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**Testimony
Of
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**Domestic Policy Subcommittee
Oversight and Government Reform Committee
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**“Between You and Your Doctor:
the Private Health Insurance Bureaucracy”**

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

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

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

1. First, an Apology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Conclusion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I implore you not to let this happen.

Thank you for considering my views.