

Thank you very much for that wonderful introduction, Jamie. Having you introduce me is honor enough.

And thank you all for inviting me to speak this morning and, especially, for honoring me with the Community Champion Award. It truly is an honor and one that, in my old job, I know I would never have been considered for, much less being chosen to receive it.

As you may know, I worked for CIGNA for nearly 15 years. What you probably don't know is that I was a part of the Legal & Public Affairs department and that my boss was a lawyer. And not just any lawyer, she was the General Counsel. I'm sure she was especially horrified to learn that I was turning whistleblower, but probably even more horrified to learn that I would be speaking to you all this morning.

It has now been just a little more than month since I changed the direction of my life by testifying before the Senate Commerce Committee.

To the chagrin of my former boss and others in the industry—who I know were hoping the media would quickly lose interest in what I have to say—I have not faded away. That's partly because I am now a citizen journalist—I was a traditional journalist in a former life—so I don't have to go through the mainstream media to get my message out, although both the mainstream media and the online media continue to be helpful.

I've lost count of the number of stories that have been written about me or quoted me. While the vast majority have been positive, I must tell you that my favorite story appeared in Talking Points Memo shortly after my Senate testimony. It was memorable not so much because of the story as the headline, which was: "How about some KY with your health insurance."

When I left my job as head of corporate communications for CIGNA, I never thought I'd find myself a few months later speaking out about an industry that I had steadfastly supported and defended for so many years.

I had a great career at CIGNA.

Over the many years I was there, I received promotions and made good money. I earned pay increases, bonuses and stock options. I had a house in the lush Main Line suburbs of Philadelphia. I drove nice cars. My children went to the best schools.

I had a good number of friends and colleagues at Cigna. And I still do.

Voluntarily giving up all of what made my lifestyle possible seemed unimaginable.

Looking back, I think my issue with being a spokesperson for the industry first began at a corporate leadership meeting I attended a few years ago. A proponent of consumer-directed plans—which I'll describe in a moment—was trying to explain their merits. During the Q&A session, it was clear that many in the audience were not buying what he was selling, or at least were not understanding why the average Joe would want to be in one of those plans.

Realizing he couldn't persuade them, he finally said, in obvious exasperation, "Look, you're just going to have to drink the Kool-Aid."

(Pause)

He really said that.

This is the kind of attitude people in the industry have had for years when trying to explain dubious concepts like consumer-directed plans. The truth is, people enrolled in these plans—which typically feature lower premiums than some other plans but much higher deductibles—usually have to pay a lot out of their own pockets before their coverage kicks in. They are good for insurers because they shift more of the financial burden away from them and onto the shoulders of patients.

Insurance executives like high-deductible plans because they think people in HMOs and PPOs don't have a sense of how expensive health really is and so they will use health care services more than they need to.

These executives believe that when people have more "skin in the game," as they call it, they will think twice before using health care. And when that happens, they believe total health care spending will decline.

In consumer-directed plans, that extra "skin" takes the form of higher copayments and coinsurance obligations.

As an industry spokesman, I would talk these plans up as the best thing since sliced bread... or at least the best thing that anyone had come up with lately to control health care costs.

Critics viewed these plans as a scheme by insurers and employers to shift more health care costs to consumers.

Over time I found the critics more credible than the people who created those plans...

... And the people--like myself--who defended them.

I worried then--and still do today--that these plans contribute to the growing problem of the underinsured.

Still, though I may have secretly hated my job and what I was becoming, I had gotten very used to my comfortable lifestyle.

Then, in July 2007, I made a trip to visit my folks in Tennessee, where I grew up. It was on that trip that I underwent a mental and emotional change so profound that I knew I'd have to find another way to earn a living.

At the start of my trip, I'd read a notice in the local newspaper that a group called Remote Area Medical (RAM) was organizing free medical and dental care at the Wise County, Va., Fairgrounds for people who couldn't afford to go to a doctor or dentist.

Wise County is in the heart of the Appalachian coal-mining region and just a few miles from my hometown of Kingsport, Tennessee.

The newspaper story said that doctors, nurses, dentists and other medical professionals would be volunteering their time over three days for those who needed care starting before dawn. I had some free time so I decided to check it out.

Nothing prepared me for what I saw.

Hundreds of people had waited in line all night to get through the fairground gates. People who could have been my relatives or my parents' neighbors. People I shared cultural roots with but who—for whatever reason—simply hadn't had the good fortune to land a high-paying job and a cushy office in a Philadelphia skyscraper.

Long lines of people waited to get to the animal stalls and makeshift tents where volunteer doctors were treating patients.

I still can't find the words to tell you how deeply that scene affected me. It was all I could do to hold back tears. I still can't talk or write about it without the risk of choking up.

The power of that experience returned a couple of weeks later as I was boarding one of my company's private Falcon jets to fly to a meeting in Connecticut.

You don't know what traveling in style means until you've flown on a Falcon. Here's how Dassault, the French company that makes the jets, describes the Falcon 900DX on its website:

"With one of the largest cabins in its class, it's obvious the Dassault engineers chose to build this able jet from the inside out. With 6 feet 2 inches of headroom and 33 feet 2 inches in cabin length, you can stretch, walk or talk at will.

"The cabin is divided into three separate seating areas to help you and your colleagues focus, relax and dine in more peace and quiet than you will ever find on the ground.

"Twenty-four panoramic windows shed natural light.

"A completely full-service galley equipped to prepare two hot meals, enables you and your colleagues to enjoy everything from hors d'oeuvres to aged port on custom china and stemware.

"Telephones, fax, SATCOM, data link, copier computer, video screens, television, custom executive desk and conference tables make every job easier."

As I was eating my hors d'oeuvres on gold-rimmed china with gold-plated forks—served to me, of course, by a flight attendant on the company payroll, my thoughts returned to the people in Wise County, especially those still in line when they finally closed the fairground gates because the volunteers had to go home.

That was the 8th annual RAM Expedition in Wise County, by the way. The 10th annual expedition was held there this past weekend. The lines were even longer this time, as you can imagine. And in two weeks, RAM will hold its first urban expedition in Los Angeles. Because the need is so great there, the expedition will stretch over eight days. One of the things I plan to do between now and then is to invite the President and members of Congress to join me there to witness it and maybe even to help register the tens of thousands of men, women and children who will gladly wait in line for hours and hours to spend a few minutes with a doctor or dentist.

Four months after my first visit to the Wise County Fairgrounds, the *New York Times Magazine* ran an eight-page photo essay of the event. The headline and subhead summed it up well: "Patients Without Borders. What do the uninsured in America do when they need health care? Some turn to a volunteer medical group that was set up to provide free services in third world countries."

That same month *Architectural Digest* ran a big feature with this headline: "Romancing the Stone. In the Hills of Eastern Pennsylvania Rises a Prototypical French Farmhouse".

The writer began the piece by describing a "timeworn stone market at the side of the winding driveway" that measures the distance from the

road to the house in kilometers, "the first of many clues" that the residence "takes its design cues, in countless ways, from the ancient stones of *la France profonde*."

The retired executive and his wife who built this 24-room mansion "wanted it to be a relatively small-scale-looking complex that didn't reveal itself in its full size until you were actually in the house."

The architect said he drew inspiration for the design of the compound from the farm buildings of rural France, "which he admires for the way they have a variety of scales and are assembled around one or two courtyards." He added that for "both relics and inspirations," he "turned to what the wife laughingly calls the 'architectural boneyards' of Europe."

When the architect came across an "allee of 17th-century Spanish columns" near Avignon, he said he told the couple, "Why don't we put these columns together and make a grandchildren's cottage?"

The writer described the kitchen as "impossibly French, with its long white-walnut winery sorting table, café chairs and distinctive hearth."

The story concluded with this: "Sitting at the long table, the wife recalls telling the architect at the start of the project that she wanted her home 'to be stalwart and safe-feeling.' Here, in the very heart of the house, it's clear how well (the architect) succeeded."

The writer didn't disclose the name of the retired executive or explain how he had made enough money to afford such a place. But it was common knowledge that he'd been chairman and CEO of one of the country's largest health insurance companies until his retirement in 2000.

His salary during his last year with the company was \$24 million, which doesn't include the millions he reaped from stock options or the enormous amount he had amassed in deferred compensation over the years.

It became clear to me, in ways it hadn't before, that the folks enrolled in his company's health plans had helped to build that 24-room

stone manse with its 17th-century Spanish columns and its impossibly French kitchen.

They paid for it with their premium payments.

And then came the case of Nataline Sarkisyan.

The doctors at UCLA told Nataline Sarkisyan that if she didn't have a liver transplant she would die.

CIGNA denied coverage for the transplant on the grounds that the transplant in her case was experimental.

Nataline was just 17, a few years younger than my own daughter. Her family turned to the media in Los Angeles for support, and to the California Nurses Association, which helped them stage a protest in front of CIGNA's California offices in Glendale.

It was just a few days before Christmas and the case attracted a lot of media attention. CNN was there to cover the protest live.

Back in Philadelphia, in corporate headquarters, on the 16th floor, my phone was ringing off the hook.

Reporters and TV producers in LA and elsewhere wanted to know if CIGNA was reconsidering its position.

After I told executive management about all the media interest in the case, the company decided to cover the transplant.

But because family members were on their way to the protest, the CIGNA case manager was not able to communicate the decision to the parents.

I called an employee at CIGNA's Glendale office and asked them to figure out a way to get the message to the family. I was watching the protest on live TV when a friend whispered in Nataline's mother's ear that CIGNA would pay for the transplant. They were joyous.

Unfortunately, the decision came too late.

Nataline died a few hours later. Being a parent, I couldn't imagine what the family was going through. Because of the tragic outcome, media attention intensified. Because I was the company spokesman, angry people from all over the country inundated me with hateful calls and emails.

Would Nataline have lived if CIGNA had approved coverage in the first place?

We'll never know, but I will always wonder.

Afterward, the family hired Mark Geragos, the famous LA lawyer, to bring suit against CIGNA.

But because Nataline's health care coverage was through a private employer that was protected by ERISA, he could not bring suit against CIGNA in state court. If he filed suit in federal court it would have been meaningless because remedies would have been limited to the value of the procedure. But since it didn't take place at all, the family would not have received anything even if they'd won.

If a patient has health coverage through a private employer, HMOs and health insurers face no financial consequences for mishandling claims. There is no accountability.

The Supreme Court decision in *Pilot Life Insurance v. Dedeaux* states that "state common law causes of action arising from the improper processing of a claim are preempted."

Under the Employee Retirement Income Security Act (ERISA) and the Pilot Life decision, lawsuits are removed to federal court where victims can only recover the cost of the procedure or service denied in the first place—no damages or penalties are allowed.

As a result, HMOs and insurers are largely free to deny access to care without fear of reprisal or financial consequences. Any health care overhaul should overturn Pilot Life and restore the reach of state common law.

The one-two punch of my visit to the fairgrounds and the case of Nataline Sarkisyan brought home the one fact I knew to be true: that health insurance companies are willing to confuse their customers and dump the sick to satisfy their Wall Street investors.

By the time I left my job as head of corporate communications at Cigna, it had become abundantly clear that the industry's charm offensive—which is the most visible part of duplicitous and well-financed PR and lobbying campaigns—could once again shape health care reform policy in a way that benefits Wall Street far more than average Americans.

In the 15 years since insurance companies killed the Clinton reform plan, the industry has consolidated to the point that it is now dominated by a cartel of large for-profit insurers.

The average family doesn't understand how Wall Street determines whether they will be offered coverage, whether they can keep it, and how much they'll be charged for it.

But in fact Wall Street plays a powerful role.

The top priority of for-profit companies is to drive up the value of their stock. Stocks fluctuate based on companies' quarterly reports, which are discussed every three months in conference calls with investors and analysts. On these calls, Wall Street investors and analysts look for two key figures: earnings per share and the medical-loss ratio, or medical-benefit ratio, as some in the industry now call it. That is the ratio between what the company actually pays out in claims and what it has left over to cover sales, marketing, underwriting and other administrative expenses and, of course, profits.

To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous three months than a year earlier and that the portion of the premium going to medical costs is falling.

To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick.

Insurers have several ways to cull the sick from their rolls. One is policy rescission. They look carefully to see if a sick policyholder may have omitted a minor illness, a pre-existing condition, when applying for coverage, and then they use that as justification to cancel the policy, even if the enrollee has never missed a premium payment.

Asked directly about this practice just a few weeks ago in the House Energy and Commerce Committee, executives of three of the nation's largest health insurers refused to end the practice of cancelling policies for sick enrollees. Why? Because dumping a small number of enrollees can have a big effect on the bottom line.

The Energy and Commerce Committee's investigation into just three insurers found that they canceled the coverage of roughly 20,000 people in a five-year period, allowing the companies to avoid paying \$300 million in claims.

Insurers also dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether--leaving workers uninsured.

This practice is known in the industry as purging.

The purging of less profitable accounts through intentionally unrealistic rate increases helps explain why the number of small businesses offering coverage to their employees has fallen from 61 percent to 38 percent since 1993, according to the National Small Business Association.

Once an insurer purges a business, there are often no other viable choices in the health insurance market because of rampant industry consolidation.

Purging through pricing games is not limited to letting go of an isolated number of unprofitable accounts. It is endemic in the

industry.

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

Unless required by state law, insurers often refuse to tell customers how much of their premiums are actually being paid out in claims. A Houston employer could not get that information until the Texas legislature passed a law a few years ago requiring insurers to disclose it.

That Houston employer discovered that its insurer was demanding a 22 percent rate increase in 2006 even though it had paid out only 9 percent of the employer's premium dollars for care the year before.

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

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

An estimated 25 million Americans are now underinsured for two principle reasons. First, the high deductible plans many of them have been forced to accept – like I was forced to accept at CIGNA – require them to pay more out of their own pockets for medical care, whether they can afford it or not.

In selling consumer-driven plans, insurers often try to persuade employers to go –full replacement, which means forcing all of their employees out of their current plans and into a consumer-driven plan.

At least two of the biggest insurers have done just that, to the dismay of many employees who would have preferred to stay in their HMOs and PPOs. Those options were abruptly taken away from them.

Secondly, the number of *underinsured* people has increased as more have fallen victim to deceptive marketing practices and bought what essentially is fake insurance.

The industry is insistent on being able to retain so-called —benefit design flexibility so they can continue to market these kinds of often worthless policies. The big insurers have spent millions of dollars acquiring companies that specialize in what they call —limited-benefit plans.

The lack of candor and transparency is not limited to sales and marketing. Notices that insurers are required to send to policyholders—those explanation-of-benefit documents that are supposed to explain how the insurance company calculated its payments to providers and how much is left for the policyholder to pay—are notoriously incomprehensible. Insurers know that policyholders are so baffled by those notices they usually just ignore them or throw them away.

And that's exactly the point. If they were more understandable, more consumers might realize that they are being ripped off.

Sen. Jay Rockefeller of West Virginia has introduced legislation that would require insurance companies to be more honest and transparent in how they communicate with consumers. This is an essential first step in holding insurance companies more accountable.

He also introduced the Consumers Choice Health Plan, which would create a strong public health insurance option as a benchmark in transparency and quality. The Senate Health, Education, Labor and Pensions Committee approved a similar bill just a few days ago.

Americans need and overwhelmingly support the option of obtaining coverage from a public plan.

But, as expected, the insurance industry and its backers are using fear

tactics, as they did in 1994, to tar a transparent, publicly accountable health care option as a "government takeover" of our health care system.

As I told Sen. Rockefeller's Senate Commerce Committee last month, and as I have been trying to communicate through my blog and in media interviews ever since, what we have today is a Wall Street-run health care system. Calling it a system is actually being too charitable. What we have is a Wall-Street run non-system that has proven itself an untrustworthy partner to its customers, to the doctors and hospitals who deliver care, and to the state and federal governments that attempt to regulate it.

The health insurance industry is particularly untrustworthy, and in our current system it is becoming increasingly accountable only to Wall Street.

In closing, I would like to thank you for the essential work you do in trying to hold the insurance industry and other rich and powerful special interests more accountable.

Thank you for being dedicated—through the Civil Justice Foundation—to safeguarding the intrinsic constitutional rights afforded to all Americans. And thank you for your generous support over the years to organizations that seek to provide a voice to the voiceless, like the thousands of men and women who have to seek care in animal stalls, and to organizations that are working for systemic change.

If there ever was a system in which systemic change is urgently needed, it is the American health care system.