STUPAK. Well, do you think it is fair you would be accepting, insurance companies accept, your premiums while they don't know if they are going to accept it or not? Shouldn't they have all of the information up front?

Ms. CUTTER. I think that there probably is a deeper level of information that could be collected up front. I would agree absolutely with that.

Mr. STUPAK. How about the fact that in Connecticut, the State insurance commissioner reviews all rescissions and makes a decision within 15 days? State Insurance Commission and the party have to make a decision within 15 days. Do you think that is fair?

Ms. CUTTER. We would be actually open to that sort of consideration.

Mr. STUPAK. OK. Is there an appeal process in Indiana? If I get rescinded, who do I appeal to?

Ms. CUTTER. The Department of Insurance. And we investigate the rescission circumstances and have the ability to work with the insurers to either overturn that rescission or make other arrangements for the policyholder to have coverage.

Mr. STUPAK. Mr. Sassi, you said that WellPoint has an appeal process, right?

Mr. SASSI. Yes.

Mr. STUPAK. How come Ms. Reilling wasn't given an appeal process when you canceled her insurance?

Mr. SASSI. We do have an appeal process. Again, I am unfamiliar with the details in Ms. Reilling's case. Everyone covered under insurance has an appeal process and particularly for rescissions in the individual market. As I detailed in my testimony—

Mr. STUPAK. Right.

Mr. SASSI [continuing]. We have multiple levels of appeal process.

Mr. STUPAK. That is why I am confused. You canceled Ms. Reilling without any appeal process. The letter just says: You are out of luck. We will offer you something else, but we are not going to offer you that.

Mr. SASSI. Again, my understanding is Ms. Reilling was not covered under an individual insurance policy. She was covered under an employer group policy.

Mr. STUPAK. So if you are covered underneath a group policy, you don't get an appeal process?

Mr. SASSI. No. We do. All of our policyholders do have an appeal process, grievance and appeal.

Mr. STUPAK. Then she should have an appeal process, right?

Mr. SASSI. Absolutely.

Mr. STUPAK. Well, take a look at the binder there, number 23 right there. I don't see anywhere it says she has an appeal process. It says, "Thank you for considering us. We have been around for over 60 years. We have helped people in the community get coverage. We are writing to your application. We deny you. We will offer you something else."

Mr. SASSI. Well, I think—

Mr. STUPAK. "And if you have life insurance, you are denied also." But I don't see anywhere it says any kind of appeal process or anything.

Mr. SASSI. Well, I think this letter does not pertain to her losing eligibility in her group insurance policy. She would have an appeal process with her group policy. It looks like—and, again, this is the first time I am looking at this—that this is the declamation for individual insurance.

Mr. STUPAK. So you are saying that she would have gotten a letter that describes an appeal process when you denied her her coverage? Somewhere it would have said she would have gotten an appeal, "You have a right to an appeal"?

Mr. SASSI. Well, if she was covered under the association plan,——

Mr. STUPAK. Right.

Mr. SASSI [continuing]. As I understand——

Mr. STUPAK. Right.

Mr. SASSI [continuing]. The employer, I believe, was responsible for providing the appeal rights.

Mr. STUPAK. The Kentucky Federation of Business had to provide her her appeal rights. Why wouldn't you? You are the insurance company.

Mr. SASSI. Well, it is an employer plan. And appeal rights are covered in all of our member——

Mr. STUPAK. She is her own employer. She was an employer. So how would she tell herself to appeal?

Mr. SASSI. Again, she was a member of a larger group.

Mr. STUPAK. Kentucky Retail Federation and Better Business. So the federation had to tell her her appeal rights? How would they know your appeal rights? Wouldn't you know your appeal rights? Wouldn't your company know? You are expecting——

Mr. SASSI. All members have access to appeal rights. It is in the member certificates that we issue to members.

Mr. STUPAK. Let me ask you this, then. I mentioned section 162. That is the section in the pertinent part of the health care bill we are marking up in committee. When I say "marking up," we are amending it and altering it and maybe change it as it goes to the full floor of the U.S. House of Representatives for a vote.

Basically what the bill says is a health insurance insurer may rescind health insurance coverage only upon clear and convincing evidence of fraud. So would you agree with that, Mr. Sassi, that they can only rescind based on clear and convincing evidence of fraud?

Mr. SASSI. Well, when looking at the House bill——

Mr. STUPAK. Right.

Mr. SASSI [continuing]. That is before you today, looking at rescission in the context of eliminating medical underwriting, having a guarantee issue in the individual market, coupled with effective and enforceable personal coverage requirement, we do agree with the rescission statements that are in the bill.

On a stand-alone basis, that is taking pieces out of context, but we do agree with the premise. Coupled with elimination of that preliminary thing in an enforceable personal coverage requirement, yes, we would agree with what is in the bill.

Mr. STUPAK. Mr. Collins, do you agree with what is in the bill?

Mr. COLLINS. Well, sir, we would certainly agree in the context of health care reform agenda that the House is pursuing that includes enforceable mandate, subsidies for low-income people. It is important that the pool of people who are outside of coverage be as small as possible and that we get as many people covered as we can in order to make this work effectively because affordability is the primary barrier to access.

Mr. STUPAK. Right, but I am not asking about affordability. I am asking about health insurance insurers may rescind health insurance coverage only upon clear and convincing evidence of fraud. Would you agree with that?

Mr. COLLINS. Well, sir, I would agree with the overall context of health care reform, that that is a workable standard, yes, sir.

Mr. STUPAK. OK. Well, then the legislation has another provision that requires insurance companies to provide “the individual with notice of such proposed rescission and an opportunity for review by an independent external third party.” Do you agree with that?

Mr. COLLINS. Well, sir, there is a host of—most states have some sort of external third party review requirements in place today for claim review, for claims that are denied, and—

Mr. STUPAK. Well, this is for rescission. So would you agree that there should be—

Mr. COLLINS. Well, I am drawing an analogy, sir.

Mr. STUPAK. OK.

Mr. COLLINS. I think that those processes work fairly well for us.

Mr. STUPAK. So you have no problem with that, then?

Mr. COLLINS. Certainly in the context of reform, it would be a valuable service to the public, sir.

Mr. STUPAK. Mr. Sassi, do you agree it should be an independent third party review?

Mr. SASSI. In 2008, WellPoint already implemented an independent third party review. So we have no issue with this.

Mr. STUPAK. Why didn't Ms. Reilling get an independent third party review, then, if you had it in there as a company policy since 2008? She was denied here in this month, June.

Mr. SASSI. Again, Ms. Reilling was not covered under an individual insurance policy.

Mr. STUPAK. So only individuals have third party review. If I am a part of a group, don't I get third party review?

Mr. SASSI. Currently. That was a change we made to our rescission practices in the individual market.

Mr. STUPAK. So if you are a group, you are out of luck?

Mr. SASSI. You have other appeal rights.

Mr. STUPAK. OK. I have to go through my employer to find out what they are or does your company tell us what they are?

Mr. SASSI. We issue certificates of coverage that detail the benefits in each of our plans. And each of those certificates of coverage has appeal rights.

Mr. STUPAK. Professor, it sounds like we are playing semantics here. Are we in a way?

Ms. KINNEY. Well, I mean, different classifications do have meanings, but it does seem that the witness earlier that Ms. Reilling had appeal rights. They ought to have been fairly clearly expressed to her and accessible.

Mr. STUPAK. One of the things I have asked the Committee to do is have an amendment ready that not only do you have only rescission based on an intentional fraud and proven by clear and convincing evidence but also have an independent third party review but give it 30 days. Is that reasonable? Connecticut has 15 days.

I guess I am trying to stop this post writing after 30 days and also have an independent review done within 30 days because if you are waiting for your bone marrow transplant, you don't have a lot of time.

Ms. KINNEY. Well, you might have an expedited process for that kind of a review. For example, with Medicare appeals processes, they have an expedited process for appealing coverage decisions that are life-threatening ostensibly.

But here I think that the insurance industry should be able to investigate a policy, but they need to do it in my judgment in a shorter period of time and not be permitted for 2 years to engage in what is basically post-claim underwriting.

Now, I think what gets to us and however you address it but what seems offensive to many is the ability to go back and review a chart and review statements looking for some kind of factor that would give rise to a conclusion that there had been a known misrepresentation.

I think that that is the practice that we really need to go after and to clarify what is knowing. And also I thought maybe coming over this morning that you might put in some kind of requirement that a decision based on a review of medical record—if the insurance company has the medical record, they have it for 3 months, then they need to look at the medical record in that period of time and make a decision about whether that complies with the policy up front before even any claims were submitted.

Mr. STUPAK. Yes. It seemed like before they take your premium, they should give you some determination based upon the records, correct?

Ms. KINNEY. Right. I suppose that the rationale would be that if you then—you know, once you take a premium, you do have insurance and that that speeds up the process of getting insurance. And you might have a situation where you have a delay in coverage if you have too many requirements up front.

But, as I understand it, another aspect of the insurance industry, you can issue riders and temporary insurance to cover that time. It seems to me a problem that does have a solution.

Mr. STUPAK. Is it fair to say that at your Center for Law and Health or Health and Law, if you have a health insurance policy and you are terminated, is it fair to say it is very, very difficult to get insurance coverage?

Ms. KINNEY. I think that the testimony and the information that has been garnered in these hearings suggest that is the case. And certainly in our research we did years ago, which it is probably a little dated, but once you have been canceled, it is hard to get insurance.

Mr. STUPAK. All right. Let me just take a look at one more thing here. Mr. Sassi, you said that the first time you heard about Ms. Reilling's case was today. Will you commit that you will have the

company take a look at that and make sure that Ms. Reilling's rights were protected before you terminated that policy?

Mr. SASSI. Yes, sir.

Mr. STUPAK. OK. Well, I want to thank you all for coming. That is going to conclude our questioning today. I want to thank all of the witnesses for coming today and your testimony.

The Committee rules provide that members have 10 days to submit additional questions for the record. I will ask unanimous consent that contents of the document binder will be entered into the record provided the Committee staff may redact any information that has business propriety or relates to privacy concerns or is law enforcement-sensitive. Without objection, the documents will be entered into the record.

[The information appears at the conclusion of the hearing.]

Mr. STUPAK. That concludes the hearing of the Subcommittee. Thank you all for coming. Thank you for participating. And thank you for being good hosts here in Indiana.

[Whereupon, at 1:00 p.m., the foregoing matter was concluded.]

[Material submitted for inclusion in the record follows:]



July 27, 2009

**HEALTH INSURANCE CEOs REFUSE TO STOP
CANCELING INNOCENT POLICYHOLDERS**
Committee on Energy and Commerce

On June 16, 2009, the Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce held a hearing to receive testimony from CEOs of three of the largest insurance companies that offer individual health insurance plans, Assurant Health, WellPoint, Inc., and Golden Rule Insurance Company.

As part of a year-long investigation, the Committee examined more than 116,000 pages of documents showing that these companies retroactively terminated, or "rescinded," nearly 20,000 policies over the past five years based on omissions in applications that the companies identified only after the policyholders became ill. These rescissions resulted in savings to the companies of more than \$300 million.

The documents revealed numerous cases in which the companies rescinded policies for omissions that were based on health conditions completely unknown to the policyholders, unrelated to the illnesses being treated, unintentional, or caused by others, including the insurance companies' own agents.

When confronted with these examples, all three CEOs testified under oath that they would not stop rescinding innocent policyholders. Testimony also revealed that policyholders rescinded by one insurance company cannot obtain insurance from other insurance companies.

Insurance company CEOs refused to stop canceling health insurance coverage for innocent policyholders.

At the hearing on June 16, Rep. Bart Stupak (D-MI), Chairman of the Subcommittee, asked the CEOs to stop rescinding coverage for innocent policyholders, but all three refused:

Chairman Stupak: Would you commit today that your company will never rescind another policy unless there was intentional fraudulent misrepresentation in the application?

Don Hamm (CEO, Assurant Health): I would not commit to that. ...

Richard Collins (CEO, Golden Rule): No, sir. We follow the State laws and regulations and we would not stipulate to that. ...

John Sassi (CEO, Consumer Business, WellPoint): No, I can't commit to that.

Policyholders rescinded by one insurance company cannot obtain insurance from other companies.

Representative Greg Walden (R-OR), Ranking Republican Member of the Subcommittee, asked whether the CEOs deny coverage to innocent applicants who have been rescinded by other insurance companies without conducting any further inquiry or investigation to determine whether the original rescission was legitimate:

Rep. Walden: "Is it your company's policy to deny coverage to any applicant that discloses that he or she has had previous policies rescinded?" ...

Don Hamm (CEO, Assurant Health): "Yes, we would not provide coverage in that situation."

Rep. Walden: "So do you ever look to see ... the circumstances around another company's rescinding of a policy?"

Don Hamm: "Our underwriting guidelines are that we would not issue that policy."

The testimony from the CEOs elicited condemnation from both Democrats and Republicans on the Committee.

Rep. Henry A. Waxman (D-CA), Chairman of the full Committee on Energy and Commerce, stated that "the market for individual health insurance in the United States is fundamentally flawed."

And Rep. Joe Barton (R-TX), the Ranking Republican on the Committee, stated:

"I think I speak for every member of the Committee on both sides of the aisle ... that if in fact there is a practice of going in after the fact and canceling policies on technicalities, we have got to do whatever is possible to prevent that. ... [I]f a citizen acts in good faith, we should expect the insurance companies who take their money to act in good faith also."

For information on the Committee's investigation and video of the CEO testimony, see http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf.



July 27, 2009

**INSURANCE COMPANY CEO CANNOT EXPLAIN
HIS COMPANY'S OWN APPLICATION FORM**
Committee on Energy and Commerce

On June 16, 2009, the Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce held a hearing to receive testimony from CEOs of three of the largest insurance companies that offer individual health insurance plans, Assurant Health, WellPoint, Inc., and Golden Rule Insurance Company.

As part of a year-long investigation, the Committee examined more than 116,000 pages of documents showing that these companies retroactively terminated, or "rescinded," nearly 20,000 policies over the past five years based on omissions in applications that the companies identified only after the policyholders became ill. These rescissions resulted in savings to the companies of more than \$300 million.

The documents revealed numerous cases in which the companies rescinded policies for omissions that were based on health conditions completely unknown to the policyholders, unrelated to the illnesses being treated, unintentional, or caused by others, including the insurance companies' own agents. The insurance applications were often vague, confusing, and filled with medical jargon that most applicants do not understand.

In his testimony on June 16, the CEO of Assurant Health, Don Hamm, stated:

Assurant Health's enrollment questionnaires are written in simple, easy-to-understand, straight-forward language so that people can easily and accurately report their medical history.

When Chairman Bart Stupak asked Mr. Hamm to define some of the terms on his company's application, however, Mr. Hamm could not.

Chairman Stupak: [Y]ou said Assurant Health's enrollment questionnaires are simple, easy to understand, straightforward language, so people can easily and accurately report their medical history. So your question says, within the last 10 years, has any proposed insured had any diagnosis, received treatment for, or consulted with a physician concerning phlebitis, TIA, cystitis, lymphadenopathy, glandular disorder. So tell me, what is TIA?

Donn Hamm (CEO, Assurant Health): I am not aware...

Chairman Stupak: If you don't know what it is, how would anyone filling out your application know what it is? So there is grounds to deny them right there. You

don't even know what it is and neither do I. How about phlebitis or lymphadenopathy? How about lymphadenopathy? What is that?

Mr. Hamm: I don't know the answer to those questions.

Chairman Stupak: Do you sincerely believe that an average applicant would know what these words mean if you don't know and I don't know?

Mr. Hamm: Sir, I believe that is an application that is not currently used at this time. ...

Chairman Stupak: It is last year's application. ... Have you changed the application in the last year? ...

Mr. Hamm: I am not aware if we have changed that application.

Chairman Stupak: So far as you know, that is your current application?

Mr. Hamm: But I believe that our current application asks questions back to 5 years, so the 10-year might be different than what we issue today. ...

Chairman Stupak: Well, it is the same questions, TIA, right, that you don't know what it is. ...

Mr. Hamm: I do not know what that is.

For information on the Committee's investigation and video of the CEO testimony, see http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf.



July 27, 2009

**CASE STUDIES: Examples of Health Insurance
Companies Rescinding Individual Policies**
Committee on Energy and Commerce

As part of a year-long investigation into business practices in the individual health insurance market, the Committee examined more than 116,000 pages of documents from three of the country's largest health insurance carriers, Assurant Health, WellPoint Inc., and UnitedHealth Group. The investigation revealed that these companies retroactively terminated, or "rescinded," nearly 20,000 policies over the past five years based on omissions in applications that the companies identified only after the policyholders became ill. These rescissions resulted in savings to the companies of more than \$300 million.

The documents revealed numerous cases in which the companies rescinded policies for omissions that were based on health conditions completely unknown to the policyholders, unrelated to the illnesses being treated, unintentional, or caused by others, including the insurance companies' own agents. In some cases, companies rescinded not only individual policyholders, but their family members as well.

Examples of rescissions include the following:

- **Cancer Patient Cancelled for not Disclosing Diagnosis He Never Received (Indiana):** A WellPoint subsidiary in Indiana rescinded a policyholder's coverage in 2006 after he developed neck cancer related to a history of smoking. The company based the rescission on the policyholder's failure to disclose a history of Chronic Obstructive Pulmonary Disease (COPD), a disease the policyholder never knew he had. The policyholder's doctor informed WellPoint that he had never informed the patient of a COPD diagnosis. After the policyholder hired an attorney and threatened legal action against the company, WellPoint reinstated the policy in January 2007.
- **Policyholder Rescinded for Not Disclosing Undiagnosed Diabetes (Indiana):** In June, 2007, a WellPoint subsidiary rescinded an Indiana man's policy because he allegedly failed to disclose that he had "diabetes or hypoglycemia." The company launched an investigation after the policyholder sought nutritional counseling. The company reinstated the policy only after the policyholder appealed the rescission, explaining that he was first diagnosed with diabetes in March 2007, several months after he obtained coverage.
- **Agent Entered Applicant's Weight Incorrectly (Virginia):** In April 2007, a WellPoint subsidiary in Virginia rescinded coverage for a patient whose insurance agent entered his weight incorrectly on his application and failed to return it to him for

review. The company's Associate General Counsel warned that the agent's actions were "not acceptable" and recommended against rescission, but she was overruled and the company rescinded the policyholder's insurance.

- **Agent Advised Applicant Not to Disclose Hypertension/Diabetes (Texas):** A WellPoint subsidiary in Texas rescinded a woman's insurance after she was diagnosed with breast cancer. An insurance agent had advised her not to disclose a history of diabetes or hypertension because she wasn't being treated or taking medication for those conditions at the time she applied. The company's underwriter recommended honoring the policy, writing: "Recommend no retroaction [rescission]. Unable to prove intent of member. No response from agent to verify if this information was told to her." The underwriter was overruled, however, and the company rescinded the policy in April 2007.
- **Otto Raddatz Rescinded for Not Disclosing Conditions He Never Knew About (Illinois):** In 2004, Fortis Health, now known as Assurant, rescinded coverage for Otto Raddatz, a policyholder in Illinois. The company launched an investigation of Mr. Raddatz after he contracted lymphoma, and it terminated his coverage days before he was scheduled for a life-saving stem cell transplant. In the course of its investigation, the company located a CT scan taken five years earlier that identified silent gall stones and an asymptomatic abdominal aortic aneurysm. Mr. Raddatz's doctor never informed him of these conditions, and he never had symptoms or required treatment. The Illinois Attorney General's office intervened on Mr. Raddatz's behalf, repeatedly pressing the company to reinstate Mr. Raddatz's policy. Only after the persistent efforts of the Attorney General's office did the company reverse its decision.
- **Wittney Horton Rescinded for Failure to Disclose a Condition She Never Had (California):** A WellPoint subsidiary in California rescinded Wittney Horton's policy after a routine doctor's visit because she did not disclose having polycystic ovarian syndrome (PCOS). While reviewing the policyholder's medical records, the insurance company discovered doctors' notes that mentioned this condition. Despite letters from Ms. Horton's doctors confirming that they never diagnosed her with PCOS or informed her of this condition, WellPoint rescinded her policy in June 2005.
- **Company Refused Coverage for Lump in Breast Because of Osteoporosis (Texas):** A WellPoint subsidiary in Texas launched an investigation into the medical history of a policyholder who was diagnosed with a lump in her breast in November 2006. The company rescinded her policy and refused to pay for her medical treatment after concluding that she failed to disclose that she had been diagnosed previously with an unrelated condition of osteoporosis and bone density loss.
- **Company Refused Coverage for Depression Because of Skin Problems (Virginia):** In April 2007, a Virginia patient with a policy from WellPoint received treatment for

depression. After launching an investigation into the policyholder's medical history, the company concluded that the patient had failed to disclose a history of hemorrhoids and psoriasis (skin rash) and gave an inaccurate body weight. In May 2007, the company rescinded the policy and refused to pay for the patient's treatment for an unrelated condition of depression.

- **Heidi Bleazard Denied Coverage Because of Husband's Back Problem (Utah):**
After Heidi Bleazard was in a serious accident in August of 2005, Regence Blue Cross Blue Shield of Utah rescinded her entire family's health insurance. According to the company, the rescission was based on the alleged failure of Mrs. Bleazard's husband, Keith, to disclose a prior diagnosis of a herniated disk and back surgery. The Bleazards had fully informed the insurance agent about Mr. Bleazard's back problems when they applied for coverage, and the company paid claims for his medications and physician visits.
- **Entire Family Cancelled When Husband Failed to Disclose Conditions (Michigan):**
When a UnitedHealth subsidiary determined in 2007 that a policyholder in Michigan failed to disclose an abnormal blood count and other conditions, the company rescinded coverage not only for him, but also for his spouse and two children. According to internal company documents, when his spouse called to find out why coverage was canceled for the whole family, a company official "[c]alled her back told her coverage was voided to medical history not on app."
- **Entire Family Cancelled When Husband Failed to Disclose Conditions (Michigan):**
A Michigan policyholder obtained health insurance for himself and three dependents in November 2007 through the Golden Rule Insurance Company, a subsidiary of UnitedHealth. After filing a claim, the company launched an investigation that identified physician visits for hypertension and alcohol abuse that were not disclosed on the policyholder's initial application. The company rescinded coverage for the entire family in May 2008.
- **Robin Beaton Denied Surgery for Breast Cancer (Texas):** Less than a week before Robin Beaton was scheduled to have a mastectomy to treat breast cancer, her insurance company, Blue Cross and Blue Shield of Texas, rescinded her policy after an investigation that was triggered by a doctor's visit for acne. The company then concluded that she had failed to disclose a rapid heart beat that was resolved years before she applied. Only after Rep. Joe Barton intervened on her behalf did the company reinstate her insurance. By that time, however, her tumor had grown nearly five centimeters, and she was forced to undergo a double mastectomy and the removal of lymph nodes in one arm.
- **Dawn Hutchins Rescinded for Failing to Disclose Esophagus Condition (Illinois):** In July 2005, Fortis, now known as Assurant, rescinded coverage for Dawn Hutchins, asserting that she incorrectly answered a question about whether she had received treatment for "stomach or ulcer or ulcer symptoms." Although Ms. Hutchins had been treated for a condition known as Barrett's Esophagus, she

correctly answered the question "no" because this condition does not involve the stomach and is unrelated to ulcer disease. After repeated intervention by the Illinois Attorney General's Office, the company reinstated Ms. Hutchins's health insurance.

For more detailed information on these cases and the Committee's investigation, see http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

June 16, 2009

To: Members and Staff of the Subcommittee on Oversight and Investigations
Fr: Committee on Energy and Commerce Staff
Re: Supplemental Information Regarding the Individual Health Insurance Market

On Tuesday, June 16, 2009, at 10:00 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing on problems with the individual health insurance market, including the controversial practice of "post-claims underwriting" and the "rescission" of coverage after policyholders become ill. This memorandum provides supplemental information to assist members and staff.

EXECUTIVE SUMMARY

Last year, the House Committee on Oversight and Government Reform initiated an investigation into problems with the individual health insurance market. This year, the Energy and Commerce Committee, and its Subcommittee on Oversight and Investigations, continued that investigation. This memorandum presents the Committee's findings.

The Committee sent document requests to 50 state insurance commissioners and three health insurance companies that provide individual health insurance policies, Assurant Health, WellPoint, Inc., and UnitedHealth Group. The Committee obtained approximately 116,000 pages of documents and interviewed numerous policyholders who had their coverage terminated, or "rescinded," after they became ill.

The Committee's investigation demonstrates that the market for individual health insurance in the United States is fundamentally flawed.

In the United States, people who do not have health insurance through their employers and do not qualify for government programs such as Medicare or Medicaid must attempt to obtain coverage in the individual health insurance market. In most states, however, insurance

companies that sell policies to individuals are allowed to deny coverage based on preexisting health conditions, leaving a significant portion of the population uninsured.

The current regulatory framework governing this market is a haphazard collection of inconsistent state and federal laws. Protections for consumers and enforcement actions by regulators vary widely depending on where individuals live. The documents produced to the Committee indicate that insurance companies take advantage of these inconsistent laws to engage in a series of controversial practices.

For example, rather than reviewing medical histories when applications are submitted, some insurance companies award policies quickly to begin collecting premiums. If the policyholders subsequently get sick and file expensive claims, these insurance companies initiate investigations to scrutinize the details of the policyholder's application materials and medical records. If the insurance companies find discrepancies, omissions, or misrepresentations, they can retroactively cancel policies, return premiums, and refuse payment for medical services. This practice is known as "post-claims underwriting."

The documents produced to the Committee also include other examples of controversial practices, including the following:

- **Insurance companies rescind coverage even when discrepancies are unintentional or caused by others.** In one case reviewed by the Committee, a WellPoint subsidiary rescinded coverage for a patient in Virginia whose insurance agent entered his weight incorrectly on his application and failed to return it to him for review. The company's Associate General Counsel warned that the agent's actions were "not acceptable" and recommended against rescission, but she was overruled.
- **Insurance companies rescind coverage for conditions that are unknown to policyholders.** In 2004, Fortis Health, now known as Assurant, rescinded coverage for a policyholder with lymphoma, denying him chemotherapy and a life-saving stem cell transplant. The company located a CT scan taken five years earlier that identified silent gall stones and an asymptomatic abdominal aortic aneurysm, but the policyholder's doctor never informed him of these conditions. After direct intervention from the Illinois Attorney General's Office, the individual's policy was reinstated.
- **Insurance companies rescind coverage for discrepancies unrelated to the medical conditions for which patients seek medical care.** In November 2006, a Texas resident with a policy from WellPoint was diagnosed with a lump in her breast. The company initiated an investigation into the patient's medical history and concluded that she failed to disclose that she had been diagnosed previously with osteoporosis and bone density loss. The company rescinded her policy and refused to pay for medical care for the lump in her breast.
- **Insurance companies rescind coverage for family members who were not involved in misrepresentations.** When a UnitedHealth subsidiary determined in 2007 that a policyholder in Michigan failed to disclose his abnormal blood count and other

conditions, the company also rescinded coverage for his spouse and two children. When his spouse called to find out “[w]hy we dropped whole family instead of husband,” the company official “[c]alled her back told her coverage was voided to medical history not on app.”

- **Insurance companies automatically investigate medical histories for all policyholders with certain conditions.** WellPoint and Assurant informed the Committee that they automatically investigate the medical records of every policyholder with certain conditions, including leukemia, ovarian cancer, brain cancer, and even becoming pregnant with twins. UnitedHealth was unable to explain specifically how its investigations are triggered, claiming that it utilized a computer program so complex that no single individual in the company could explain it.
- **Insurance companies have evaluated employee performance based on the amount of money their employees saved the company through rescissions.** The Committee obtained an annual performance evaluation of the Director of Group Underwriting at WellPoint. Under “results achieved” for meeting financial “targets” and improving financial “stability,” the review stated that this official obtained “Retro savings of \$9,835,564” through rescissions. The official was awarded a perfect “5” for “exceptional performance.”

In written testimony for today’s hearing, all three insurance companies stated that the passage of comprehensive health care reform legislation, including a system where coverage is available to everyone and all Americans are required to participate, would eliminate the controversial practices of denying coverage based on preexisting conditions and rescinding policyholders for omissions in their medical records.

BACKGROUND

In 2008, the Committee on Oversight and Government Reform initiated an investigation into business practices in the individual health insurance market, including the practice of rescinding coverage after policyholders become ill. The Oversight Committee held a hearing on July 17, 2008, and heard testimony from policyholders, state regulators, a federal regulator, and the health insurance industry trade association.¹

Following the hearing, the Oversight Committee sent information requests to 50 state insurance regulators with primary responsibility for regulating the individual health insurance market. The Committee requested information about the size of the individual insurance market in each state, legal standards governing rescissions, and investigations relating to rescissions.²

¹ House Committee on Oversight and Government Reform, *Hearing on Business Practices in the Individual Health Insurance Market: Terminations of Coverage*, 110th Cong. (2008) (online at www.oversight.house.gov/story.asp?ID=2089).

² See, e.g., Letter from Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Ken Vines, Commissioner, Wyoming Department of Insurance (Oct. 9, 2008).

The Oversight Committee also sent letters to three insurance companies that sell individual policies: Assurant Health, WellPoint, Inc., and UnitedHealth Group. Each company issues individual policies through various corporate subsidiaries, such as John Alden Life Insurance Company and Time Insurance Company (Assurant), Anthem Blue Cross of California and UniCare (WellPoint), and Golden Rule Insurance Company and PacifiCare of California (UnitedHealth). The Oversight Committee requested information relating to company policies and practices for investigating policyholders and rescinding coverage.³

This investigation was transferred to the Committee on Energy and Commerce this year. In May 2009, the Subcommittee on Oversight and Investigations requested additional information from Assurant, WellPoint, and UnitedHealth, including underwriting guidelines and a sample of files regarding rescinded policies.⁴

The Committee received a total of approximately 116,000 pages of documents from the 50 state insurance regulators and the three companies. The Committee also spoke with numerous individuals who had their individual health insurance coverage rescinded, three of whom are testifying at today's hearing.

I. DENYING COVERAGE FOR PREEXISTING CONDITIONS

In the United States, there is generally no prohibition against health insurance companies denying coverage to individuals based on preexisting health conditions.⁵ In most states, people who apply for individual health insurance go through medical underwriting, a process by which companies attempt to determine whether applicants have preexisting conditions and can be excluded from coverage.⁶ Individuals complete application forms with information about their medical histories and any health conditions existing at the time of the application, and they make their medical records available for insurance companies to review.⁷

³ See, e.g., Letter from Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Robert Pollock, President and CEO, Assurant Health (Oct. 10, 2008).

⁴ See, e.g., Letter from Rep. Henry A. Waxman, Chairman, House Committee on Energy and Commerce, and Rep. Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, to Robert Pollock, President and CEO, Assurant Health (May 22, 2009).

⁵ Families USA Foundation, *Failing Grades: State Consumer Protections in the Individual Insurance Market* (June 2008).

⁶ *Id.* (noting that in Maine, Massachusetts, New Jersey, New York, and Vermont, insurance companies participating in the individual market must offer all policies to all applicants, regardless of health status).

⁷ Congressional Research Service, *Health Insurance: A Primer* (Report No. RL32237) (updated Mar. 17, 2009).

Based on this process, insurance companies assess risk and decide whether to place limits on coverage or reject coverage altogether. As a result, people who do not have insurance through their employers and do not qualify for government programs such as Medicare or Medicaid are left with few options if they have an illness when they seek insurance in the individual market. In written testimony for today's hearing, Professor Karen Pollitz of Georgetown University's Health Policy Institute explains why this system is problematic:

Particularly in this economy, as layoffs sever access to job-based health coverage, people need desperately to find secure, affordable coverage on their own. The individual market is the place where they turn, but too often this market fails to deliver adequate, affordable, and secure health coverage. In most states individual health insurance is medically underwritten, which means eligibility based on health status. Even slight health problems can trigger denial of an application.⁸

Rather than reviewing individual medical histories at the time applications are submitted, some insurance companies award policies quickly to begin collecting premiums. If the policyholders subsequently get sick and file expensive claims, these insurance companies initiate investigations to scrutinize the details of the original application materials and medical records in order to find discrepancies, omissions, or misrepresentations. This practice is known as "post-claims underwriting."

Based on the results of post-claim investigations, insurance companies may rescind coverage, retroactively cancel policies, return premiums, and refuse payment for medical services. Rescinding health insurance policies has implications not only for policyholders and their families, but also for physicians, hospitals, and other health care providers that seek reimbursement for their services. A Mississippi court described why this practice is controversial:

An insurer has an obligation to its insured to do its underwriting at the time a policy application is made, not after a claim is filed. It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is not insured, and, therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs. ... If the insured is not an acceptable risk, the application should [be] denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury.⁹

⁸ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Karen Pollitz, Research Professor, Health Policy Institute, Georgetown University, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

⁹ *Lewis v. Equity Nat. Life Ins. Co.* (Miss. 1994) 637 So. 2d 183, 188-189, cited in *Hailey v. California Physicians' Services (dba Blue Shield California)* 158 Cal.App.4th 452, 465 (2007) (emphasis in original).

II. DISPARATE REGULATORY FRAMEWORK

The current regulatory framework governing the individual health insurance market is a haphazard collection of inconsistent state and federal laws. Protections for consumers and enforcement actions by regulators vary widely depending on where individuals live.

In October 2008, the Oversight Committee requested information from 50 state insurance regulators about the size of the individual insurance market in each state, legal standards governing rescissions, and investigations relating to rescissions.¹⁰ Most states were unable to answer basic questions about rescissions and the individual health insurance markets in their states. For example:

- Only four states, Hawaii, Kansas, Texas, and Washington, were able to provide the total number of rescissions that occurred within their jurisdictions.
- Only ten states were able to provide the number of individual health insurance policies in effect in their jurisdictions.
- Over one-third of state commissioners were unable to supply a complete list of the companies within their jurisdictions that offer individual health insurance policies.

One significant area of confusion and dispute is whether insurance companies are legally permitted to rescind coverage without demonstrating that policyholders intentionally misrepresented health information. At the federal level, the Health Insurance Portability and Accountability Act prohibits insurance companies that offer products in the individual health insurance market from rescinding or otherwise discontinuing coverage unless there has been fraud or intentional misrepresentation of a material fact by the applicant or policyholder. The Act states:

[A] health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.¹¹

The Act creates an exception when “the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.”¹² During an appearance before the Oversight Committee on July 17, 2008, Abby Block, Director of the Center for Drug and Health Plan Choice at the Centers for Medicare and

¹⁰ See, e.g., Letter from Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Ken Vines, Commissioner, Wyoming Department of Insurance (Oct. 9, 2008).

¹¹ Section 2742 of the Public Health Service Act, 42 U.S.C. 300gg-42.

¹² *Id.*

Medicaid Services, testified that the Act provides a right to “guaranteed renewability” unless a policyholder “acted fraudulently or made an intentional misrepresentation of material fact.”¹³

Insurance companies do not necessarily follow this law, however, when they are operating in states that do not require proof of intentional or fraudulent activity. According to responses to the Committee’s 50-state survey, the majority of states do not require a showing of fraud or intent before insurance companies may rescind coverage. In these states, insurance companies may rescind policies based on any material misrepresentations, even if accidental or unintentional.¹⁴

The three insurance companies appearing at today’s hearing have informed the Committee that they do not believe they are required to demonstrate intentional or fraudulent activity by policyholders before rescinding coverage unless state law expressly requires it. For example, WellPoint stated that it “follows each state’s statutes and applicable case law as its standard for rescission.”¹⁵

III. SPECIFIC EXAMPLES OF ABUSE

The three insurance companies testifying at today’s hearing reported to the Committee that they rescinded at least 19,776 policies from 2003 to 2007.¹⁶ This number significantly undercounts the total number of rescissions because one company, UnitedHealth, failed to provide data for 2003 and 2004, and another company, WellPoint, did not provide data from all of its subsidiaries.

¹³ House Committee on Oversight and Government Reform, Testimony of Abby L. Block, Director, Center for Drug and Health Plan Choice, Centers for Medicare & Medicaid Services, *Rescission of Individual Health Insurance Policies*, 110th Cong. (July 17, 2009).

¹⁴ Examples of states that do not require a showing of fraud or intent include Alabama, Arkansas, Indiana, Michigan, and North Carolina. Several other states require intent, but only after a certain number of years have elapsed. Examples include Alabama, Florida, Illinois, Kansas, Maryland, Mississippi, Nebraska, North Carolina, Oklahoma, Oregon, South Dakota, Virginia, and West Virginia.

¹⁵ Letter from Stephen J. Northrup, Vice President, Federal Affairs, WellPoint Inc., to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Nov. 5, 2008).

¹⁶ Letter from Stephen J. Northrup, Vice President, Federal Affairs, WellPoint, Inc., to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, Ex. A (Nov. 17, 2008) (WLP01-3) (attaching a table reporting 9,524 rescissions for its Blue-branded and Unicare-branded subsidiaries); Letter from Jennifer Kopps-Wagner, Senior Vice President, General Counsel, Assurant Health, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Dec. 31, 2008) (AH000219-226) (attaching a table reporting 8,520 rescissions for its Time and John Alden subsidiaries); Letter from K. Lee Blalack, Counsel to United HealthGroup, to Rep. Henry A. Waxman, Chairman, House Committee on Energy and Commerce (May 19, 2009) (UHG00214) (attaching a table reporting 1,732 rescissions for its Golden Rule subsidiary).

The three companies also reported saving more than \$300 million as a result of rescissions during this five year period. The specific amounts reported by the companies were:

WellPoint:	\$128.9 million
Assurant:	\$151.6 million
UnitedHealth:	\$18.7 million ¹⁷

According to documents provided by the companies, as well as first-hand accounts from individuals who obtained individual health insurance, it appears that insurance companies have taken advantage of the haphazard regulatory framework by engaging in a series of controversial practices involving rescissions.

A. Rescinding Coverage for Unintentional Discrepancies

Documents produced to the Committee indicate that insurance companies rescind coverage even when omissions or discrepancies are unintentional or caused by others.

In one case reviewed by the Committee, a subsidiary of WellPoint, Anthem Blue Cross and Blue Shield, rescinded coverage for a patient in Virginia whose agent apparently entered his weight incorrectly on his application. According to the case file, the insurance company launched an investigation of the policyholder after he filed a claim for surgery in May 2006. During this investigation, the insurance company discovered that the patient's weight at the time of surgery was listed as 310 pounds, while his weight listed on the application was 215 pounds.

In response to a letter from the company asking him to explain this discrepancy, the patient wrote back that "there was clearly a typo" and that the insurance agent "took care of filling out the on-line application for me."¹⁸

An internal company document obtained by the Committee appears to support this assertion. A chronology of the steps taken during this investigation notes that on March 9, 2007, the company's investigator confirmed that the agent entered the application information. The document states: "Spoke to agent ... no written app[lication] – he took information over the phone."¹⁹

¹⁷ Letter from Stephen J. Northrup, Vice President, Federal Affairs, WellPoint, Inc., to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Dec. 23, 2008); Letter from Jennifer Kopps-Wagner, Senior Vice President, General Counsel, Assurant Health, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Dec. 31, 2008); Letter from K. Lee Blalack, Counsel to United HealthGroup, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Dec. 3, 2008). These amounts do not include the value of future medical costs the companies avoided by rescinding coverage.

¹⁸ Letter from Policyholder to Anthem Blue Cross and Blue Shield (Feb. 1, 2007).

¹⁹ Investigator Chronology Notes, Anthem Blue Cross and Blue Shield (undated) (WLP0007531).

Less than a week later, however, on March 15, 2007, the company formally rescinded coverage, writing to the patient: "Had we known of your true build, coverage would have been declined."²⁰

During a subsequent review, company employees warned that this rescission was improper because the agent never returned the application for the patient to review. On April 6, 2007, the company's Underwriting Manager e-mailed several other officials regarding the agent's actions. She wrote: "we need to know if he mailed a copy of the application to the applicant with the letter stating if anything is incorrect to let us know."²¹

Later that day, another company official e-mailed her response: "In my notes, I have that since he said he took the application over the phone, he did not send anything to the member."²² The Associate General Counsel then asked: "So he submitted electronically ... and never sent a copy of the application to the applicant for review? Am I understanding this correctly?"²³ The Underwriting Manager replied: "Yes you are correct."²⁴

On April 24, 2007, the Associate General Counsel e-mailed the Underwriting Manager, stating: "If the agent did not send the app[lication] then we can't rescind. I need the [sic] get the agent's name so he can be contacted. His actions are not acceptable!"²⁵ Later that day, the Underwriting Manager agreed and directed another official to "pull the file and reverse any decisions that may have been made on this account."²⁶

Despite these internal warnings and the advice of the company's Associate General Counsel, the company upheld the rescission the next day. On April 25, 2008, a company official sent an e-mail informing the Underwriting Manager of this determination. She wrote: "As

²⁰ Letter from Anthem Blue Cross and Blue Shield to Policyholder (Mar. 15, 2007).

²¹ E-mail from Underwriting Manager, Anthem Blue Cross and Blue Shield, to Official, Anthem Blue Cross and Blue Shield (Apr. 6, 2007).

²² E-mail from Official, Anthem Blue Cross and Blue Shield, to Underwriting Manager, Anthem Blue Cross and Blue Shield (Apr. 6, 2007).

²³ E-mail from Associate General Counsel, Anthem Blue Cross and Blue Shield, to Underwriting Manager, Anthem Blue Cross and Blue Shield (Apr. 19, 2007).

²⁴ E-mail from Underwriting Manager, Anthem Blue Cross and Blue Shield, to Associate General Counsel, Anthem Blue Cross and Blue Shield (Apr. 20, 2007).

²⁵ E-mail from Associate General Counsel, Anthem Blue Cross and Blue Shield, to Underwriting Manager, Anthem Blue Cross and Blue Shield, *et al.* (Apr. 24, 2007).

²⁶ E-mail from Underwriting Manager, Anthem Blue and Cross Blue Shield, to Official, Anthem Blue Cross Blue Shield, *et al.* (Apr. 24, 2007).

discussed in the ARC today, this member will remain rescinded.”²⁷ No documents in the case file produced to the Committee explain why the company insisted on rescinding this policy.

In another case reviewed by the Committee, a different subsidiary of WellPoint, UniCare, rescinded coverage for a woman in Texas who relied on her agent for advice on how to fill out the application. In July 2006, this policyholder was diagnosed with breast cancer. Her claim immediately triggered an investigation, and the company began a detailed review of her medical records. The investigation revealed notes from a health clinic visit in 2005 in which a doctor wrote that her medical history was “notable for diabetes and hypertension.”²⁸

When the policyholder applied for coverage in November 2005, she asked her agent whether she should list her conditions of diabetes and hypertension. Her agent advised her to mark “no” for these conditions because she had been controlling these conditions with diet and exercise and without medication at the time of the application.²⁹

On March 22, 2007, the primary underwriter reviewing her case recommended against rescinding her coverage, stating: “Recommend no retroaction [rescission]. Unable to prove intent of member. No response from agent to verify if this information was told to her.”³⁰ Despite this recommendation, and despite the fact that the policyholder’s breast cancer was completely unrelated to diabetes or hypertension, the company rescinded her coverage in April 2007.³¹

B. Rescinding Coverage for Unknown Conditions

Documents produced to the Committee indicate that insurance companies have rescinded coverage for conditions that are unknown to policyholders.

In August 2003, for example, Otto Raddatz obtained an individual insurance policy from Fortis Health, now known as Assurant. More than a year later, in September 2004, Mr. Raddatz was diagnosed with Stage IV Non-Hodgkin Lymphoma and immediately began chemotherapy in preparation for stem cell transplant.³²

Before Mr. Raddatz could receive the transplant, however, the insurance company launched a review of his medical file and notified him on April 15, 2005, that his coverage would be rescinded. The company claimed that Mr. Raddatz failed to disclose a CT scan five

²⁷ E-mail from Official, Anthem Blue Cross and Blue Shield, to Underwriting Manager, Anthem Blue Cross and Blue Shield (Apr. 25, 2007).

²⁸ Letter from UniCare to Policyholder (Apr. 2007).

²⁹ Committee Decision, Recommending No Retroaction, UniCare, WellPoint (Mar. 22, 2007) (WLP0021570).

³⁰ *Id.*

³¹ Letter from UniCare to Policyholder (Apr. 2007).

³² Letter from Otto Raddatz to Office of the Illinois Attorney General (Apr. 21, 2005).

years earlier that identified gall stones and an abdominal aortic aneurysm (weakening of the blood vessel wall).³³

On April 21, 2005, Mr. Raddatz sought assistance from the Illinois Attorney General's Office, writing to explain that he was never informed of these conditions. He stated:

I am being accused of falsely stating my health history. I fully disclosed my history to them. I have no knowledge of having gall stones or any blood clots. ... It is a matter of extreme urgency that I receive my transplant in 3 weeks. ... This is an urgent matter! Please help me so I can have my transplant as scheduled. Any delay could threaten my life.³⁴

On May 3, 2005, the Attorney General's office intervened and wrote to the company, stating:

Clearly, he did not know that he had an aneurysm until recently, when his policy with Fortis insurance was terminated as the result of post-medical underwriting following chemotherapy treatment.³⁵

As a result of this intervention, the company ultimately reversed its decision, and Mr. Raddatz was able to get his transplant, although after some delay. In written testimony for today's hearing, Mr. Raddatz's sister, Peggy Raddatz, states:

What the Fortis Insurance Company did was unethical. To deny a dying person necessary medical treatment based upon medical conditions a patient has never had knowledge of, never complained about, or never been treated for is cruel.³⁶

In another case, an individual who obtained a policy from WellPoint subsidiary Anthem Blue Cross and Blue Shield in Indiana in March 2006 was diagnosed with neck cancer related to a history of smoking. In response to this diagnosis, the company initiated a review of his medical records. On January 5, 2007, the company rescinded his policy, stating that he failed to disclose a previous diagnosis of Chronic Obstructive Pulmonary Disease (COPD).³⁷

³³ Letter from Senior Individual Medical Underwriter, Fortis Health, to Otto Raddatz (Apr. 15, 2005).

³⁴ Letter from Otto Raddatz to Office of the Illinois Attorney General (Apr. 21, 2005).

³⁵ Letter from Dr. Babs Waldman, Office of the Illinois Attorney General, to Fortis Health (May 3, 2005).

³⁶ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigation, Testimony of Peggy M. Raddatz, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

³⁷ Letter from Anthem Blue Cross and Blue Shield to Policyholder (Jan. 5, 2007).

On January 24, 2007, the policyholder's attorney wrote to the company explaining that no doctor ever informed the policyholder of this diagnosis. The letter explained: "He answered no because his physician ... never used ... COPD or chronic obstructive pulmonary disease when discussing his history."³⁸ The policyholder's doctor also wrote to the insurance company to explain that he had never informed the patient of this diagnosis. The individual's attorney relayed the doctor's account to the insurance company, writing:

I have enclosed a copy of a letter from Dr. [redacted] dated January 9, 2007 wherein he specifically indicates that he did not explain to [redacted] that he was describing COPD.³⁹

The company ultimately reversed this rescission and reinstated the policy on January 25, 2007.⁴⁰

In another case, Wittney Horton obtained insurance in 2005 through a WellPoint subsidiary, Blue Cross of California, after disclosing a common thyroid condition in her application. After Ms. Horton sent the company a bill for a routine doctor's visit with her endocrinologist several months later, the company launched a review of her medical records.

In June 2005, the company rescinded her coverage, stating that she failed to disclose that she had polycystic ovarian syndrome (PCOS) and had taken the drug Glucophage. According to Ms. Horton's written testimony for today's hearing, "This letter was the first time I ever heard about this condition."⁴¹

Although Ms. Horton's medical records contained a note from her physician regarding polycystic ovarian disease, she was never diagnosed with the disease or informed that she might have it. According to her written statement:

My doctor suspected I might have PCOS, wrote it down in her notes, then told me she was prescribing glucophage for weight management. I never knew what she wrote down in her notes because she never told me.⁴²

Ms. Horton's doctors also wrote letters to the company explaining that she was never diagnosed with polycystic ovarian syndrome.⁴³ Despite the information provided by Ms. Horton and her doctors, the company refused to overturn the rescission. Ms. Horton is now the lead

³⁸ Letter from Douglas E. Ulmer, Attorney, to Anthem Blue Cross and Blue Shield (Jan. 24, 2007).

³⁹ *Id.*

⁴⁰ Investigator Notes, WellPoint, Inc. (undated) (WLP0010307).

⁴¹ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Wittney Horton, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 15, 2009).

⁴² *Id.*

⁴³ *Id.*

plaintiff in a class action lawsuit against Blue Cross of California regarding insurance rescissions.

C. Rescinding Coverage for Unrelated Discrepancies

Documents produced to the Committee indicate that insurance companies rescind coverage for application discrepancies that are entirely unrelated to the medical conditions for which patients seek medical care. When policyholders submit claims for significant medical conditions, some insurance companies conduct investigations, identify alleged failures to disclose completely different medical conditions, and rescind policies on that basis.

In April 2007, for example, a Virginia patient with a health insurance policy from WellPoint received treatment for depression. After launching an investigation of the policyholder's medical history, the company concluded that the patient had failed to disclose a history of hemorrhoids and psoriasis (severe skin rash) and gave an inaccurate body weight. In May 2007, the company rescinded the policy and refused to pay for the patient's treatment for depression.⁴⁴

In November 2006, a Texas resident who had a policy with Wellpoint received treatment relating to a diagnosis of a lump in her breast. The company initiated an investigation into the patient's medical history and concluded that she failed to disclose that she had been diagnosed previously with osteoporosis and bone density loss. On March 29, 2007, the company rescinded her policy and refused to pay for medical care for the lump in her breast.⁴⁵

Other cases discussed in this memorandum are also examples of rescissions based on discrepancies that are completely unrelated to the medical conditions that triggered the investigations. The following chart lists several examples.

Rescission Date	State	Company	Condition Triggering Investigation	Formal Basis for Rescission
April 15, 2005	Illinois	Assurant (Fortis)	Non-Hodgkin's Lymphoma	Gall Stones/Aneurysm
January 17, 2006	Utah	Regence Blue Cross	Bike Accident/ Neck and Back Fracture	Spouse's Back Surgery
March 22, 2007	Texas	WellPoint (UniCare)	Breast Cancer	Diabetes/Hypertension

⁴⁴ Committee Decision to Rescind, WellPoint, Inc. (May 2007) (WLP0014310); Letter from WellPoint, Inc. to Policyholder (Apr. 2007).

⁴⁵ Committee Decision, Recommendation to Rescind, UniCare, WellPoint, Inc. (Mar. 22, 2007) (WLP0027086).

D. Rescinding Coverage for Family Members

Documents and testimony provided to the Committee demonstrate that some insurance companies rescind health insurance coverage for family members of policyholders, even if they were not involved in any omissions or misrepresentations.

One case involved Heidi and Keith Bleazard, who obtained a family health insurance policy from Regence Blue Cross Blue Shield of Utah in February 2005. According to Mrs. Bleazard's testimony to Congress in 2008, she was involved in a serious accident in August 2005, suffering several fractures in her neck and spine and incurring hospital bills of more than \$100,000.⁴⁶

The company launched an investigation and rescinded coverage for both Mr. and Mrs. Bleazard. According to the company, the rescission was based on Mr. Bleazard's failure to disclose a prior diagnosis of a herniated disk and back surgery. These conditions were all presented when the Bleazards applied for coverage, and the company paid claims for Keith's back medications and physician visits. As Ms. Bleazard testified:

Regence did not try to talk to either me or our agents before they rescinded the policy. If they had, we would have told Regence that our agent and the nurse knew all of Keith's medical history. ... We had no intention of misleading Regence to any degree on our application.⁴⁷

In another case, an individual obtained health insurance for himself and three dependents in November 2007 through UnitedHealth subsidiary Golden Rule Insurance Company.⁴⁸ On April 18, 2008, the company notified the policyholder that he was being investigated.⁴⁹ The investigation uncovered physician visits in 2006 and 2007 for hypertension and alcohol abuse that were not disclosed on his initial application. In a letter dated May 2, 2008, the company rescinded coverage for his entire family.⁵⁰

⁴⁶ House Committee on Oversight and Government Reform, Testimony of Heidi Bleazard, *Hearing on Business Practices in the Individual Health Insurance Market: Terminations of Coverage*, 110th Cong. (July 17, 2008).

⁴⁷ *Id.*

⁴⁸ Application for Short Term Medical Insurance, Golden Rule Insurance Company, UnitedHealth (File Number 07177886) (Nov. 26, 2007) (UHG23949-23950).

⁴⁹ Letter from Golden Rule Insurance Company, UnitedHealth, to Policyholder (File Number 07177886) (Apr. 18, 2008) (UHG23957).

⁵⁰ Letter from Golden Rule Insurance Company, UnitedHealth, to Policyholder (File Number 07177886) (May 2, 2008) (UHG23903-23905).

In another case involving Golden Rule, an individual in Michigan applied for a policy for himself, a spouse, and two dependent children on January 31, 2007.⁵¹ The company rescinded his policy on August 21, 2007, for failing to disclose abnormal blood count, chronic obstructive pulmonary disease, and other conditions.⁵² In addition to rescinding the individual's coverage, however, the company also rescinded coverage for his family members. A company telephone log produced to the Committee indicates that the spouse called the company on August 29, 2007, to ask why the entire family lost coverage. The log states:

Why we dropped whole family instead of husband. ... Insured called back in wanting to know why this was rec[ind]ed for the whole family. ... Called her back told her coverage was voided to medical history not on app.⁵³

E. Investigating All Cases of Certain Conditions

Documents produced to the Committee demonstrate that insurance companies automatically investigate the medical histories of all policyholders with certain conditions or illnesses, including leukemia, ovarian cancer, brain cancer, and even becoming pregnant with twins. It does not appear that applicants are informed of this practice before insurance companies accept their applications.

On October 10, 2008, the Oversight Committee sent requests to three insurance companies, WellPoint, Assurant, and UnitedHealth Group, to explain when and how they launch investigations into the medical histories of policyholders in order to find discrepancies and potentially rescind coverage.⁵⁴

Two companies, WellPoint and Assurant, informed the Committee that they automatically initiate a claims review every time policyholders receive medical treatment for certain conditions. These reviews can lead to full-blown investigations of discrepancies between past medical records and information provided during the application process. Each company provided the Committee with a list of diagnostic codes they use to automatically trigger medical

⁵¹ Application for Insurance, Golden Rule Insurance Company, UnitedHealth (signed Jan. 31, 2007) (UHG25320-25331).

⁵² Letter from Claim Department, Golden Rule Insurance Company, UnitedHealth, to Policyholder (Aug. 21, 2007).

⁵³ Phone Call Records, Golden Rule Insurance Company, UnitedHealth (Aug. 30, 2007) (UHG25481).

⁵⁴ Letter from Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Robert B. Pollock, President and CEO, Assurant (Oct. 10, 2008); Letter from Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Stephen J. Hemsley, President and CEO, UnitedHealth Group (Oct. 10, 2008); Letter from Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform, to Angela F. Braly, President and CEO, WellPoint, Inc. (Oct. 10, 2008).

history investigations. These codes are based on the International Classification of Diseases (ICD) coding system.⁵⁵

WellPoint's list of automatic triggers includes more than 1,400 diagnosis codes, including breast tumors, cystic fibrosis, schizophrenia, bronchitis, asthma, chronic sinusitis, and rheumatoid arthritis.⁵⁶ Assurant's list contains more than 2,000 diagnosis codes that trigger an investigation, including leukemia, asymptomatic HIV, breast cancer, brain cancer, ovarian cancer, and schizophrenia.⁵⁷ The medical conditions on these lists range from very common diseases, such as diabetes or hypertension, to more rare conditions, such as Down syndrome.⁵⁸

UnitedHealth informed the Committee that its subsidiary, Golden Rule Insurance Company, has an electronic claims review process that determines which claims to refer for additional investigation. This automated process utilizes a number of variables, such as the diagnosis code, date of the claim, effective date of the policy, and type of treatment received.⁵⁹

On June 9, 2009, Committee staff conducted an interview of Michael Corne, the Vice President of Health Products, Marketing, Government, and Regulatory Affairs for Golden Rule. Mr. Corne asserted that the company maintains no single list of diagnoses that automatically trigger reviews.⁶⁰ Mr. Corne was unable to explain in detail the company's process for triggering investigations, but he did confirm that one variable considered is the cost of the treatment.⁶¹

⁵⁵ Centers for Disease Control and Prevention, *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* (online at www.cdc.gov/nchs/about/otheract/icd9/abtcd9.htm and www.cdc.gov/nchs/icd9.htm) (accessed June 10, 2009) (explaining that "the International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics").

⁵⁶ Individual Plans: Table of DX Subject to Retroaction Review, Blue Cross of California and BC Life & Health, WellPoint, Inc. (Sept. 12, 2006) (WLP00012.A001.A001-WLP00012.A003.A001) (used by WellPoint subsidiaries operating in California, Colorado, and Nevada).

⁵⁷ Letter from Mike McNamara, Counsel to Assurant Health, to Rep. Henry A. Waxman, Chairman, House Committee on Energy and Commerce (June 5, 2009) (attaching list of diagnosis codes) (AH1000001-4).

⁵⁸ *Id.* (both Assurant Health and WellPoint automatically investigate claims involving diabetes and hypertension, while Assurant investigates cases of Down syndrome).

⁵⁹ Letter from K. Lee Blalack, Counsel to UnitedHealth Group, to Rep. Henry A. Waxman, Chairman, House Committee on Oversight and Government Reform (Nov. 20, 2008).

⁶⁰ Interview of Michael Corne, Vice President of Health Products, Marketing, Government, and Regulatory Affairs, Golden Rule Insurance Company, by Staff, House Committee on Energy and Commerce (June 9, 2009).

⁶¹ *Id.*

F. Evaluating Employee Performance Based on Rescissions

Documents produced to the Committee indicate that at least one insurance company, WellPoint, has evaluated employee performance based on the amount of money its employees saved the company through retroactive rescissions of health insurance policies.

The Committee obtained an annual performance evaluation of the Director of Group Underwriting at WellPoint prepared on February 26, 2004. One objective this official was evaluated for was her ability to meet financial “targets” and improve financial “stability.” Under “results achieved,” the review stated that this official obtained “Retro savings of \$9,835,564,” indicating that she helped save the company nearly \$10 million through rescissions. For this objective, the official was awarded a perfect “5” for “exceptional performance.”⁶²

Similarly, the Committee also obtained a performance review for an Underwriting Supervisor at WellPoint prepared on January 29, 2004, presumably from within the same corporate unit as the Director of Group Underwriting. This performance review stated that the official “has achieved a high level of performance as evidenced by ... Retro savings of \$9,835,564.”⁶³

In written testimony for today’s hearing, Brian Sassi, the President and CEO of Consumer Business at WellPoint, stated that his company did not “provide a systematic ‘reward’ or job performance recognition for employees regarding rescissions.” He also stated that “rescission is about stopping fraud and material misrepresentations that contribute to spiraling health care costs.”⁶⁴

But WellPoint has been forced to reverse thousands of rescissions and pay millions of dollars for improperly terminating health insurance coverage in recent years. In July 2008, a subsidiary of WellPoint, Anthem Blue Cross, entered into a settlement with the California Department of Managed Health Care under which the company reversed 1,770 rescissions and paid a \$10 million fine.⁶⁵ This year, in February 2009, the company entered into an additional

⁶² 2003 Strategic Performance Management of [name redacted], Director, Group Underwriting, WellPoint, Inc. (Feb. 26, 2004).

⁶³ 2003 Strategic Performance Management of [name redacted], Underwriting Supervisor, WellPoint, Inc. (Jan. 29, 2004).

⁶⁴ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Brian Sassi, President and CEO of Consumer Business, WellPoint, Inc., *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

⁶⁵ California Department of Managed Health Care, *Press Release: DMHC Director Ehmes Issues Statement Regarding Settlement with Anthem Blue Cross to Offer Coverage to 1770 Formerly Rescinded Members* (July 17, 2008) (online at www.dmhc.ca.gov/library/reports/news/bcstatment.pdf).

settlement with the California Department of Insurance under which it reversed 2,300 more rescissions and paid an additional \$15 million penalty.⁶⁶

The practice does not appear to be an isolated incident. In 2008, a judge ruled that another health insurance company, Health Net, had rescinded a California woman undergoing chemotherapy in bad faith and awarded \$9 million in damages. It was revealed that Health Net paid bonuses in part based on meeting or exceeding annual targets for rescinding policies.⁶⁷

IV. CONCLUSION

In written testimony for today's hearing, all three insurance companies stated that the passage of comprehensive health care reform legislation would eliminate the controversial practices of denying coverage based on preexisting conditions, investigating policyholder medical records for omissions, and the rescission of coverage for policyholders.

Richard Collins, the CEO of UnitedHealth Group's subsidiary, Golden Rule Insurance Company, stated:

[O]ur country needs comprehensive health reform. ... Until comprehensive reform is achieved, we believe that the medical underwriting of individual policies will continue to be necessary. If these changes are instituted, most of the reasons for individual medical underwriting — as well as most of the reasons that individual policies are rescinded or terminated — would cease to exist.⁶⁸

Similarly, Brian Sassi, the President and CEO of Consumer Business at WellPoint, Inc., stated:

[T]he elimination of medical underwriting combined with an effective and enforceable personal coverage requirement ... would render the practice of rescission unnecessary.⁶⁹

⁶⁶ California Department of Insurance, *Press Release: Insurance Commissioner Steve Poizner Announces \$15 Million Settlement with Blue Cross Over Rescission Practices* (Feb. 11, 2009).

⁶⁷ *Health Net Ordered to Pay \$9 Million After Canceling Cancer Patient's Policy*, Los Angeles Times (Feb. 23, 2008).

⁶⁸ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Richard Collins, CEO, Golden Rule Insurance Company, UnitedHealth Group, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

⁶⁹ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Brian Sassi, President and CEO of Consumer Business, WellPoint, Inc., *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

Finally, Don Hamm, the President and CEO of Assurant Health, stated in his written testimony:

[W]e can achieve the goal we share — providing health care coverage for all Americans. ... If a system can be created where coverage is available to everyone and all Americans are required to participate — the process we are addressing today — rescission — becomes unnecessary.⁷⁰

Beginning next week, the Energy and Commerce Committee will take up comprehensive health care legislation that is intended to address some of the problems identified during this investigation.

⁷⁰ House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Testimony of Don Hamm, President and CEO, Assurant Health, *Hearing on Terminations of Individual Health Policies by Insurance Companies*, 111th Cong. (June 16, 2009).

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2827
Minority (202) 225-3641
July 22, 2009

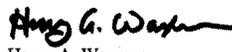
Ms. Angela F. Braly
President and Chief Executive Officer
WellPoint, Inc.
120 Monument Circle
Indianapolis, IN 46204

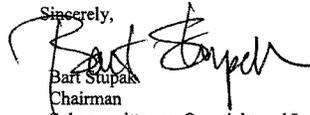
Dear Ms. Braly:

The Committee on Energy and Commerce and its Subcommittee on Oversight and Investigations are investigating business practices in the health insurance market. On May 22, 2009, we sent a letter requesting case files of policyholders who were rescinded by your company. In response, you provided the case files, but you redacted information that would identify the individuals whose policies were rescinded. Your counsel suggested that, due to patient privacy concerns, you would not voluntarily produce these identities unless compelled by the Committee through a subpoena.

Rather than issue a subpoena, we request that you send the attached letter to the four policyholders identified by your company as code numbers 59717, 60586, 60720, and 60853. As you can see, the letter simply requests that the policyholders contact the Committee, if they choose, to discuss their specific cases. We believe this approach will allow the Committee to obtain the information it requires without resorting to compulsory measures.

We ask that you send the attached letter, which was provided to you previously on July 20, by e-mail, facsimile, or overnight mail no later than Wednesday July 22, 2009. Please contact Michael Gordon of the Committee staff at (202) 226-2424 with any questions and to notify the Committee upon completion of this request.


Henry A. Waxman
Chairman

Sincerely,

Bart Stupak
Chairman
Subcommittee on Oversight and Investigations

Enclosure

cc: Joe Barton
Ranking Member

Greg Walden
Ranking Member
Subcommittee on Oversight and Investigations

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641
July 20, 2009

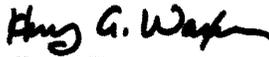
Dear current or former WellPoint policyholder:

The Committee on Energy and Commerce and its Subcommittee on Oversight and Investigations are investigating improper terminations of individual health insurance policies. On June 16, 2009, the Subcommittee held a hearing on this topic. Information regarding the hearing can be found at the Committee's web site, at http://energycommerce.house.gov/index.php?option=com_content&view=category&layout=blog&id=133&Itemid=73.

We have asked WellPoint to provide this letter to you. In connection with our investigation, the Committee obtained documents from WellPoint relating to insurance policies the company sought to rescind, including yours. To protect privacy interests, the files were produced to the Committee without names, addresses, or other information that would identify the policyholder.

We are writing to request the opportunity for Committee staff to speak to you regarding WellPoint's prior efforts to terminate your health insurance policy. If you are willing to assist the Committee, please contact Michael Gordon of the Committee staff at (202) 226-2424.

Sincerely,



Henry A. Waxman
Chairman



Bart Stupak
Chairman
Subcommittee on Oversight and
Investigations

Enclosure

cc: The Honorable Joe Barton
Ranking Member

The Honorable Greg Walden
Ranking Minority Member
Subcommittee on Oversight and
Investigations



120 Monument Circle
Indianapolis, IN 46204
Tel (202) 628-7840
Fax (202) 628-1096
stephen.northrup@wellpoint.com

Stephen J. Northrup
Vice President
Federal Affairs

July 22, 2009

The Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Bart Stupak
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Chairmen:

I have been asked to respond to your letter of today to Angela Braly, who is traveling on business and out of the office, requesting that WellPoint send letters on behalf of the Committee to certain current and former policyholders in Indiana. While we have made every effort to cooperate with your requests for information over the past several months, federal law prevents us from fulfilling the request you made today.

You asked that WellPoint send a letter to certain policyholders whose de-identified files WellPoint produced to the Committee earlier this year. The letter you have proposed would explain that there is an ongoing Committee inquiry and would invite the policyholders to call a Congressional staff member who works for the Committee. However, as WellPoint's outside counsel advised your staff by telephone yesterday, we are prohibited by the federal Health Insurance Portability and Accountability Act (HIPAA) from using our policyholders' protected health information (PHI) for this purpose.

The privacy regulations promulgated pursuant to HIPAA (HIPAA Privacy Rule) govern both the use and disclosure of PHI. The Committee is requesting a voluntary use of the policyholders' protected health information by WellPoint for a purpose that is not permitted by the HIPAA Privacy Rule. A policyholder's name, address and the fact that they are or were a WellPoint member are considered PHI because it is information created or received by the health plan; is related to the provision of health care to an individual or the past, present, or future payment for the provision of health care to an individual; and identifies an individual. See 45 C.F.R. s. 160.103. The use by WellPoint of the PHI for this mailing does not fall within any of the permitted uses under the HIPAA Privacy Rule. It cannot be considered a use for treatment, payment or health care operations of WellPoint and it does not fall within the health-oversight, public-health or required-by-law provisions as these terms are defined in the HIPAA Privacy Rule.

If you would like to discuss our response and the issues raised by this federal law, please have a member of your staff contact me at 202-628-7840.

Very sincerely yours,

A handwritten signature in black ink, appearing to read "S. Northrup".

Stephen J. Northrup
Vice President, Federal Affairs



MEMORANDUM

July 23, 2009

To: House Energy and Commerce Committee
 Attention: [REDACTED]

From: [REDACTED] Legislative Attorney

Subject: The HIPAA Privacy Rule and the Use or Disclosure of Protected Health Information For a Mailing

You have asked "[i]s there any law, regulation, or other provision in HIPAA or anywhere else that prohibits an insurance company from contacting its own current or former policyholders in order to provide them information from Congress?" As per your request, we have confined our answer to that specific question, and therefore are not considering or analyzing any other relevant issues.

In particular, you inquired as to whether an insurance company could send a letter about a congressional committee investigation to its former plan participants without violating the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You indicated that the Energy and Commerce Committee would not receive any identifying information about participants from the company. According to information that you subsequently provided to us, the insurance company claims the following provisions of HIPAA prevent the company from providing this letter to their policyholders: 45 CFR 164.502(a), 164.501, 164.104.

The company at issue clearly falls within the definition of a covered entity under 45 CFR 164.104(a)(1) because it is a health plan. Under 45 C.F.R. 164.502(a)(1)(i) of the HIPAA regulations, a covered entity is permitted to use or disclose an individual's protected health information (PHI) to the individual. Thus, the HIPAA Privacy Rule would seemingly permit the company to send the letter to its policyholders.¹

In addition, it should be noted that section 164.512(d) of the HIPAA Privacy Rule permits a covered entity to disclose protected health information to a health oversight agency for oversight activities authorized by law, including other activities necessary for appropriate oversight of the health care system. Under 45 C.F.R. 164.501, a health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, ... that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant." This provision has been relied on in other instances to facilitate disclosures of PHI to congressional committees for oversight purposes. For more information on congressional oversight in this area, see CRS report RL30240, Congressional Oversight Manual.

¹ We note that the HIPAA Privacy Rule does not require the company to send the letter.



Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

July 21, 2009

The Honorable Henry A. Waxman
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

The Honorable Bart Stupak
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Re: *H.R. 3200, Rescissions in the Individual Health Insurance Market.*

Dear Chairman Waxman and Chairman Stupak:

On October 31, 2008, the Illinois Department of Insurance (IDOI) submitted information in support of the Committee on Oversight and Government Reform's inquiry into the rescission practices of companies providing individual health insurance in Illinois. In light of your continued examination of the fundamental challenges, if not flaws, of the individual health insurance market, and due to the imperative for broader reforms as now contemplated, we offer this updated information and related comments. Please accept my congratulations and appreciation for your sustained effort on behalf of America's health insurance consumers.

"America's Affordable Health Choices Act of 2009" creatively addresses the most significant challenge for health insurance consumers in Illinois: health status as grounds for underwriting, pricing and coverage denial. While some argue that competitive forces should drive the private insurance market, the truth is that competition for profit will never cover those who are or may become injured or ill.

Rescission-related Complaints

As noted in my prior correspondence, IDOI received 383 rescission-related consumer complaints from 2003-2007. IDOI has since received and investigated fifty (50) complaints from consumers during 2008, and has already received an additional thirty-five (35) complaints in 2009.

The reason that IDOI does not receive more rescission-related complaints, despite Illinois' significant population, is that health insurers operating in Illinois can deny coverage to any individual for any reason that does not disproportionately impact a protected class of residents. Recently, a woman and her children, all in perfect physical health, were denied health insurance in the individual market because the mother informed the prospective insurer that she attended a group grief counseling session after the death of her husband.

100 West Randolph
Suite 9-301
Chicago, Illinois 60601-3395
(312) 814-9200
insurance.illinois.gov

IDOI experts thoroughly reviewed the 200 most recent rescission-related complaint files and identified characteristics and findings common to most.

- When underwriting an application for individual health insurance, for purposes of acceptance insurance companies rely on an applicant's self-reported answers to questions about her health status and health history. If a claim is submitted within the policy's initial two-year "contestability period," as allowed under Illinois law, the insurer will initiate an investigation of the applicant's medical history and a close examination of her responses to the health questions on the original application. A company may use even a minor, unintentional or unrelated discrepancy, or purported misrepresentation, as the basis for a policy rescission.
- Some health insurance applications appear constructed to mislead or entrap an applicant into providing incorrect or incomplete responses. The health portions of applications range from 5 broad questions to a list of 125 distinct disorders or conditions. Nearly all applications, however, include at least one question found to be ambiguous and potentially misleading. For example, one consumer's policy was rescinded in part because he responded that he had never "consulted with a physician or medical professional concerning alcohol abuse." Medical records produced by the company indicate that the man was "encouraged" by his physician, during the course of a routine physical examination, to reduce his alcohol intake. This, according to the company, qualified as a "consultation with a physician" concerning alcohol abuse and justified the policy rescission.
- In many cases, the alleged misrepresentation or omission relates to a diagnosis or condition that may not have been known by the policyholder. In one consumer complaint, for example, a woman's policy was rescinded when the company concluded she had failed to disclose an abnormal test result from several years prior. Further examination of the complainant's medical records, however, revealed that she was not notified of this abnormal result in person, but rather via a message left on her home answering machine. Without documentation to verify the content of the message, or that the complainant ever actually received it, the company agreed to reinstate the woman's policy.
- Many of the victims of rescission attributed the alleged incorrect or incomplete response to a miscommunication with, or intentional misrepresentation by, the insurance agent filling out the application. Although the individual applicant must sign the application and is ultimately responsible for its contents, many consumers trust insurance agents and defer to the agent's advice or judgment when deciding how to respond to health questions on an application.
- Forty-three (43) of the 468 rescission-related complaints filed with IDOI since 2003, or 9.2%, resulted in reinstatement of the rescinded policy. Some of the reversals took place only after persistent advocacy by IDOI staff, while others were more readily initiated by the company after new information was presented by the insured, the insured's provider, or the insurance agent.

Illinois' Legal Standard for Rescission

To rescind a health insurance policy in Illinois, a health insurer must show only that "the insured has withheld material information or answered material questions incorrectly on an application which would have resulted in the insurer, at the time of the original application: (1) denying coverage; (2) restricting the level of coverage as applied for; or (3) rating up the premium normally charged for the coverage as applied for" [50 Ill. Admin. Code 2005.40(d)]. The Illinois standard does not require a nexus between any alleged misrepresentation and the actual claim. Rather, current Illinois law vests the insurer with broad discretion and ability to rescind, or to engage in post-claim underwriting that results in the policyholder receiving less coverage than that for which she originally bargained. With such broad discretion, terms such as "withheld" or "answered material questions incorrectly" are subject to multiple interpretations, perhaps dependent upon the nature and cost of the policyholder claim.

Illinois law does not presently establish an evidentiary standard on which any rescission determination is to be based. For example, the insurer can retroactively apply the criteria on which a rescission must be based *and* that insurer can determine information was "withheld" simply based on a purportedly reasonable doubt, or ten percent (10%) of the information.

H.R. 3200 – Necessary Restraints on Rescission

With the passage of much-needed health insurance reform legislation, as proposed in the House Tri-Committee legislation known as "America's Affordable Health Choices Act of 2009," an individual's health status will not remain the shibboleth on which health care is offered. Indeed, when health status loses its current status as an insurer's priority consideration, rescissions should soon become a relic.

However, the Committee should anticipate that health care reform as contemplated in H.R. 3200 will incentivize more insurers, during the interim or transition period, to unload those individuals less likely to be profitable in a modernized health insurance marketplace. A higher legal standard for rescissions during the transition period, as proposed in Section 162 of H.R. 3200, will be necessary to ensure that abusive rescission practices do not increase at the expense or to the detriment of individual policyholders.

Section 162 includes three key elements: (1) fraud requirement; (2) evidentiary standard requiring "clear and convincing" evidence of fraud; and (3) independent, external review of proposed rescissions. Fraud is an appropriately high legal threshold because such a standard includes five essential elements (knowing misrepresentation of a material fact intended to induce reliance and that does induce reliance to the detriment of the insurer) that must be demonstrated by any insurer. In other words, a fraud standard demands a fact-based direct link between the alleged misrepresentation, the insurer's reliance, and the claim submitted.

Section 162 also eliminates the legal ambiguity regarding the evidentiary standard on which a rescission must be based. For example, in Illinois, as mentioned above, a rescission may be based on a "reasonable belief" supported by perhaps ten percent (10%) of the information. By imposing a standard requiring that the alleged fraud be proven by a "clear and convincing" evidentiary standard, the unilateral discretion of the insurer is restricted to facts relevant to the individual claim. Most importantly, the insurer cannot whimsically decide to deny a claim and rescind a policy simply based on an incomplete answer to a confusing question.

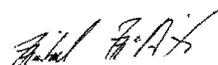
Finally, Section 162 subjects all rescission decisions to independent, external review. As a deterrent to insurers, and as a mechanism to impose accountability on insurers, such a process will enhance the

consumer protections needed to ensure individuals and families receive the health care for which premiums have been paid. While tedious and unduly stressful on individuals and families, independent, external review can aid consumers without the financial or personal resources needed to engage an attorney or other private advocate.

"America's Affordable Health Choices Act of 2009" represents a significant step toward modernizing the Illinois health insurance market. Section 162 of the Act, which imposes appropriate rescission protections during the period of transition to a new insurance marketplace, will appropriately restrain this pernicious industry practice and assure our families have access to essential health care.

Please do not hesitate to contact me if you have any questions or would like additional information.

Very truly yours,



Michael T. McRaith
Director

03/24/03

WELLPOINT

2003 Strategic Performance Management
Section 1

For period of: 03/24/03 to: 12/31/03

Name: [REDACTED]

Social Security Number: [REDACTED]

Job Title: Underwriting Supervisor

Salary Grade: 37

Prepared by: [REDACTED]

Director of Underwriting &
Prepared by Job Title: Individual Underwriting Policy

Date: January 29, 2004

RECEIVED
Mar 16 2004
HRD Central Filing

Page 1

2003 Objectives & Performance Assessment
Section 2

XXXXXXXXXXXX

Business/Behavioral Objectives. List Business/Behavioral Objectives. Manager enters weight for each objective ensuring total weight for all objectives equals 100%. At the end of the performance period, manager reviews 2003 Objectives & Performance Assessment, determines ratings for each objective, calculates the weight for each objective, then calculates the Overall Weighted Rating for Business/Behavioral Objectives. Space is provided for up to 15 objectives. Delete any unused row(s) using the directions at the bottom of this page.

No.	Objectives	Results Achieved	Rating (Number One to Five)	Weight (Number One to Hundred)	Weighted Rating (Press "E" key to calculate or recalculate if changes are made)
4.	Develop associate personnel to achieve desired levels of performance and leadership and increase member satisfaction.	<ul style="list-style-type: none"> effectively handles all the differing viewpoints within her IORT department. She has proven to be skilled in working through unresolvable demands. She has since developed a structure and department that is now her own. This team has achieved a high level of performance as evidenced by: <ul style="list-style-type: none"> Pro-ox claims savings of \$1,366,503 Retro savings of \$9,835,564 Reduction of claims inventory of 1280 down to 500. 	3	20	60.00
5.	Achieve budget goals regarding associate utilization and administrative costs.	<ul style="list-style-type: none"> has achieved budget goals by monitoring and reducing her FTE's, OT FTE's and office supplies. 	3	5	15.00

Delete unused rows: Highlight Row(s), On Menu, Click 'Edit' then Click 'Cut'

Page 3

2003 Strategic Performance Management
Part 1A

For period of: 01/01/03 to: 12/31/03

Name: [REDACTED]

Job Title: Director, Group Underwriting

Salary Grade: 41

Prepared by: [REDACTED]

Prepared by Job Title: General Manager, Individual Services

Date: 2/26/2004

2003 Business Objectives & Performance Assessment
Part 2A

No.	Objective	Metric	Weight (Number One to Hundred)	Results Achieved	Rating (Number One to Five)
1.	<p>Business Objectives: List Business Objectives and Metrics. Rater enters weight for each objective ensuring total weight for all objectives equals 100%. At the end of the performance period, Rater reviews Business Objectives & Performance Assessment, determines ratings for each objective, and then calculates the Overall Weighted Rating for Business Objectives. After entering Ratings and Weights, use the instructions below to calculate column totals and the Overall Weighted Rating for Business Objectives.</p> <p>Meet financial and enrollment targets</p> <ul style="list-style-type: none"> a) Maintain flat premium b) Evaluate and review underwriting guidelines, policies and procedures and workflows to meet operational metrics and maintain financial stability. c) Evaluate and refine underwriting audit process to improve quality and financial stability. 		20	<p>Reduced departmental premium from .7871 to .7480 while meeting/exceeding unit metrics.</p> <p>_____ has streamlined the Underwriting workflow and processes to maximize production, improve service levels, while improving accuracy as evidenced by a reduction in inventory from 14,000 to 3,900, improved turn around times from 10 days to 24 hours, decreased FTE count from 101 to 90 resulting in a savings of \$900,000; reduced medical records requests from 42% to 28%; instituted electronic submission and retrieval of medical records which improved service levels from 15 days to 8 days, while reducing costs by \$1,400,000.</p> <p>Enhanced process workflows, partnering with claims and MRU, enabling the QRT department to review 6039 claims that resulted in a Pre-Ex savings of \$1,366,303 and a Retro savings of \$9,835,564.</p>	5

WLP0007524
247M59798

0
9
/
2
0
0
7

[Redacted]
From: [Redacted]
Sent: Wednesday, April 25, 2007 12:14 PM
To: [Redacted]
Subject: RE: Speak now ltr

As discussed in the ARC today, this member will remain rescinded.

Thanks,

[Redacted] ltr

From: [Redacted]
Sent: Tuesday, April 24, 2007 10:51 AM
To: [Redacted]
Cc: [Redacted]
Subject: RE: Speak now ltr

[Redacted] please pull the file and reverse any decisions that may have been made on this account.

Thanks

[Redacted]
Underwriting Manager
KY0302-A625

From: [Redacted]
Sent: Tuesday, April 24, 2007 6:05 AM
To: [Redacted]
Cc: [Redacted]
Subject: RE: Speak now ltr

If the agent did not send the app then we can't rescind. I need the get the agent's name so he can be contacted. His actions are not acceptable!

From: [Redacted]
Sent: Monday, April 23, 2007 7:12 AM
To: [Redacted]
Subject: RE: Speak now ltr

broker

[Redacted]
Underwriting Manager
KY0302-A625

04/25/2007

10998

From: [REDACTED]
Sent: Friday, April 20, 2007 5:29 PM
To: [REDACTED]
Subject: RE: Speak now ltr

Captive or broker?

From: [REDACTED]
Sent: Friday, April 20, 2007 2:08 PM
To: [REDACTED]
Subject: RE: Speak now ltr

Yes you are correct

[REDACTED]
Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Thursday, April 19, 2007 4:12 PM
To: [REDACTED]
Subject: RE: Speak now ltr

So he submitted electronically with VS and never sent a copy of the application to the applicant to review? Am I understanding this correctly?

From: [REDACTED]
Sent: Friday, April 06, 2007 9:06 AM
To: [REDACTED]
Subject: FW: Speak now ltr

See below for further update

[REDACTED]
Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Friday, April 06, 2007 9:03 AM
To: [REDACTED]
Subject: RE: Speak now ltr

There is a note in the file dated 3/29/07 by [REDACTED] that says "Per [REDACTED] build is rescind either way- rescind per committee." The rescission was completed on 3/29/07, so should I still contact the agent? In my notes, I have that he said he since he took the application over the phone, he did not send anything to the member. I will try to get him to send me that in writing. I am sending him an email, I will copy you on it.

[REDACTED]

From: [REDACTED]
Sent: Friday, April 06, 2007 8:58 AM

04/25/2007

10999

To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Speak now ltr

Yes, and we need to know if he mailed a copy of the application to the applicant with the letter stating if anything is incorrect to let us know.

Underwriting Manager
[REDACTED]
KY0302-A625

From: [REDACTED]
Sent: Friday, April 06, 2007 8:33 AM
To: [REDACTED]
Subject: RE: Speak now ltr

The agent never sent me anything. When I contacted him and finally spoke to him, he stated he did not have a paper application, that this was taken over the phone. I asked him to send me an email stating that and have never received it. I had to call him several times to even speak with him about this. Should I try again?

From: [REDACTED]
Sent: Friday, April 06, 2007 8:10 AM
To: [REDACTED]
Subject: FW: Speak now ltr

See below. Can someone get me an update?

Underwriting Manager
[REDACTED]
KY0302-A625

From: [REDACTED]
Sent: Thursday, April 05, 2007 7:00 PM
To: [REDACTED]
Subject: RE: Speak now ltr

What happened with this one?

Associate General Counsel
Mail P.O. Box: KY0301-A806
Tel: [REDACTED]
Fax: [REDACTED]

From: [REDACTED]
Sent: Thursday, March 01, 2007 1:24 PM

04/25/2007

11000

To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Speak now ltr

I thought if the agent received a paper application they had to send us the paper application because we had to audit the paper against what was keyed. We need to go back to the agent and see if they have the paper application because we only have the on-line on Ultra.

[REDACTED]
Underwriting Manager
KY0302-Aezs

From: [REDACTED]
Sent: Thursday, March 01, 2007 1:06 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: Speak now ltr

Sarah,

In yesterday's committee meeting, a file was reviewed on [REDACTED] whose weight was put on the application as 215lbs on 4/8/06 and we have records stating his weight on 5/8/06 was 310lbs. His reply to the speak now letter came in yesterday afternoon and he thinks that the agent may have mis-keyed his weight off the original written application. The member states his build at the time of the application was 5'10" 275 lbs. It was decided yesterday to rescind this member due to build. My question is, should we still rescind him based on the information in the speak now letter?

Thanks,

[REDACTED]
Individual Underwriting
[REDACTED]

Confidentiality Statement:
This message, including attachments, is for the sole use of the intended recipients and may contain confidential and privileged information. Any unauthorized use, disclosure or distribution is prohibited. If you are not the recipient, please contact the sender by reply e-mail and destroy all copies of this message.

04/23/2007

11001

