

Testimony of

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Mr. Chairman, thank you for the opportunity to be here this afternoon.

My name is Wendell Potter and for 20 years, I worked as a senior executive at health insurance companies, and I saw how they confuse their customers and dump the sick – all so they can satisfy their Wall Street investors.

I know from personal experience that members of Congress and the public have good reason to question the honesty and trustworthiness of the insurance industry. Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand—or even to obtain—information we need. As you hold hearings and discuss legislative proposals over the coming weeks, I encourage you to look very closely at the role for-profit insurance companies play in making our health care system both the most expensive and one of the most dysfunctional in the world. I hope you get a real sense of what life would be like for most of us if the kind of so-called reform the insurers are lobbying for is enacted.

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

A few months after I joined the health insurer CIGNA Corp. in 1993, just as the last national health care reform debate was underway, the president of CIGNA's health care division was one of three industry executives who came here to assure members of Congress that they

would help lawmakers pass meaningful reform. While they expressed concerns about some of President Clinton's proposals, they said they enthusiastically supported several specific goals.

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

Today we are hearing industry executives saying the same things and making the same assurances. This time, though, the industry is bigger, richer and stronger, and it has a much tighter grip on our health care system than ever before. In the 15 years since insurance companies killed the Clinton plan, the industry has consolidated to the point that it is now dominated by a cartel of large for-profit insurers.

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

To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going

to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9% to 79.4% a year later.

To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick. Insurers have several ways to cull the sick from their rolls. One is policy rescission. They look carefully to see if a sick policyholder may have omitted a minor illness, a pre-existing condition, when applying for coverage, and then they use that as justification to cancel the policy, even if the enrollee has never missed a premium payment. Asked directly about this practice just last week in the House Energy and Commerce Committee, executives of three of the nation's largest health insurers refused to end the practice of cancelling policies for sick enrollees. Why? Because dumping a small number of enrollees can have a big effect on the bottom line. Ten percent of the population accounts for two-thirds of all health care spending.¹ The Energy and Commerce Committee's investigation into three insurers found that they canceled the coverage of roughly 20,000 people in a five-year period, allowing the companies to avoid paying \$300 million in claims.

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

¹ Samuel Zuvekas and Joel Cohen, "Prescription Drugs And The Changing Concentration Of Health Care Expenditures," *Health Affairs*, 26 (1) (January/February 2007): 249-257.

leaving workers uninsured. The practice is known in the industry as “purging.” The purging of less profitable accounts through intentionally unrealistic rate increases helps explain why the number of small businesses offering coverage to their employees has fallen from 61 percent to 38 percent since 1993, according to the National Small Business Association. Once an insurer purges a business, there are often no other viable choices in the health insurance market because of rampant industry consolidation.

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

Purging through pricing games is not limited to letting go of an isolated number of unprofitable accounts. It is endemic in the industry. For instance, between 1996 and 1999, Aetna initiated a series of company acquisitions and became the nation’s largest health insurer with 21 million members. The company spent more than \$20 million that it received in fees and premiums from customers to revamp its computer systems, enabling the company to “identify and dump unprofitable corporate accounts,” as The Wall Street Journal reported in 2004.² Armed with a stockpile of new information on policyholders, new management and a shift in

² “Behind Aetna’s Turnaround: Small Steps to Pare Cost of Care,” Wall Street Journal, August 13, 2004.

strategy, in 2000, Aetna sharply raised premiums on less profitable accounts. Within a few years, Aetna lost 8 million covered lives due to strategic and other factors.

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

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

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

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

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

An estimated 25 million Americans are now underinsured for two principle reasons. First, the high deductible plans many of them have been forced to accept – like I was forced to accept at CIGNA – require them to pay more out of their own pockets for medical care, whether they can afford it or not. The trend toward these high-deductible plans alarms many health care experts and state insurance commissioners. As California Lieutenant Governor John Garamendi told the Associated Press in 2005 when he was serving as the state’s insurance commissioner, the movement toward consumer-driven coverage will eventually result in a “death spiral” for managed care plans. This will happen, he said, as consumer-driven plans “cherry-pick” the youngest, healthiest and richest customers while forcing managed care plans to charge more to cover the sickest patients. The result, he predicted, will be more uninsured people.

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

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

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

Thank you, Mr. Chairman, for beginning this conversation on transparency and for making this such a priority. S. 1050, your legislation to require insurance companies to be more honest and transparent in how they communicate with consumers, is essential. So, too, is S.

1278, the Consumers Choice Health Plan, which would create a strong public health insurance option as a benchmark in transparency and quality. Americans need and overwhelmingly support the option of obtaining coverage from a public plan. The 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-run system.” But what we have today, Mr. Chairman, is a Wall Street-run 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.