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Congress of the United States

House of Representatives

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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approximately 116,000 pages of documents and interviewed numerous policyholders who had their coverage terminated, or "rescinded," after they became ill.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]

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[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]

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[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]

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[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

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[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.

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[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]

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[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

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[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

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[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]

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[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

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[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]

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[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[inded] 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

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[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]

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[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/abticd9.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) (AH10000001-4).

[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

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[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 Ehnes 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]

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[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.

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[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).