

**TERMINATION OF INDIVIDUAL HEALTH POLICIES
BY INSURANCE COMPANIES**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
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COMMERCE
HOUSE OF REPRESENTATIVES
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TERMINATION OF INDIVIDUAL HEALTH POLICIES BY INSURANCE COMPANIES

TUESDAY, JUNE 16, 2009

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

The subcommittee met, pursuant to call, at 10:08 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Bart Stupak [chairman of the subcommittee] presiding.

Members present: Representatives Stupak, Braley, Schakowsky, Green, Sutton, Dingell, Waxman (ex officio), Walden, Deal, Burgess, Gingrey and Barton (ex officio).

Staff present: Karen Lightfoot, Communications Director, Senior Policy Advisor; Theodore Chuang, Chief Oversight Counsel; Mike Gordon, Deputy Chief Investigative Counsel; Scott Schloegel, Investigator, Oversight and Investigations, Daniel Davis, Professional Staff Member; Ali Golden, Investigator; Jennifer Owens, Special Assistant; Jennifer Berenholz, Deputy Clerk; Lindsay Vidal, Special Assistant; Julia Elam, Fellow; Paul Jung, Public Health Service Detailee; Karen Christian, Counsel; Krista Rosenthal, Counsel; Alan Slobodin, Chief Counsel for Oversight; and Sean Hayes, Counsel.

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

Mr. STUPAK. This meeting will come to order.

Today we have a hearing entitled "Terminations of Individual Health Policies by Insurance Companies." The chairman, the ranking member and the chairman emeritus will have 5 minutes for an opening statement. Other members of the subcommittee will be recognized for 3 minutes.

Before we begin, I am going to ask unanimous consent that the contents of our document binder be entered into the record provided that the committee staff may redact any information that is business proprietary, relates to privacy concerns or is law enforcement-sensitive. Without objection, the documents will be entered into the record and we will ask that a copy of our document binder be placed at the front table in case witnesses wish to refer to it.

I am going to begin opening statements. I will start with my opening statement for 5 minutes.

Every night across America, more than 45 million Americans go to sleep without health insurance coverage. They do so in fear of a nightmare scenario of developing a catastrophic illness and being

unable to pay for treatment. It is this fear that has caused many hardworking Americans who are not covered by an employer or government-sponsored health care plan to purchase individual health insurance policies. But those Americans fortunate enough to afford individual health care coverage are not immune from the nightmare scenario. That is because a practice called health insurance rescission.

Here is what happened to one victim of rescission. Otto Raddatz was a 59-year-old restaurant owner from Illinois who was diagnosed with an aggressive form of non-Hodgkin's lymphoma, a cancer of the immune system. He underwent intensive chemotherapy and was told that he had to have a stem cell transplant in order to survive. With coverage provided by his individual insurance policy, he was scheduled to have the procedure performed. But then his insurance company suddenly told him it was going to cancel his insurance coverage. Otto could not pay for the transplant without health insurance. The stem cell transplant surgery was cancelled. The insurance company told him that it found when he applied for his insurance, he had not told the company about a test that had shown that he might have gallstones and an aneurysm, or weakness of the blood vessel wall. In fact, Otto's doctor had never told him about these test results. He didn't have any symptoms, and these conditions did not have anything to do with his cancer, but the insurance company was going to rescind his policy, effectively tearing up the contract as if it never happened and it would not pay for his stem cell transplant.

Otto made a desperate plea to the Illinois Attorney General's Office seeking help to get his insurance company to reverse its decision. He told them, and I quote, "I was diagnosed with non-Hodgkin's lymphoma. 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 scheduled. Any delay could threaten my life." The Illinois Attorney General's Office launched an investigation, confirmed that Otto's doctor had never even told him about the test findings and sent two letters to press the insurance company to reinstate his policy. The company relented and Otto received his stem cell transplant. He was able to live 3 more years before passing away earlier this year.

Otto was one of the lucky ones. This committee has concluded an investigation into the practice of health insurance rescission and results are alarming. Over the past 5 years almost 20,000 individual insurance policyholders have had their policies rescinded by three insurance companies who will testify today: Assurant, United Health Group and WellPoint. From a review of case files, the committee has identified a variety of abuses by insurance companies including conducting investigation with an eye toward rescission in every case in which a policyholder submits a claim relating to leukemia, breast cancer or any of a list of 1,400 serious or costly medical conditions, rescinding policies based on an alleged failure to disclose a health condition entirely unrelated to the policyholder's current medical problem, rescinding policies based on policyholder's failure to disclose a medical condition that their doctors never told them about, rescinding policies based on innocent mistakes by policyholders in their applications, and rescinding coverage for all

members of a family based on a failure to disclose medical condition of one family member.

The investigation has also found that at least one insurance company, WellPoint, evaluated employee performance based in part on the amount of money its employees saved the company through retroactive rescissions of health insurance policies. According to documents obtained by the committee, one WellPoint official was awarded a perfect score of five for exceptional performance based on having saved the company nearly \$10 million through rescissions. These practices reveal that when an insurance company receives a claim for an expensive lifesaving treatment, some of them will look for a way, any way, to avoid having to pay for it. This is eerily similar to what we found last year in our investigation of long-term-care health insurance policies where unscrupulous salespeople would sell policies to seniors, then change or revoke the policies once the enrollee was locked into a plan and making payments.

The companies who engage in these rescission practices argue that they are entirely legal, and to an extent, they are, but that goes against the whole point of insurance. When times are good, the insurance company is happy to sign you up and take your money in the form of premiums but when times are bad and you are afflicted with cancer or some other life-threatening disease, it is supposed to honor its commitment and stand with you in your time of need. Instead, some of these companies use a technicality to justify breaking its promise at a time when patients are too weak to fight back.

I would also like to mention and compliment the staff on their supplemental information regarding the individual health insurance market. It is attached to my opening statement and will be part of the record.

Today we will hear from victims of this practice of rescissions as well as three of the leading companies that engage in it. We hope to learn more about this problem so that we in Congress perhaps through a comprehensive national health care reform bill can curb abuses and put an end to this unconscionable practice once and for all.

I would next like to now turn to my ranking member, Mr. Walden from Oregon, for an opening statement, please.

Mr. WALDEN. Thank you, Mr. Chairman. Before I give my opening statement, I just want to clarify something. You indicated in your opening statement you do plan to put this supplemental information in the record?

Mr. STUPAK. Yes, sir. I am going to attach it as part of my opening statement. This is the supplemental information regarding the individual health insurance market dated June 16. I realize a lot of members haven't had time to look at it. I know they were putting it together last night. In the last couple days they went through about 50,000 pages, and it just helps members for questioning so I wanted to put it in there because it is supplemental, and members can use it in questioning witnesses.

Mr. WALDEN. OK. I misunderstood what you were saying then. I thought you told me you weren't going to put it in since the minority didn't see this until 9:20 this morning.

Mr. STUPAK. Right. I wasn't going to put it in as part of the document binder so I will put it as part of my opening statement and then it is attributable to me and the majority side and not the minority side, because as you had indicated, it is on committee stationery and Mr. Barton had not had time to see it so I did not want to say that Mr. Barton approved so I just made it part of my opening statement.

Mr. WALDEN. I appreciate that.

Mr. STUPAK. Thank you.

Mr. WALDEN. I hope in the future we can work those things out in advance as we have in most hearings in the past.

Mr. STUPAK. I agree.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Today's hearing is the second in a series of hearings investigating the individual health insurance market. Approximately 16 million Americans have individual health insurance policies. Once people apply and are issued their insurance cards, they breathe a sigh of relief and figure their health care is covered. Unfortunately, that sigh of relief may turn into a frenzied panic if the Friday before the Monday a patient is to undergo a double mastectomy she receives a call from her insurance company saying her insurance has been cancelled and they will no longer pay any claims. This is what happened to one of our witnesses here today, Ms. Robin Beaton from Texas, Ranking Member Barton's constituent. We will also hear from Mrs. Horton and Mrs. Raddatz where the threat or actual termination of insurance policies caused pain, frustration and great expense.

While we may be here to discuss valid uses for and procedural aspects of rescissions, medical underwriting and other corporate practices, there are some actions we should no longer allow insurance companies to do. Playing gotcha with policyholders who have serious illnesses and huge expenses must stop. Insurance companies cannot wait until customers are sick or filing claims to verify their medical history and decide whether or not they want them as a customer. This is what they are supposed to be doing when they sign the member up. If the company does not conduct a review of unclear or incomplete information on the application, then the plan should not use subsequently acquired information as a basis for rescinding coverage. This practice is known as post-claims underwriting. The company should conduct its due diligence at the time the application is filled out and submitted prior to issuing coverage. Rescission should not be a license to find loopholes by investigating someone's medical history whenever they file a claim well after being accepted for coverage, not if the company hurried through the application process, not if the company blindly accepted most applicants and not if the company gladly collected their money with no questions asked. This is inappropriate and it should be stopped.

I understand that companies just like the federal government need ways to protect themselves from insurance fraud, which does occur. Some applicants willfully lie on the application to get insurance and pay lower premiums. This increases the cost of coverage for the insurers and other policyholders. When a company discovers

this behavior and believes rescission is the appropriate action, the burden must rest on the insurer. The company should prove the insured failed to disclose material information that he or she was aware of at the time of the contract that would have resulted in different contracts altogether. After all, the company has the money, employees and resources to meet that burden. They are the ones making the assertion and they are the ones ultimately denying the coverage. It is not enough for companies just to send a letter to the insured stating that an investigation into their file has begun, and if they choose to send in any additional information to the company. The company needs to attempt to communicate directly with the insured, his or her doctor and review all pertinent information to prove the insured did make a material misstatement.

The majority requested all cases files that resulted in rescission in 2007 in four States. For United, this was 206 case files, for Assurant, this was 321 case files, and for WellPoint, this was 742 case files. To date, the committee has received more than 650 of these case files. My staff had the opportunity to review several of these files including working all weekend. In some, there is documentation or evidence that the insured intentionally withheld pertinent medical information that would have affected their coverage. In others, it is unclear whether the applicant was even aware of the condition or notation cited by an investigator in an old medical chart as evidence to rescind.

Today three individual policyholders will explain their stories and illustrate how they were unaware of conditions, symptoms or other possible diagnoses that were written in a medical chart but never expressed to the patient. So you have to ask yourself, can a person make a material omission or a misstatement if he or she was not aware of a fact? I don't think so. But if I am wrong, I want the companies to explain it to me.

In 2008 and 2009, these companies entered into settlement agreements with rescinded policyholders and providers in sums topping tens of millions of dollars. Some of the companies remain in litigation with other rescinded policyholders. I also recognize some of these companies have initiated internal reforms. These include steps to improve their application process, improve communication with the insured during the investigation and rescission process and offer independent third-party review of rescission decisions if requested by the policyholder.

I want to know what appropriate actions Congress can take and what else these companies can do better to ensure that all Americans have access to health care coverage. Health care reform is coming and we need to have a better understanding of the individual health insurance market and its practices. We need to figure out first and foremost how to make quality health insurance affordable and reliable while keeping protections in place to combat insurance fraud. I hope that as this process moves forward we work in a bipartisan way to design a system that achieves the ultimate goal of getting those who need medical care the attention they need. Thank you.

Mr. STUPAK. Thank you, Mr. Walden.

Mr. Waxman for an opening statement, please.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Today we are going to hear the results of a yearlong Congressional investigation into abuses in the individual insurance market. We began this investigation last year when I served as chairman of the House Oversight Committee and we continued it this year with Chairman Stupak's leadership as the chairman of the Oversight Subcommittee of Energy and Commerce. As part of this investigation, we conducted a 50-State survey of insurance commissioners and we sent document requests to some of the largest companies that offer individual health insurance. We received more than 116,000 pages of documents and our staff talked with many policyholders who had their insurance policies cancelled after they became ill. Some of them are here today to testify, and I thank them very much for being here.

Overall, what we found is that the market for individual health insurance in the United States is fundamentally flawed. One of the biggest problems is that most States allow individual health insurance policies to deny coverage to people with preexisting conditions. So if you lose your job and you can't qualify for a government program like Medicare or Medicaid, it is nearly impossible to get health insurance if you are sick or have an illness. This creates a perverse incentive. In the United States, insurance companies compete based on who is best at avoiding people who need lifesaving health care, and this incentive manifests itself in a wide variety of controversial practices by the insurance companies when we know that when people apply for insurance policies and they put down that they have some preexisting condition, they are going to be denied. But what we found is that when people with individual policies become ill and then they submit their claims for expensive treatments, then insurance companies launch an investigation. They scour the policyholder's original insurance application and the person's medical records to find any discrepancy, any omission or any misstatement that could allow them to cancel the policy. They try to find something, anything so they can say that this individual was not truthful in that original application. It doesn't have to even relate to the medical care the person is seeking and often it doesn't. You might need chemotherapy for lymphoma, but then when the insurance companies find that your coverage was based on a failure to disclose gallstones, well, they want to cancel your policy after the fact. It may come as a surprise to most people but the insurance companies believe they are entitled to cancel the policies even when these omissions or discrepancies are completely unintentional and they believe that they have the right to cancel policies even when someone else like an agent who sold the policy was responsible for the discrepancy in the first place.

In addition, they can terminate coverage not just for the primary policyholder but they go to terminate the policies for the entire family including innocent children who did nothing wrong. Some insurance companies launch these investigations every single time a policyholder becomes ill with a certain condition. In other words, if you happen to have ovarian cancer, you should be prepared to

be investigated. It is the same with other conditions such as leukemia.

In the written statements for today, the three insurance companies downplay the significance of these practices, arguing that rescissions are relatively rare. But these three companies saved more than \$300 million over the past 5 years as a result of rescissions, and I am sure they view this amount as significant. More importantly, however, these terminations are extremely significant to the tens of thousands of people who needed health care and couldn't get it during these 5 years because their policies were rescinded.

In my opinion, of course, the solution to these problems is to pass comprehensive health reform legislation and based on the written testimony I think the three insurance companies testifying here today agree with that assessment. But until that happens, insurance companies deny people coverage if they have a preexisting condition and then afterwards if they gave them the coverage for insurance they want to see if there is some reason they can rescind it after the fact, after they have already given out the insurance to see if they can rescind that policy. I think it is shocking. It is inexcusable. It is a system that we have in place and we have got to stop.

Mr. Chairman, I am pleased that you are holding this hearing and I thank you for the time allotted to me.

Mr. STUPAK. Thank you, Mr. Waxman.

Mr. Barton for an opening statement, please.

**OPENING STATEMENT OF HON. JOE BARTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BARTON. Thank you, Mr. Chairman.

This is my month for witnesses from Waxahachie, Texas. Last week we had Mr. Frank Blankenbecker, who is the owner of Carlisle Chevrolet in Waxahachie. Today we have Ms. Robin Beaton, who is a citizen of Waxahachie. So I want to extend to her my very best wishes and let her and the other two panelists on this first panel know that there is nothing to be afraid of. You speak for tens of thousands if not hundreds of thousands of American citizens, and the country is very interested through the auspices of this hearing to hear your story, so we appreciate all three of you being here.

This is an important hearing. It addresses part of the need to reform our health care system. We are going to hear today about a problem under the current system that can occur in the handling of individual health insurance policies when claims are actually submitted for coverage under those policies. As I just said, I want to extend a warm welcome to our first panel of witnesses. Each of you has a personal story that you wish to share and we know that it is a story that is worth hearing. We also know that it takes courage to testify, and as I just said, there is nothing to be afraid of at this hearing today.

We hear of problems as Congressmen and -women when our constituents tell us what those problems actually are. Today we are going to hear from one of my constituents, Ms. Robin Beaton. No one should have to go through what she has had to go through the last several years. In June of last year, she was diagnosed with an

aggressive form of breast cancer and her doctor said that she needed immediate surgery. The Friday before the Monday that she was to undergo a double mastectomy, she received a letter from her carrier, Blue Cross of Texas, that rescinded her insurance policy. The letter stated that the company would not pay for the surgery. The letter further informed Ms. Beaton that an investigation into her claim for benefits when the company had thoroughly reviewed her medical records that she submitted when she applied for the coverage and that they discovered that she had misinformed them on several pieces of information. One of them was that she didn't list her weight accurately, and the other, that she failed to disclose some medication that she had taken for a preexisting heart condition. The record will show that she was not taking that medication at the time that she submitted her initial application for coverage. Robin's claim in June of 2008 was not for weight control, it was not for a heart condition, it was for cancer surgery, a double mastectomy for breast cancer, yet her policy was rescinded 3 days before that surgery was scheduled to take place. It was bad enough that she had to deal with the trauma of breast cancer but to be denied coverage right before potentially lifesaving surgery quite frankly is something that no human being should have to undergo. She had no insurance and no way to pay for her scheduled surgery. So obviously it was postponed.

She called my office. My staff went to work. They had several conference calls with officials of Blue Cross/Blue Shield. In those conference calls, Blue Cross and Blue Shield was unyielding. They were adamant. It went to the counsel, the general counsel of Blue Cross/Blue Shield and that individual said there was no way they were going to reinstate her coverage. Never take no for an answer. I called the president of Blue Cross/Blue Shield. I appealed to him personally, gave him the facts as I knew them, and he promised that he would personally investigate Ms. Beaton's case, and he further promised that if the facts were as she said and I said, that her coverage would be reinstated. Good to his word, the president called me back within 4 hours and said that Ms. Beaton's coverage would be reinstated. However, precious time was lost. Luckily for Robin, she was finally able to get the surgery, not through Blue Cross/Blue Shield though, as I understand it. She is now undergoing chemotherapy because the cancer has spread to her lymph nodes, but she is still with us, thank God, and she is here today to tell us her personal story.

Robin's situation was what caused me to draft an amendment to Representative DeLauro's breast cancer bill last year to protect people like Robin by prohibiting rescissions of health insurance if non-disclosure of information is not related to the claim, not related to the claim and inadvertent. There is no reason on God's green earth that somebody ought to have their health insurance revoked because of some inadvertent omission that is not related to the claim that is being submitted to the health insurance company. This bill with my amendment passed the House last year but it died in the Senate. It has been reintroduced and hopefully it will pass this year. I support the right of an applicant to request a third-party independent review of an insurer's rescission prior to pending or denying payments of claims. I understand that there is

another side to this story. I understand that there are people that do try to scam insurance companies. I understand that there is a rule of reason, but again, if somebody inadvertently omits something or there is something that is not material to the claim, that claim in my opinion should be paid, end of story.

As we head towards reforming health care, it is important that we promote honesty on behalf of the insured and the insurers. Congress needs to be confident that there are consumer protections in place to protect people like Robin Beaton as well as procedures for companies to protect themselves from insurance fraud. Companies need to have open and clear rules on when they terminate policies. Applicants need to be truthful when applying for coverage. Every American, and this is something that members on both sides of the aisle support, needs to have access to affordable, quality health care.

This is an important hearing towards that goal, Mr. Chairman, and I thank you for holding it. I also think that we should give special condition to one of our panelists here on the dais. The gentlelady from Chicago injured herself yesterday and has a broken leg and yet she is here today at this health care hearing, so appreciate Ms. Schakowsky here.

Ms. SCHAKOWSKY. And fortunately with good health insurance, so I am happy about that too.

Mr. BARTON. And again, thank you, Mr. Chairman, for holding this hearing.

Mr. STUPAK. Thank you, Mr. Barton, and thank you again for helping us obtain witnesses for this hearing.

Mr. Dingell for an opening statement, please.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Thank you, Mr. Chairman, and I commend you for holding this hearing on the rather vicious practice of post-claims underwriting and the detrimental effect that such practices have on hundreds of Americans, and I want to thank the witnesses for appearing in what I hope will be an informative hearing today on which the committee may begin some actions to correct what appears to be a very serious abuse, and I remember, Mr. Barton, the way we worked together on this and your outrage last year when we were addressing similar questions.

Health care costs have risen sharply. In response to this, insurance providers have taken drastic measures to reduce costs and to improve profit margins. Unfortunately, the health insurance industry is attempting to do so by giving in to unscrupulous industry practice including the practice of post-claims underwriting. I want to be clear. I have no sympathy for individuals who intentionally misrepresent their health status in the applications they submit for health insurance coverage. These actions are dishonest and have a negative impact on the cost of health care for everyone else, and they are clearly wrongdoing and they should be punished. However, I have far less sympathy for health care providers and insurance providers who have made it a customary practice to exploit current laws meant to protect individuals and to take advantage of

the most vulnerable Americans in order to turn a profit. They do this by seeing to it that they avoid risk as opposed to practicing good insurance practices.

As we have seen time and time again, insurance providers have made a living out of refusing to compete on quality and choosing instead to compete by avoiding financial obligations at all costs. In the current market, health insurance providers are allowed to pick and choose whom they will cover in the individual market. We have allowed this cherry picking or cream skimming to go on for years, but when we weren't looking the industry decided to up the ante. In some cases, industry underwrote countless claims for individuals that cherry picked and then it began to quietly punish those individuals if they got sick and used their insurance for its intended purpose, to cover major medical claims. In some cases, industry didn't just drop the individual policyholder but retroactively rescinded the contract as if the agreement had failed to exist. They refused to pay hospitals, doctors and nurses that sought reimbursement for services rendered.

To our witnesses who are appearing this morning to share their personal experience with post-claims underwriting, we will work to ensure these practices come to a sharp end. To the CEOs testifying this morning, I would like them to know this: We don't regulate for the fun of it. We regulate when the private sector refuses to honor its commitments to the American public. As we work to reform the Nation's health care system, we will work to reform the current health insurance market. We will work to ensure such reform will prohibit insurers from excluding preexisting conditions or engaging in any other unfair and discriminatory practice. We will also work to ensure these reforms include fair grievance and appeals mechanisms, very much lacking in the insurance world today, and will ensure information transparency and plan disclosure. These new reforms alone will not fix the problems. We will also have to work to ensure that there is strong oversight on both the federal and state level. Furthermore, these insurance industry practices are precisely the reason why we need a public health insurance option included in our proposal to reform the health care system, a public plan that leads by example and competes through quality and innovation rather than unfair industry practices is what is needed to keep the private industry in the insurance business honest.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Dingell.

Next for a 3-minute opening statement, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you.

Generally, insurance is a form of risk management that allows individuals to pay a monthly premium in exchange for a company taking on their financial risk in the event of a health care catastrophic loss. Health insurance, on the other hand, is not typical insurance. For a monthly premium, individuals purchase health insurance to financially support them in the event of a catastrophic incident such as a broken leg, as the gentlelady from Chicago just recently experienced, or major surgery. Patients also use their in-

insurance for such things as doctor visits or monthly prescriptions. In many respects, health insurance has become the means by which patients see their providers and they receive treatment.

Primary responsibility for regulating the individual health insurance market rests with the State regulators. However, in the Health Insurance Portability and Accountability Act of 1996, HIPAA, Congress made very clear that an individual insurance policyholder has a right to guarantee renewability. In other words, an insurer must renew or continue an individual's existing coverage unless some specific exception is made. Those exceptions include a policyholder moving out of a network plan service area, or if the policyholder intentionally misrepresents a material fact concerning their condition when contracting with the insurer.

I believe it is unfair for an individual to be denied coverage for a claim when he or she has been upfront about their condition. They played by the rules of the contract. They paid their premiums on a regular timely basis only to be denied coverage when a health care incident arises as described by my colleague, Mr. Walden, what we would call post-claims underwriting. The impact it has on patients and their loved ones can be devastating. I have actually personally experienced that in my own family and it literally took an act of Congress to change that.

With these things in mind, I look forward to the testimony of our witnesses today. I want to thank the entire panel, this first panel particularly, as well as the second panel for coming in today and sharing your stories with us, and Mr. Chairman, I look forward to the hearing and to the questions, and at this time I yield back.

Mr. STUPAK. Thank you, Mr. Gingrey.

Mr. Green of Texas for an opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman, and I think all of us appreciate you calling this hearing today because like my ranking member from Texas talked about, we deal with this all the time through our constituents, and as a State legislator in Texas, we have had that same problem for many years, and I appreciate you bringing this out and hopefully we will address this in our health care reform. I want to thank our witnesses for being here today.

Most individuals in the country have health insurance through their employer, Medicare or Medicaid. But millions of Americans do not have insurance through their employers or through the public market so they turn to the individual insurance market to purchase insurance policies. Individuals who purchase the insurance through the individual market must go through an application process and supply their medical history including any mental, physical or chronic conditions. Insurance companies are supposed to review those applications and review the applicant's medical history before approving the individual for coverage. Oftentimes this medical history never occurs and the insurance companies will cover individuals who have conditions they would not necessarily cover. These individuals believe their coverage is current and when they submit a claim they often find themselves subject to that medical history investigation and dropped from their insurance and lia-

ble for all claims under the policy. In other instances, individuals submit a claim for a serious illness such as cancer and find themselves subject to a medical history investigation and dropped from their policy because the insurance company claims the individual did not disclose a medical condition when filling out their initial application. Both these instances leave the individual without health insurance coverage and uninsurable because they have to report having their coverage rescinded. Individuals who are undergoing medical treatment for conditions such as cancer are dropped from their coverage often face life-and-death situations because the insurance company does not want to pay for their treatments. I can't imagine the pain and suffering that these individuals go through at the expense of an industry seeking healthy patients to make a profit.

A few States, including Texas, have taken actions to prevent insurance companies from post-claims underwriting. As we are working through health reform, we need to examine the individual market and ensure individuals never have to face losing their coverage for simply using their coverage, and Mr. Chairman, again, I thank you for calling this hearing. I yield back my time.

Mr. STUPAK. Thank you, Mr. Green.

Mr. Burgess for 3-minute opening statement, please, sir.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman, for the consideration.

Let me just say at the outset, I do believe in the individual market. I believe it has a place in this country. Indeed, I was a client and a customer in the individual market for my family's coverage for a period of time. And I also believe that the barriers that we, the federal government, the Congress puts in place on the individual market sometimes creates unnecessary difficulties for the people who sell in the individual market or the people who wish to be their customers. But no one can defend, and I certainly cannot defend the practice of denying coverage after the fact and I cannot be comforted by the fact or the statements that are made that this is in fact an infrequent occurrence because as the cases in front of us at the witness table demonstrated this morning, there is no acceptable minimum to denying coverage after the fact when the coverage was duly paid for and entered into in an honest fashion and then only when the coverage was required was it found to be not there.

Now, I don't think anyone on either side of the dais believes that anyone would ever lie about something on a medical history, maybe fudge your weight a little bit, maybe the number of times we actually go the gym or what we actually do there, but no one would willfully do that. The question before us today is, do people intentionally lie in order to manipulate companies into giving them coverage when they know that they have a preexisting condition, and the legal jargon that we apply to that is rescission, and should insurance companies post procedure be allowed to terminate individual contracts based upon the omission of disclosure of a pre-existing condition irrespective of whether it was intentional on behalf of the individual seeking coverage or not, and I am troubled

by that inability to distinguish between those who intentionally act with fraud and those who honestly answer broad, vague or confusing questions on the contracts to obtain health coverage. Those are not equivalent conditions. An omission without intent does not signify fraud and no insurance company who hides behind filling out their request for insurance as a strict liability should be protected. Intent is crucial because those who act fraudulently should not be protected by the law nor should it be our desire to do so.

It is interesting to me that all of the insurance companies today that we are going to hear from on our panel today are private for-profit companies, but Ms. Beaton's insurer, whose case proved near intractable until her Member of Congress got involved, was Blue Cross and Blue Shield, and I wonder, Mr. Chairman, why Blue Cross and Blue Shield is not in one of our panels today. Clearly as a nonprofit company, they would not have a purely profit-driven motive to engage in this type of behavior. So theirs is perhaps particularly curious and I think there are a number of questions that we would like to pose to a company that does in fact function as a nonprofit. It is the responsibility of each insurance company whether for profit or not for profit to do their due diligence before the contracts are entered into and not use rescission as an excuse for lazy or incomplete underwriting.

Thank you, Mr. Chairman. I will yield back the balance of my time.

Mr. STUPAK. Thank you, Mr. Burgess.

Ms. Sutton for opening statement, please.

**OPENING STATEMENT OF HON. BETTY SUTTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. SUTTON. Thank you, Chairman Stupak, for holding this critical hearing.

Simply put, rescission of coverage by insurance companies puts dollars ahead of the lives of Americans, and I am not exaggerating when I say that insurance accountability is something that I have fought and advocated for at every stage of my professional life. During my time as a representative in the Ohio General Assembly, I worked on behalf of Ohioans to ensure that when benefits were promised, benefits were given. And now I am here in Congress to continue that fight.

Rescission of coverage is a problem that we in Congress are seeking to eliminate and it is our hope, you have heard from the comments here, that when we have finished reforming our health care system, coverage discrimination will be a thing of the past, but today it is still a problem that exists and must be eliminated. When a health insurance policy rescission occurs, it creates waves throughout the entire health care system. Make no mistake, these decisions deprive people of needed care. They deprive hospitals and doctors of the reimbursement they have earned for their service. For some, a rescission is a costly process that can result in a doctor or hospital having to seek payment from the individual. For others, it means a delay in access to a lifesaving procedure or treatment. That is unacceptable.

Today we will hear from citizens, and I thank you all for coming to provide your testimony and your stories about your lives that

have been turned upside down by the insurance industry policy of rescission. We will hear from executives who will tell us that in the name of uncovering insurance fraud and corruption, they had no choice but to remove these beneficiaries from their rolls. But I think the testimony of the people who have lived through this trauma will tell a different story.

The number of uninsured in this country is now thought to be 47 million. It is a major flaw in our country that so many people go without their basic right to have health care coverage and millions more who have insurance still don't get the care they need when they need it. It is hard to understand how we allow those who are legitimately covered to join the ranks of the uninsured due to the stroke of a pen or the decision of an insurance company executive.

Unfortunately, Mr. Chairman, I have another hearing that is going on simultaneously with this one so will be shuttling back and forth, but I want the panelists to know that I will be listening carefully to the testimony, both for myself and for the people of Ohio that I am so honored to represent, and I thank you all again for coming and I thank you, Mr. Chairman, for your attention to this matter.

Mr. STUPAK. Thank you, Ms. Sutton, and that is a good reminder. Members will be coming back and forth as there is a committee two floors up. The Telecommunications and Internet Subcommittee is also meeting, and in that vein, Congresswoman Donna M. Christensen, who is a member of this subcommittee, has submitted her opening statement for the record. Without objection, it will be entered into the record.

Next I will turn to Ms. Schakowsky for an opening statement, please, and you can tell us how you broke your leg.

Ms. SCHAKOWSKY. Well, I wish there was a dramatic story, Mr. Chairman, although it was in a fairly dramatic place. I did go to Guantanamo Bay yesterday and fell and ended up breaking my foot in two places. I hope soon with the help of the attending physicians I will have a boot or a cast or something. That was just yesterday, and I—

Mr. STUPAK. Well, we wish you well and thanks for being here.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. And I am grateful that I do have good health insurance to cover that.

I appreciate today's hearing examining one of the truly egregious practices occurring in the individual health insurance market. I want to extend a special welcome to Ms. Peggy Raddatz from my home State from La Grange. I thank you for being here and sharing your family's story with us. I know it isn't always easy to discuss personal matters but you certainly are helping us to make better health care policies, and I thank all the witnesses for helping us.

When a consumer goes to buy a health insurance policy, they examine their options and they try to identify the best policy to meet the health care needs of their family and at no time do they ever imagine that once they buy a policy they might get sick and their

insurance will simply rescind their policy and leave them without coverage but with a high pile of bills. The practice of post-claims underwriting in the private market is wrong and we should prohibit it. Let us face it is, it is already hard enough for an individual or small business owner to find health insurance. In my State of Illinois, there is no requirement that insurers take all comers, and I have heard from constituents over and over again who are unable to find a policy really at any price. Those who do get through the insurance industry gauntlet know that they are not home free. They know they may face high out-of-pocket costs, denial of doctor-prescribed treatments, prior approval requirements, caps on services and other devices that are designed to limit the insurance company payments. But few know that when they need care the insurance company that has been collecting their premiums may now go back and comb through their personal history in order to find an excuse not to pay just when the policyholder needs the coverage the most.

There are some who argue that rescissions are used to stop fraud on the part of enrollees who misrepresent their health histories in order to obtain coverage. One has to wonder why we would put up with a health care system in which people have to hide their illnesses in order to get access to care, but we also know that this isn't about that. It is most often about a company looking for an undisclosed headache 10 years ago in order to deny coverage for a brain tumor today. The practices of the private insurance market have less to do with the consumer and a lot to do with company profits. As we move forward with health care reform, we have to put an end to practices that discourage patients from seeking out care. Insurance coverage should be a pathway, not a barrier to care.

Mr. Chairman, I look forward to working with you to improve care coverage, refocus our attention on patients, and I really again thank our witnesses for being here today, and with that, I yield back.

Mr. STUPAK. Thank you.

Mr. Braley for an opening statement, please.

**OPENING STATEMENT OF HON. BRUCE L. BRALEY, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Mr. BRALEY. Thank you, Mr. Chairman. This is a very important hearing but I would like to start by talking about the very concept that we are here to discuss because the term "post-claims underwriting" is an oxymoron. Insurance companies are structured into different departments. They have an underwriting department and a claims department, and the underwriting department is supposed to do pre-issuance risk assessment to determine whether an individual policy is worth the company investing in that person as a health care risk. The claims department is designed to respond to requests for coverage after a policy has been issued. So the very theory we are here to talk about today isn't even supposed to exist in a rational health care delivery system, and it wouldn't exist if we had a rational health care delivery system. But when you read news stories where the CEO of one private health insurance company is sitting on stock options valued at \$1.6 billion, it shouldn't

come as a shock to any of us that we are sitting here today hearing these horror stories of patients who have been caught up in an inefficient, unsustainable private health insurance delivery system.

And Ms. Raddatz, I wish that every claims examiner at every insurance company and every underwriter who gets engaged in post-claims underwriting determinations had to go through what you went through and the other witnesses who are here today because one of the most profound experiences I have had in my life was spending about a month at a pediatric oncology unit at the University of Iowa Hospitals and Clinics when I was in the Big Brothers/Big Sisters program and my little brother was diagnosed with acute large-cell non-Hodgkin's lymphoma and spend time every day watching young patients with no hair, with IVs in their arms or in their chests going into a port, walking around and taking care of each other much better than our health care industry takes care of patients in their time of need, and it is a slander on the names of the health care professionals who do everything they can to keep patients like your brother, like my little brother alive when we don't give them the support that they need after they have invested their hard-earned dollars by paying premiums to a health care insurance company who turns their back on the patient in their hour of need, and that is why I am a strong supporter of the public health insurance option and I am proud that my colleagues on this committee, Chris Murphy and Peter Welch, have joined me in introducing the Choices bill to give health insurance patients a public health insurance option with no discrimination so we don't have to go through these nightmares anymore.

With that, I yield back.

Mr. STUPAK. Well, thank you, and that concludes the opening statements of all members. One of our witnesses had to step out just for a moment so let us stand in recess for just 5 minutes and we come right back in about 5 minutes, OK? We will give everyone a chance to stretch their legs and we will be in recess for 5 minutes.

[Recess.]

Mr. STUPAK. This hearing will come back to order.

As I stated before we had the brief recess there, that concludes the opening statements by members of the subcommittee and now I would like to call upon our first panel of witnesses. On our first panel, we have Robin Beaton, who is a policyholder from Waxahachie, Texas; Ms. Peggy Raddatz from La Grange, Illinois, who is the sister of the late policyholder, Otto Raddatz; and Ms. Wittney Horton, who is a policyholder from Los Angeles, California. Welcome, all of you. Thank you for coming.

It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony. Do you wish to be represented by counsel during your testimony? You are all shaking your heads no, so OK. Then I am going to ask to please rise and raise your right hand and to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative. They are now under oath. We will hear a 5-minute

opening statement from each of you. Ms. Beaton, would you like to start first with an opening?

Ms. BEATON. I would like to be last.

Mr. STUPAK. You would like to be last. Ms. Horton, do you mind going first?

Ms. HORTON. No.

Mr. STUPAK. Would you pull that mic forward and turn on the green—there should be a green button there. Pull that mic forward. It doesn't pick up as well as it should.

Ms. HORTON. Can you hear me now?

Mr. STUPAK. I can hear you. Thank you.

TESTIMONY OF WITTNEY HORTON, POLICYHOLDER, LOS ANGELES, CALIFORNIA; PEGGY RADDATZ, RELATIVE OF POLICYHOLDER, LA GRANGE, ILLINOIS; AND ROBIN BEATON, POLICYHOLDER, WAXAHACHIE, TEXAS

TESTIMONY OF WITTNEY HORTON

Ms. HORTON. Good morning, ladies and gentlemen. I want to start by thanking the committee for this opportunity to testify this morning. I am very pleased that Congress has decided to take a close look at rescission so that it can understand just how damaging this practice has been to so many people across the country.

When Blue Cross cancelled my coverage, I had no idea what rescission meant, but now after my life has been turned upside down for the past 4 years, I have come to understand what a despicable practice it is. Insurance companies require you to fill out an application that is deliberately confusing and they don't do anything to make sure you understood the questions or that you supplied all the information they need to decide whether they want to insure you or not. They just accept you and accept your premium checks. It is after you see a doctor that everything changes.

When your doctors file claims, the insurance company starts looking for reasons not to pay them. They dig through your medical records and compare what they find to the information you put down on the application. It is called post-claims underwriting, and in California where I live, it is illegal, but insurers ignore the law, and when they find a discrepancy or an omission, they rescind the policy and refuse to pay any of your medical bills, even for routine treatment or treatment they previously authorized.

Blue Cross's decision to rescind my insurance was devastating to my husband and me, and I consider myself one of the lucky ones. As the lead plaintiff in a class-action lawsuit against Blue Cross, I represent 6,000 Californians who are all stripped of their insurance by Blue Cross. You can't imagine how horrifying some of those stories are.

Blue Cross rescinded some of these people right after they had undergone open-heart surgery or were receiving chemotherapy treatment for cancer. Some of these people were left with hundreds of thousands in unpaid medical bills. One thing we all have in common, we all were left to somehow stay healthy and fend for ourselves after Blue Cross walked away from its promise to provide health insurance.

I sought insurance with Blue Cross in 2005 because my parents raised me to believe that health insurance was an absolute necessity that should never be taken for granted. I work in the film industry in Los Angeles, California, where employment is generally temporary and done on a freelance basis. So for me and many others in the industry, individual coverage is a necessity. At the time I applied for coverage, I had just left a temporary staffing agency for Sony Pictures to go to work on a specific movie. When I made the move, I had to give up the stability of my group health care plan. So I immediately sought out individual health care coverage.

When I applied for coverage with Blue Cross, I wanted to make sure that I did everything correctly to ensure that there would be no problems. I filled out the application to the best of my ability, even though it was long and confusing. I wrote down everything I could remember about my health history including hypothyroidism, a condition I have had since I was 18. I even listed the contact information for my treating doctor. Then I turned my application in to my insurance broker. She told me everything looked good and sent it in to Blue Cross and they quickly accepted my application. I was only 27 at the time.

Two months later, I went to my endocrinologist for a checkup. I had routine blood work performed and the doctor's office sent the bill to Blue Cross. I received a letter back from Blue Cross shortly afterwards saying that they wanted all of my medical records from both my endocrinologist and my gynecologist. I consented, having nothing to hide. A couple of months later in June of 2005, I received a letter from Blue Cross stating they were rescinding my insurance because I didn't disclose on the application that I had taken the drug Glucophage and because of irregular menstruation. I had taken Glucophage the previous year but was no longer taking it when I filled out the application. My doctor had prescribed it hoping that it might help me lose weight, but it did not. I stopped taking the medication when I saw that it was not working for me.

In its rescission letter, Blue Cross said it would have never accepted me for coverage if it had known that I had polycystic ovaries. This letter was the first time I had ever heard about this condition. I later learned that polycystic ovaries, or PCOS, as it is known, is a diagnosis of exclusion and very difficult to prove. Doctors often proceed on suspicions of a person having it without actually having proven it. This is what happened in my case. 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.

After I was rescinded, I had two of my doctors write letters to Blue Cross telling them this but they didn't care. They just wrote back that they were upholding their decision to rescind. After being rescinded, I showed my original application to my sister and her husband, both radiologists, to ask them what I could have possibly done wrong in filling out the application. They felt that the application was worded in such a way as to be purposely confusing and that it asked the same question in multiple ways to trip people up. I am a college graduate and no dummy, and I still couldn't make sense of Blue Cross's tricky application.

The worst part about my rescission is that I have been unable to get insurance anywhere else. I applied for individual insurance through Blue Shield but on their application they ask if the applicant has ever had insurance rescinded. When they learned that I had, they informed me that they would not accept me for coverage. Every insurance company asks if you have ever had health care coverage rescinded. For the rest of my life I will never be able to get individual coverage again because of Blue Cross. As someone who works in an industry that relies on individual coverage plans, this is a really big deal. Since my rescission, I have had to take jobs that I do not want and put my career goals on hold to ensure that I can find health insurance. Fortunately, after my husband and I got married, I was able to gain coverage through his company's group health care plan. However, if he ever loses his job or I don't have employment with a company that offers group health insurance, I might have to go without.

As I mentioned before, I consider myself one of the lucky ones. I don't have large outstanding medical bills and I am relatively healthy. In fact, I was able to pay my doctors back for the blood work and office visits that Blue Cross refused to pay. But many people who have been rescinded are far less fortunate, and as the lead plaintiff against Blue Cross, I feel an obligation to speak for them as well. What Blue Cross has done to us is wrong and they must not be permitted to continue getting away with it. Americans desperately need health care reform. As my experience shows, owning an insurance policy does not necessarily equal access to health care. If insurance companies are not prevented from canceling or restricting coverage after patients get sick, insurance policies are not worth the paper they are printed on.

Insurance companies are making record profits by collecting premiums in exchange for the promises that they make to be there when people need them. Make them keep that promise. Thank you.

[The prepared statement of Ms. Horton follows:]

Statement of Jennifer Wittney Horton - June 16, 2009

Good morning ladies and gentleman. I want to start by thanking the Committee for this opportunity to testify this morning. I am very pleased that Congress has decided to take a close look at rescission so that it can understand just how damaging this practice has been to so many people across the country.

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Blue Cross' decision to rescind my insurance was devastating to my husband and me. And, I consider myself one of the lucky ones. As the lead plaintiff in a class action lawsuit against Blue Cross, I represent 6,000 Californians who were all stripped of their insurance by Blue Cross. You can't imagine how horrifying some of their stories are.

Blue Cross rescinded some of these people right after they undergone open heart surgery, or were receiving chemotherapy treatment for cancer. Some of these people were left with hundreds of thousands in unpaid medical bills. One thing we all had in common: we all were left to somehow stay healthy and fend for ourselves after Blue Cross walked away from its promise to provide health insurance.

I sought insurance with Blue Cross in 2005 because my parents raised me to believe that health insurance was an absolute necessity that should never be taken for granted. I work in the film industry in Los Angeles, CA, where employment is generally temporary, and done on a freelance basis. So, for me and many others in the industry, individual coverage is a necessity. At the time I applied for coverage, I had just left a temporary staffing agency for Sony Pictures to go work on a specific movie. When I made the move, I had to give up the stability of my group health care plan. So, I immediately sought out individual health care coverage.

When I applied for coverage with Blue Cross, I wanted to make sure that I did everything correctly to ensure that there would be no problems. I filled out the application to the best of my ability even though it was long and confusing. I wrote down everything I could remember about my health history, including hypothyroidism, a condition I have had since I was 18. I even listed the contact information for my treating doctor. Then, I turned my application into my broker. She told me everything looked good and sent it in to Blue Cross, and they quickly accepted my application. I was only 27 at the time.

Two months later, I went to see my endocrinologist for a check up. I had routine blood work performed and the doctor's office sent the bill to Blue Cross. I received a letter back from Blue Cross shortly afterwards saying that they wanted all of my medical records from both my endocrinologist and my gynecologist. I consented, having nothing to hide.

A couple of months later (June '05), I received a letter from Blue Cross stating they were rescinding my insurance because I didn't disclose on the application that I had taken the drug "glucophage," and because of irregular menstruation. I had taken glucophage the previous year, but was no longer taking it when I filled out the application. My doctor had prescribed it hoping that it might help me lose weight, but it did not. I stopped taking the medication when I saw that it was not working for me. In its rescission letter, Blue Cross said it would have never accepted me for coverage if it had known that I had "polycystic ovaries". This letter the first time I ever heard about this condition. I later learned that polycystic ovaries, or PCOS, as it is known, is a diagnosis of exclusion and very difficult to prove. Doctors often proceed on suspicions of a person having it without having actually proven it. This is what happened in my case. 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. After I was rescinded, I had two of my doctors write letters to Blue Cross telling them this, but they didn't care. They just wrote back that they were upholding their decision to rescind.

After being rescinded, I showed my original application to my sister and her husband, both radiologists, to ask them what I could have possibly done wrong in filling

out the application. They felt that the application was worded in such a way as to be purposefully confusing and that it asked the same question in multiple ways to trip people up. I'm a college graduate, and "no dummy," and I still couldn't make sense of Blue Cross' tricky application.

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Fortunately, after my husband and I got married, I was able to gain coverage through his company's group health care plan. However, if he ever loses his job, or I don't have employment with a company that offers group health insurance, I might have to go without insurance.

As I mentioned before, I consider myself one of the lucky ones. I don't have large outstanding medical bills, and I am relatively healthy. In fact, I was able to pay my doctors back for the blood work and office visits that Blue Cross refused to pay. But many people who have been rescinded are far less fortunate. And, as the lead plaintiff against Blue Cross, I feel an obligation to speak for them as well. What Blue Cross has done to us is wrong, and they must not be permitted to continue getting away with it.

Americans desperately need health care reform. As my experience shows, owning an insurance policy does not necessarily equal access to health care. If insurance companies are not prevented from canceling or restricting coverage after patients get sick, insurance policies are not worth the paper they are printed on. Insurance companies are making record profits by collecting premiums in exchange for the promises they make to be there when people need them. Make them keep that promise. Thank you.

Mr. STUPAK. Thank you, Ms. Horton.

Ms. Raddatz, and on behalf of Otto Raddatz, would you like to give your opening statement? And thank you for being here.

TESTIMONY OF PEGGY RADDATZ

Ms. RADDATZ. Thank you, very much Mr. Chairman, and thank you to all the members of the committee for all your kind words and your wonderful statements.

My name is Peggy Raddatz and I am appearing here today to testify on behalf of my brother, Otto S. Raddatz. My brother was a business owner of a restaurant that he ran with his wife, Marie. He purchased a health insurance policy from Fortis Insurance Company in August of 2003. On the application, he indicated he had kidney stones and smoked. He also listed all physicians who had treated him. Otto's health application with Fortis was accepted and his coverage began in August of 2003. A year later, my brother found himself inexplicably losing a large amount of weight. His wife, Marie Raddatz, urged him to see a doctor.

In September of 2004, my 59-year-old brother at the time was diagnosed with stage IV non-Hodgkin's-type lymphoma. The very next day, he began an intensive course of chemotherapy treatments. Due to the aggressive type of cancer Otto had, being mantle zone lymphoma, he was given six more rounds of chemotherapy by January of 2005. He suffered a lot during this period of time and was often unable to work. Otto was referred to a specialist in stem cell transplantation and for high-dose chemotherapy. Otto began more chemotherapy for purposes of preparing him for a stem cell transplant. These treatments were long and difficult in nature. In the midst of the chemo treatments, Otto received a phone call and letter from Fortis Insurance Company stating his insurance was cancelled.

It was rescinded all the way back to the effective date of August 7, 2004, which was before his diagnosis for cancer. This meant none of his cancer treatments would be covered at all. Most importantly, he would not be able to receive the stem cell transplant needed to save his life. My brother only had a very small window of time in which to have the stem cell transplant. He needed to be scheduled within the next three to four weeks or he would not be able to have the transplant at all and his life would be ended very shortly. My brother was told he was cancelled during what they called a routine review during which they claimed to discover a material failure to disclose, as they stated in their letter. Apparently in 2000, his treating doctor had done a CT scan which showed a small aneurysm and some very insignificant gallstones. My brother was never told of either one of these conditions nor was he ever treated for them, nor did he ever report any symptoms from them either.

After months of preparation, the stem cell transplant could not be scheduled. My brother's hope for being a cancer survivor was dashed. His prognosis was only a matter of months without the procedure. By this time, he could no longer work and ultimately had to sell his restaurant because of it.

Mr. STUPAK. Wait a minute.

Ms. RADDATZ. Thank you, Mr. Chairman.

When I called the hospital to see if I could schedule the stem cell transplant for him because he was in such a weakened state both physically and emotionally, I was callously told unless your brother brings in cash and a bundle of it, he is not going to get the procedure without insurance. My brother was accused by Fortis Insurance Company of falsely stating his health history, despite the fact that he had no knowledge of ever having any gallstones or aneurysms. Luckily, I am attorney and I was able to aggressively become involved in solving this life-threatening situation. I got on the phone and literally made dozens of phone calls day after day after day. I put my personal work aside and worked on this literally round the clock calling people. I finally was told to contact the Attorney General's Office and received immediate and daily assistance from the Illinois Attorney General's Office and from Dr. Babs Waldman, the medical director of their Health Bureau. I cannot thank them enough for their daily assistance in support of myself and my brother through this difficult time.

During their investigation, they located the doctor who ordered the CT scan. He was not only retired, he was on a fishing trip at the time, and through their unbelievable resolve, they were able to get a hold of him on the fishing trip and he had no recollection—he recalled my brother and his treatment of my brother but he had no recollection of ever disclosing the information to my brother or treating him for gallstones or for a small aneurysm. After two appeals by the Illinois Attorney General's Office, Fortis Insurance Company finally overturned their original decision to rescind my brother's coverage and he was reinstated without lapse. This is after weeks of constant phone calls between myself and the Attorney General's Office and we were literally scrambling hour by hour to get this accomplished so that my brother wouldn't lose his 3- to 4-week window of opportunity that he had prepared for and lose his opportunity to have the procedure.

What Fortis Insurance Company did was unethical. To deny a dying person necessary medical treatment based upon medical conditions a patient never had knowledge of, never complained about or never been treated for is cruel. It is the hope of our family that this information will benefit other patients who are in need of life-saving medical treatments and who do not have the knowledge or means necessary to fight against the health insurance companies. It is further our desire to expose these practices of Fortis Insurance Company so that others do not have to suffer as victims, as my brother did.

Thank you very much, Mr. Chairman, and thank you so much, members of the committee, for all your efforts.

[The prepared statement of Ms. Raddatz follows:]

Statement of Peggy M. Raddatz

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,


Peggy M. Raddatz

Mr. STUPAK. Thank you.

Ms. Beaton, would you like to give your opening statement now? Take your time.

TESTIMONY OF ROBIN BEATON

Ms. BEATON. Mr. Chairman and members of the committee, I am very honored to be here to share my story.

My name is Robin Beaton. I am 59 years old. I was a registered nurse for 30 years. I had insurance. I was in good health. I retired from nursing, started my own small business, obtained a personal individual policy from Blue Cross and Blue Shield in December 2007. In May 2008, I went to a dermatologist for acne, pimples. A word was written down my chart, which was considered to mean precancerous. In June 2008, I was diagnosed with invasive HER-2 genetic breast cancer, a very aggressive form of this cancer. I needed a double mastectomy immediately. Blue Cross and Blue Shield precertified me for my surgery and for a hospital stay.

The Friday before I was to have my double mastectomy, Blue Cross and Blue Shield called me by telephone and told me that my chart was red flagged. What does that mean, I said. They said that due to the dermatologist's report, that was what red flagged my chart in the beginning, that I would not be able to have my surgery on Monday and they launched a 5-year medical investigation into my medical history for the last 5 years. I had to give them every hospital, every doctor, every—

Mr. STUPAK. Take your finger off. There you go.

Ms. BEATON. I had to give them every pharmacy, every doctor, every hospital and they threatened me that if I left anything out, that it would be really bad, so I truly tried everything in the world I could to list every single doctor, everywhere I had ever been. I immediately got in touch with the dermatologist. He immediately called Blue Cross and Blue Shield and he begged them. He said this is a misunderstanding. He said this is not precancerous. He said all she has is acne, pimples. He said please don't hold up her cancer surgery for this. He begged them. He was the nicest man. Anyway, I was frantic. I did not know what to do. I didn't know how to pay for my surgery. The hospital wanted a \$30,000 deposit and I was by myself. I didn't have that kind of money.

I turned to the only person that I had to turn to, and that was Joe Barton, my Congressman. The next day I get a letter canceling my insurance, rescinding it to the first day that they had covered me. Can you imagine having to walk around with cancer growing in your body with no insurance? It is the most terrible thing in the world to not have anybody to turn to, not have anywhere to go. So I just can't even say how bad it was. The sad thing is, Blue Cross and Blue Shield took my high premiums. The very first time I ever had a claim, the very first time and was suspected of cancer, they took action against me searching high and low. They turned over every single thing they could in my medical history to pull out anything that would cause any suspicion on me so they didn't have to pay for my cancer.

A nurse who attends my church works full time for Blue Cross and Blue Shield. She looks through medical records searching for reasons to cancel people. She came to me and she said I feel so bad,

she said, I just can't even tell you how sorry I am this has happened to you. Blue Cross and Blue Shield has control over life and over death. People have to be able to count on what they have paid for, count on having insurance. Blue Cross and Blue Shield will do anything to get out of paying for cancer, anything. Sad fact is, anyone with a catastrophic illness who is not a part of a group who has an individual policy stands a really high chance of getting cancelled, left out in the cold with no insurance. I go to a cancer support group every week. Four girls in my cancer support group have had their insurance canceled, and two of those girls have had to declare bankruptcy because of cancer.

It is very difficult for me to speak out. My insurance could be cancelled again. I live in fear every day of my insurance company. I looked everywhere for help. No one found anything to help me until Joe Barton and Krista Townsend after working for a really, really long time. Every day they worked hard. I had given up hope. I didn't have any hope left and they never gave up hope. They did everything they could to help me and they got my insurance reinstated.

After being diagnosed in June 2008 with aggressive breast cancer, I was placed back on a list to get a mastectomy, which I finally got to have my cancer surgery October 2, 2008. My tumor grew from 2 to 3 centimeters all the way to 7. I had to have all my lymph nodes removed in my arm, everything. Delaying cancer treatment, it only worsens the condition, costing more to treat and treatment is much more intensive. Also, the outcome is not as good. I go to chemotherapy every 3 weeks and I will have to be going for the next year. Cancer is expensive and no one wants to pay for cancer. I pray no one has to go through the sheer agony that I have had to ensure for one year. I did not deserve to have my insurance cancelled. Blue Cross and Blue Shield set out to get rid of me. They searched high and low until they found enough to cancel me and they did. I owe my life to Joe Barton. I pray that you will listen to my story and help people like me who are powerless against the big insurance companies. And today when I met Mr. Barton, that was the very first time I ever met him. He helped me not even knowing me, just because as a good man he just helped me. But I went everywhere. I went to the county hospital, I went everywhere looking for help, and you just get on a waiting list, and when you get on a waiting list your cancer grows.

So I just want to thank you all for listening to me and just please do something about it because I couldn't even tell you the people I know that have been through this. It is a horrible thing to go through. Thank you all so much.

[The prepared statement of Ms. Beaton follows:]

Testimony of Robin Beaton

My name is Robin Beaton, and I am 59 years old. I was a registered Nurse for 30 years. I worked in a hospital, had insurance, and was in good health. I retired from nursing, and started a small business. I got an individual policy with Blue Cross and Blue Shield ("Blue Cross") in December 2007.

In May 2008, I went to the dermatologist for acne. A word was written on my chart and interpreted incorrectly as meaning pre-cancerous. Shortly thereafter, I was diagnosed with Invasive HER-2 Genetic Breast Cancer, a very aggressive form of breast cancer. I was told I needed a double mastectomy. When the surgeons scheduled my surgery I was pre-certified for my two days hospitalization. The Friday before the Monday I was scheduled to have my double mastectomy, Blue Cross red flagged my chart due to the dermatologist report. The dermatologist called Blue Cross directly to report that I only had acne and please not hold up my coming surgery. Blue cross called me to inform me that they were launching a 5 year medical investigation into my medical History and that this would take approximately 3 months.

I was frantic. I did not know what to do or where to turn. I knew I could not pay for the surgery myself. Shortly thereafter I turned to my Congressman Joe Barton for help. Mr. Barton and Christy Townsend worked tirelessly to help me.

Next, I found out that my insurance was completely cancelled; this was devastating. I had to completely refocus on what to do where to turn because my insurance cancelled me. Cancer is expensive and no one wanted to pay for it. This is America and we deserve good Health Care.

Earlier in my life off and on I had a fast beating of my heart which was not a current problem, just something that happened when I was upset. I truly did not even think about this when I applied for insurance; I even offered to go take a physical they said no.

The sad thing is Blue Cross gladly took my high premiums and the first time I filed a claim and was suspected of having cancer they searched high and low for a reason to cancel me. There is a nurse who attends my church who works fulltime for Blue Cross and all she does is read medical records looking for reasons to cancel people. After she heard what happened to me, she told me how very sorry she was.

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

One of the main things I look forward to in my life is attending a cancer support group every Monday and Tuesday. We meet others who have cancer and share our lives. Four of the woman in my group had their insurance cancelled because of cancer. The women in my group frequently talk about once you have cancer you are considered uninsurable. This has been very difficult to speak because I could be cancelled again. I live with fear everyday of my insurance company.

Continuing my story after Blue Cross cancelled my policy I went everywhere looking for help. I went to County Hospital where I was placed on a waiting list to get a Mastectomy. Several times I went back to the County Hospital they would always say the same thing, "Why are you here?" I answered, "I have cancer and need a mastectomy." The county hospital stated, "Sorry we have misplaced your records." The process was unending trying to get help for cancer

I did every thing to get help. Everywhere you go takes time. No help was found until Joe Barton after working a great long time got Blue Cross to reinstate my insurance. After being diagnosed with invasive breast cancer in June 2008, I was placed back on the surgeons list to get my Mastectomy. I finally received the surgery on October 2, 2008. My tumor grew 2.3 cm to 7 cm also; I had to have all my Lymph nodes removed due to waiting from June to October 2.

I am still undergoing chemotherapy every three weeks. Cancer is expensive and no one wants to help. I pray with all my heart that no one has to go through the sheer agony that I have endured for 1 year.

I did not deserve to have my insurance cancelled. Blue Cross set out to get rid of me. Blue Cross searched high and low until they found enough to get rid of me.

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

Thank You
Robin Beaton
June 11, 2009

Mr. STUPAK. Thanks, Ms. Beaton.

Now we will turn for questions and I will begin. We will go for 5 minutes on questions. We will probably go a round or two per panel.

For our three panelists here, I would like to get your thoughts on some information the committee gathered about the economics of rescissions for insurance companies. The three CEOs who will testify after you have all made the case that their companies use rescission as a tool to rule out fraud by those who apply for coverage. But at the same time, we find these companies have also reported savings of an estimated \$300 million as a result of the rescissions from 2003 to 2007. That doesn't include all their subsidiaries and doesn't include all their files. But that is what we have come up with. And like I said, this figure doesn't include the savings gained by avoiding future medical costs of rescinded policyholders. So let me ask each of you, do you believe that the insurance companies use rescissions primarily as a fraud prevention tool or as a cost-savings instrument that will help them boost their corporate profits? Ms. Horton.

Ms. HORTON. I think it is all about the money.

Mr. STUPAK. Ms. Raddatz.

Ms. RADDATZ. It is absolutely about the money.

Mr. STUPAK. Ms. Beaton.

Ms. BEATON. Absolutely indeed. Try to use it, they will just keep on taking your money.

Mr. STUPAK. Well, each of you, as I have listened to your testimony, Ms. Beaton, you were an R.N., Ms. Raddatz, you are an attorney, and Ms. Horton, you had family members who were in the medical field, radiologists. You seem like a little bit more—you had access to people who could help you on this. What happens in your groups and people you have talked with, what happens to people who don't have that kind of support mechanisms within their family? What happens to them? Ms. Horton?

Ms. HORTON. They fall through the cracks. You know, there is nothing—even having radiologists in my family, you know, I had the opportunity to consult them before filling out the application. They live cross country. They have children. They work all the time, you know, and I don't know what those people would do.

Mr. STUPAK. Ms. Raddatz.

Ms. RADDATZ. As I stated in my testimony, my brother was very fortunate because of the fact that I have education and I know lots of people, and even all the attorneys that I know and judges who I went to to ask for help did not know what to do in this situation other than go through the court system. Unfortunately, when you have cancer or you are in a position where your life is shortened to a matter of months, you can't go through the court system because you don't have the time to do that. And what do people do? They do—many, many people throughout the United States do nothing because they don't have the ways or the means or the knowledge to take the steps necessary. They don't know all the—I know hundreds of attorneys. I have been practicing a lengthy period of time. They don't know all those people I know. So what do they do? They get the letter and they don't get the treatment that they need and many of these people die, and they think that is the

way it is supposed to be because they just don't know what to do. And I believe honestly that the insurance companies depend upon that lack of knowledge and lack of laws, federal laws in place, and that is one of the ways that they encourage their profits.

Mr. STUPAK. Ms. Beaton, do you want to add anything on that?

Ms. BEATON. I was going to say that a lot of people in my cancer group, they get letters like this. They just give up. They fade away and they die.

Mr. STUPAK. Well, you were fortunate, Ms. Beaton. You had our ranking member, Mr. Congressman Barton, who intervened or else you might not be with us here today. Was it clear to you in dealing with the insurance company that if you didn't have a U.S. Congressman working on your behalf that your insurance wouldn't have been reinstated?

Ms. BEATON. There is not doubt in the world that they would have even given me the blink of an eye if it hadn't been for him, and I just could never tell you how he worked. If you only knew how many hours he worked. They called me every day just working hours and hours and hours. This took a long time. This was like a many, many months' process. This didn't just happen overnight. So for his office to take that kind of a dedication to me, you know, I will be forever grateful. If I live and don't die of cancer, you know, it will be because of them. So only because of my Congressman, only because of him did I get help for my cancer. If it wasn't for that, it never would have happened.

Mr. STUPAK. Ms. Raddatz, sort of parallel to Ms. Beaton there, in your brother's case, the Illinois Attorney General's Office and Dr. Babs Waldman intervened and actually had to write two letters to the insurance company. In fact, one of them is at tab number 4 in the document binder there if you care to look at it. But the Attorney General's Office wrote, and I quote, "I find the behavior on the part of Fortis Health to be extremely troubling, if not unethical. Clearly there is no justification for rescinding this gentleman's insurance beyond avoiding the cost of his future treatment. To rescind, terminate his policy at this point is not only devastating but probably fatal to Mr. Raddatz." And then in the second letter, the company finally reversed its decision. So how did your brother know to enlist the assistance of the attorney general? Was that through you?

Ms. RADDATZ. Yes, it was absolutely through myself, and like I said, even I had difficulty in finding that outlet. It took me a while to get to the Attorney General's Office but we are fortunate in the State of Illinois to have a Health Bureau in Lisa Madigan, Attorney General's Office. We are very, very lucky to have an aggressive unit and they are available for the citizens of the State of Illinois who go through the same situation that my brother did. But again, most people, you know, do not have the knowledge that I have, and by the way, it took two appeals to them. The first time she wrote the letter, they said no. So it took a further letter to them before they did, you know, reverse their decision.

Mr. STUPAK. Thank you.

Mr. Barton for questions.

Mr. BURGESS. Mr. Chairman, may I ask a question?

Mr. STUPAK. No, it is Mr. Barton's turn unless he wants to yield you time.

Mr. BARTON. I will be happy to—

Mr. BURGESS. It is just purely a technical question. As a doctor, I get nervous with so many lawyers around me. There is an active—

Mr. STUPAK. You should feel secure.

Mr. BURGESS. It is less than secure. It is the opposite of secure.

As I understand it, there is an active class-action suit of one of the witnesses before us this morning?

Mr. STUPAK. In California, I believe, it has been going on for some time. I think Ms. Horton is maybe a plaintiff in that action.

Mr. BURGESS. Well, the speech and debate clause notwithstanding, are we subjecting ourselves to possible subpoena to testify in that court by our questions here today or our opening statements here today?

Mr. STUPAK. No, but if you wish to, we could arrange it.

Mr. BURGESS. No, I don't want a trip to California. That is the last thing I want. Again—

Mr. STUPAK. No, I think we are OK. We are not asking anything about the nitty-gritty of the lawsuit or anything like that. This is a committee investigation, and we would be exempt.

Mr. BURGESS. Can counsel answer that question for us?

Mr. STUPAK. Do either one of you care to comment on it? We are in an official setting. This is an official hearing of the U.S. Congress. Speech and debate protection certainly helps us but I don't think any of us are going to ask about the class-action suit. Yes, the speech and debate clause certainly applies.

Mr. BURGESS. I thank the chairman.

Mr. STUPAK. Mr. Barton, questions, please.

Mr. BARTON. Thank you, Mr. Chairman.

I want to again thank each of the three witnesses. I want to make a comment on what Ms. Beaton said about myself. There are 435 Congressmen and every one of us, our job is to help constituents. I have four full-time caseworkers. Mr. Wright, to my left here, was my district director at the time. I had Kristi and Debra and Jody and Ron, Linda Gillespie, all of them intervened for you. I came in at the very end and talked to the president but, you know, not just myself but every Member of Congress, we help hundreds and sometimes thousands of people every year. Your case just happened to be life and death and we put a lot of extra effort into it because we knew how important it was to get you health care as quickly as possible. But it is not just me, it is every Member of Congress that tries to serve our constituents.

My first question will be to the gentlelady down to the far right. You said that your application, they asked several questions several different ways and they were very tricky. Is it your understanding that that is a standard practice in the individual insurance market? Do they start out with the intention of setting you up so that later on they may disqualify you? Is that your opinion?

Ms. HORTON. Yes, that is my opinion. You know, I believe that they ask you the same question several times so that if you disclose it in one area and then don't realize that you need to disclose it

again, that they can somehow say then that you have, you know, committed fraud.

Mr. BARTON. Are you aware since your lawsuit if they have made some changes to that questionnaire?

Ms. HORTON. I believe that was one of the things they were trying to negotiate with Blue Cross, was changing the application, but I don't know what the status of it is.

Mr. BARTON. My next question is to the gentlelady there in the middle. Your brother, has he had his stem cell transplant?

Ms. RADDATZ. He did indeed receive the stem cell transplant. It was extremely successful. It extended his life approximately 3½ years. He did pass away January 6, 2009, and he was about to have a second stem cell transplant. Unfortunately, due to certain situations, his donor became ill at the last minute and so he did pass away on January 6. But again, it extended his life nearly 3½ years and at his age, each day meant everything to him and each day that we had him was wonderful, and my daughter, who is behind me, and I and his wife and his other brother, Richard, we spent the last 30 days, every single day with him at his side, and like I say, there couldn't be any better memorial to my brother than what this committee is doing because life is so precious and in spending those last moments of his life with him for 30 days, at the end we realized how important this work you are doing is and we just want to say again from our family, thank you all so much. We know with Mr. Gordon here that you have been working round the clock 7 days a week and very, very hard, and Mr. Gordon, thank you and your staff for all your hard work. Thank you.

Mr. BARTON. Ms. Beaton, what have your doctors told you your condition would have been had you had the mastectomy immediately as originally scheduled? Would you have had to undergo the chemotherapy and is it probable that the cancer would have spread to the lymph nodes as it apparently has?

Ms. BEATON. They said that every day that I put off the surgery was a really, you know, day that the cells just multiplied and grew, and I think there is a strong chance that in the beginning that maybe I didn't have to have—I could have had a lesser surgery and not have had my lymph nodes taken out. I would have had to have chemo but maybe not for quite as long a period of time.

Mr. BARTON. If it is personal—it is personal—you don't have to tell us, but would you tell us as much as you can about your prognosis right now? Is the expectation positive for your chemotherapy and cancer remission or is it still up in the air?

Ms. BEATON. It is still up in the air.

Mr. BARTON. Mr. Chairman, my time is about expired. I am going to yield back. I think I speak for every member of the committee on both sides of the aisle, we want to hear from the insurance companies in the next panel, but it is clear that if in fact there is a practice of going in after the fact and canceling policies on technicalities, we have got to do whatever is possible to prevent that. I think a company does have a right to make sure that there is no fraudulent information but it is obvious to me that—I will guarantee you in Ms. Beaton's case there was no fraud intended, and I am convinced with the other two witnesses that they were being truthful and honest also, and if a citizen acts in good faith,

we should expect the insurance companies who take their money to act in good faith also. And I will tell you, Ms. Beaton, we will monitor your case and we will stay in touch with Blue Cross/Blue Shield of Texas and so long as you do what you are supposed to do, I will guaran-damn-tee you they will do what they are supposed to do.

With that, Mr. Chairman, I will yield back.

Mr. STUPAK. Thank you, Mr. Barton.

Ms. Schakowsky for questions, please.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and after hearing the testimony, I want to thank the witnesses even more for sharing this.

I wanted to talk about rescissions for unrelated medical conditions. I understand that they scour the records to find anything but, Ms. Beaton, let me understand what happened to you. After your insurance policy began, you developed breast cancer and the insurance company decided to investigate your application but it didn't find any evidence that you had breast anything before you got your policy, did it?

Ms. BEATON. No.

Ms. SCHAKOWSKY. So it was rescinded because essentially of pimples, right? Is that what you're saying?

Ms. BEATON. They rescinded because of—what it all started with was the red flag. What that means is something suspicious, so they red flag you. Then they go back and they just cut your chart apart, and what they found was on my weight, I think I put down—I said what woman is going to tell you what she really weighs, you know. I weighed more than what I put down, and they said that they might not have given me a policy because I was overweight. And the second thing was, I had—in my early years I had a previous fast beating of my heart and I didn't have a problem with that anymore, but anyway, that was brought up. Everything they could possibly dig up in my whole life history got brought up, unrelated to the cancer, nothing related to the cancer.

Ms. SCHAKOWSKY. So if we lie about our weight at all, we better look out, huh?

Ms. BEATON. They will get you.

Ms. SCHAKOWSKY. I better change my driver's license.

Ms. Raddatz, it sounds like your brother had a similar experience. He signed up for an insurance policy, then was stricken with an aggressive form of lymphoma, and the insurance company, which is now part of Assurant, investigated his application but it didn't find any evidence that your brother had cancer before his insurance policy, right?

Ms. RADDATZ. That is correct.

Ms. SCHAKOWSKY. So—

Ms. RADDATZ. He did not have cancer prior to—at the time he signed up, he did not have cancer.

Ms. SCHAKOWSKY. So it rescinded his policy based on alleged misstatement about gallstones and you said aneurysm, which is what? A weak blood vessel, right? Does that have anything to do with anything?

Ms. RADDATZ. Nothing whatsoever.

Ms. SCHAKOWSKY. And he didn't—

Ms. RADDATZ. The gallstones actually, like I said, he never even knew he had gallstones. He actually wrote down he had kidney stones and was treated for kidney stones. So when he got that letter, he thought that was an error, oh, they must have meant the kidney stones, but he disclosed that he did have kidney stones and they knew that when they gave him the insurance. He never knew he had minor gallstones, never to his death was ever treated for any gallstones, and was never treated for any aneurysm.

Ms. SCHAKOWSKY. So in addition then to having an unrelated medical condition, it was something he didn't know about at all. So when we hear, as perhaps we will, about fraud from the insurance companies, he even mentioned kidney stones that he didn't have, are you saying?

Ms. RADDATZ. He did have kidney stones and he did disclose those and was treated for those, and he was given insurance despite the fact that he had kidney stones. But had they not been able to find his doctor, who was retired and on a fishing trip in another State, they still might not have believed him because he had no knowledge of it. Luckily, they were able to find the doctor, who was able to say oh, yes, I never discussed those issues with him, I never treated him for those, they were very minor and they appeared on a CT scan but we never engaged in any treatment for those whatsoever and I never disclosed them to him.

Ms. SCHAKOWSKY. But ultimately even that, didn't it take the attorney general to get it changed?

Ms. RADDATZ. Oh, yes, it did, it absolutely did. Like I said, Lisa Madigan, the Attorney General's Office, and Dr. Babs Waldman were wonderful and their staff were just incredible. They were working daily on this file because they knew that the clock was ticking every day and their investigations were—

Ms. SCHAKOWSKY. But what I am asking is, even if they found the doctor on the fishing trip and the doctor had said what he thought, that wasn't enough apparently?

Ms. RADDATZ. It wasn't. At that point they still wrote a letter saying no, too bad, it was a material lack of disclosure, and Dr. Waldman had to contact them again and discuss it further.

Ms. SCHAKOWSKY. And Ms. Horton, your situation is that your policy was rescinded because you were seeking some insurance coverage, or how did that work for you?

Ms. HORTON. I was seeking the policy when I was going over from a group health insurance plan.

Ms. SCHAKOWSKY. So this is just a denial from the beginning because of—

Ms. HORTON. I was accepted and then the first time I went to see a doctor I received a letter from Blue Cross stating that they wanted all of my medical records, and it was a bill for just routine blood work. It was to test my T4 level, which is your thyroid hormone, and so it was routine blood work that anyone who has an underactive thyroid, which I disclosed, would get and I had paid almost three times more in premiums than they needed to pay out and they still sent me to this, you know, post-claims underwriting department where they went through my medical records, they found, you know, a mention of something in her notes that she never disclosed to me, and both of my doctors wrote letters in sup-

port of the fact that they had not discussed the condition with me that they suspected I had but could prove.

Ms. SCHAKOWSKY. So we know that—it seems obvious that anything that might relate to cancer treatment they are going to scour the records. In your case, it might have been something about the blood work that you were having?

Ms. HORTON. In my case, it just proves that there is no condition too small that they are willing to send you to this department for. You know, I did not have anything even close to life-threatening nor as expensive as some of the people on the panel, and it just shows you that you can't be too young or you can't be too healthy for them to send you to this department.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Burgess for questions, please.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. Beaton, let me ask you, Blue Cross and Blue Shield came back to you after finding out you needed the surgery and said that they were taking your insurance and the date of rescission was dated back to the date of enactment of the insurance. Is that correct?

Ms. BEATON. I am kind of hard of hearing.

Mr. BURGESS. Your rescission was effective on 12/07, which was the date that the insurance was initiated. Is that correct?

Ms. BEATON. Right. They gave me back all my premiums.

Mr. BURGESS. OK. That was going to be my question. They refunded the—

Ms. BEATON. I never cashed the check because Mr. Barton told me never to cash it and I never did. They rescinded all my money back to the day that they said—in simple language, they wanted nothing to do with me. They gave me back every penny that I had ever given them and they considered never being insured by them.

Mr. BURGESS. And Ms. Raddatz, what about in your brother's situation? Was there a refund of premium back to the date of the rescission?

Ms. RADDATZ. Yes, they didn't actually get to that point because it got resolved before they refunded the money but they sent a letter stating yes, you are rescinded to the date of the original contract, which was before my brother had any cancer treatments at all, and \$200,000 back, so my brother would have to pay out of pocket over \$200,000 in medical expenses.

Mr. BURGESS. But they never got to the point where they sought that refund from your brother?

Ms. RADDATZ. Well, again, the \$200,000 was the amount that his medical bills—

Mr. BURGESS. So those were subsequent bills?

Ms. RADDATZ. Right. That would have been what he would have had to pay out because they were rescinding their contract and so they were then stating we are rescinding all the way back to the original date of the contract so you have never had any insurance at all for the entire time you have had cancer. You now have no insurance.

Mr. BURGESS. So that was actually—that retroactive pronouncement also dealt with the money that they had used to pay for his cancer treatment to date. Is that correct?

Ms. RADDATZ. That is correct.

Mr. BURGESS. Now, in your brother's situation also, I think you said that he was told he would have to have a certain sum of money or he couldn't get the bone marrow transplant. Is that correct?

Ms. RADDATZ. That is correct.

Mr. BURGESS. But that wasn't the insurance company that told him that, that was the medical facility?

Ms. RADDATZ. That was the hospital coordinator. When I called to literally beg her to schedule the stem cell transplant because my brother was on pins and needles being ill, going through aggressive chemotherapy and readying himself for this transplant, which is a long step-by-step procedure medically, then they wouldn't schedule him because the insurance company said he is no longer insured so we will not schedule you for your stem cell transplant that you were supposed to have within the next 3 weeks, we will not schedule you. So I got on the phone and literally begged her, and no.

Mr. BURGESS. Let me ask you a question. It doesn't really have to do with the subject of the hearing today but it figures into the larger discussion that we are having. Was any other plan delineated for you then, another option you might have would be medical school at Northwestern or Cook County or were there any other options discussed?

Ms. RADDATZ. No, there really weren't because my brother's doctor was one of the most renowned doctors in the whole world on the specific routine of treatment and he had a very specific type of cancer that really had to be treated by that doctor in that hospital at that time, and you can't just say well, OK, you can have it a couple months down the road or you can wait. I mean, again, the Attorney General's Office realized thankfully because it is headed by a doctor, medical doctor, that time was of the essence.

Mr. BURGESS. It is just that I can recall multiple times when I was in practice you come up on these situations and you find a way to make it work for the patient. I guess I am a little frustrated in your situation in that you were essentially allowed or offered no other option. I appreciate the fact that particularly for that type of non-Hodgkin's lymphoma that it may require very, very specialized type of care. My frustration is as a physician, I just cannot tell you the times that I found another hospital or another way to make it happen and not wait the lengths of time that you all are discussing.

Ms. Beaton, in Tarron County, I mean, there is a county hospital. Was that ever—did anyone ever try to help you through that tangle to try to get any care through John Peter Smith?

Ms. BEATON. I couldn't qualify for that, but what I did do is, I moved in with my sister in Cedar Hill for a while so I could declare residency and went to Parkland Hospital, the Dallas county hospital, tried to get help there. You get on a waiting list for a mastectomy. And three or four times I went there and they lost my medical records. They said why are you here. I said I am here, I have cancer, I need to get a mastectomy. They said we will put you on the waiting list. Well, I do believe with all my heart that today my name still wouldn't be up on the waiting list because they never even contacted me back, but I am thankful to say that in trying

to get help, like you said, going to all the county hospitals, applying for the State programs, doing all that kind of stuff, Mr. Barton got my insurance reinstated and I was able to have insurance with the original doctor who I wanted to have insurance with.

Mr. BURGESS. Sure, and I appreciate that and I think that is—I believe in continuity of care and I believe that is important, and again, the other aspect is not really a part of our discussion today but it is part of our broader discussion as we talk about strategies for the future. I want to thank every one of our panelists for being here today. Ms. Horton, I didn't get to you. It is not because I was afraid to get to you, I just didn't have an opportunity, but thank you too for your testimony as well. It was all very important today.

Thank you, Mr. Chairman. I will yield back.

Mr. STUPAK. Mr. Gingrey for questions, please.

Mr. GINGREY. Mr. Chairman, thank you, and I am going to direct my question to Ms. Beaton.

Am I pronouncing that right?

Ms. BEATON. It doesn't matter, Beaton, Beaton.

Mr. GINGREY. Ms. Beaton, we of course heard and listened very intensely to your testimony and quite compelling, and I wanted to take one quote from your written testimony and I think you said when you get on a waiting list, cancer grows, and I think that was in reference to the fact as you just testified to Dr. Burgess that you were on that waiting list at the county hospital. There was an alternative but thank God that your Congressman and my colleague, Joe Barton, was able to intervene and you were able to get the care at the private hospital and by your physician that you trusted and that you wanted to do the surgery. This statement that you made is absolutely right. I don't know if you know it, but I am a physician too, an OB/GYN doctor before being elected to Congress, and your statement is a profound one indeed: when you get on a waiting list, cancer grows. And when we look at statistics of countries where you routinely get put on a waiting list like the U.K. and others, in particular in the treatment of breast cancer, in our country where hopefully you don't get put on a waiting list when you have breast cancer, you get operated on quickly, the 5-year overall survival rate for breast cancer is 98 percent. But in the U.K. system where you frequently get put on a waiting list, the 5-year survival rate for breast cancer is 78 percent. That is a significant change, and as you described to us, that 2-centimeter mass grew to 7 centimeters and lo and behold you have to have your lymph nodes removed and I guess some of those were positive by the time you finally got operated on. Is that the case?

Ms. BEATON. Yes.

Mr. GINGREY. Well, with that information, let me just ask you this question, and it relates to you in particular but it relates to everybody in general, and I would appreciate your thoughts on ways that you think that we can strengthen the private market so that other people, anyone with chronic illness can find affordable health insurance or do you think we should turn over our health care system lock, stock and barrel to the compassion and efficiency of our federal bureaucracy?

Ms. BEATON. All I can say is that I did go many, many different places trying to get help and I spent hours and quit working and

did all my focusing, instead of focusing on getting well and focusing on my cancer, I focused on trying to get treatment, and I went to every hospital in Dallas. I went to county hospital, I went to Fort Worth, I went everywhere, and I don't know how to fix it but all I know is there something terribly wrong with the health care system because when you go to big hospitals and there is so many people there waiting for help, I went to all the clinics. I sat with all the people that I just—you can't even imagine how many people are there waiting for help. You spend hours and hours. You probably spend the whole day trying to see a doctor. I did that. I did that for weeks and never got help. So and the bad thing about that is, when you go to different hospitals they give you different opinions. Every time I went to a different hospital, my tumor was a different size. Every time I went to another hospital, one person wanted to do one thing, one person wanted to do another. You get a difference in diagnosis, a difference in treatment plans. So who do you listen to, who do you know to listen to? And I don't know how to fix it but all I know is, when you have to go through this like every one of us has been through what we have been through, you just realize that it is something that is broken.

Mr. GINGREY. Ms. Beaton, I am going to reclaim my time because I just have a few seconds left, but I really thank you for that testimony, and I think you are absolutely right. There is something that needs to be fixed, something is broken, and when we hear from the second panel from the insurance companies, I am going to make some suggestions to them how we can fix this system, but it is my firm belief, Ms. Beaton, the other two, Ms. Horton, Ms. Raddatz, that we can fix this system without, as I say, turning it over lock, stock and barrel to a federal bureaucracy that routinely is going to ration and put people on the waiting list. But we will get into that later and I want to thank all three of you for being here today and giving us such compelling testimony.

Mr. STUPAK. We will go to Mr. Walden, but please don't accept Mr. Gingrey's description of a possible health care plan for the Nation based upon those comments. Some of us on the other side see it a little differently. But Mr. Walden for questions, please.

Mr. WALDEN. Thank you, Mr. Chairman. I appreciate the opportunity. I had to step out to another hearing I am involved in upstairs but I read your testimony this morning and so I appreciate what you have been through, although none of us can really understand what it is like to be in your shoes or that of your loved ones. It is not a good thing.

We have two physicians here, both Dr. Gingrey and my colleague from Texas, Dr. Burgess, and I think that is good to have. I hope at some point, given some CMS's role in overseeing HIPAA that perhaps we could have the federal agency that also has a role in this to come before our subcommittee as well to find out their take on what is happening.

Ms. Horton, you stated that you think the applications are deliberately confusing. I have looked through some of those, and I understand what you mean. Could you be a little more specific the kinds of questions that you found difficult and confusing?

Ms. HORTON. I haven't looked at the application in 4 years since I first filled it out so I can't be super specific but I do remember

them, you know, after looking at it again with my sister and brother-in-law, they both said you would have to be a doctor or a lawyer in order to figure out the application and fill it out to 100 percent accuracy.

Mr. WALDEN. How would each of you improve that application process? Because it seems to me that that is kind of the crux of the argument here is, there are things that you didn't know that were on your medical records or your loved one's medical records that they didn't know. I don't know you ever disclaim knowledge of something you have no knowledge of. That to me is one point here. And then the second is to know as a layperson if you are on some medication years ago and you haven't been taking it, it would be easy to forget that, I would think, or perceive that you no longer have whatever that was that you took the medication for so you don't note it or you forgot it, and yet, you know, we also know there are cases of fraud and those people that were like you with individual policies paying more because people were deliberately trying to get on the rolls, and our files that we got from the companies indicate that too. So I am trying to figure out, how do we get a balance here where people like you and your loved ones aren't rescinded from coverage and yet find this balance and it seems to get back to the initial application process, the review of those applications and then better understanding for those of us who may be signing up for that type of health insurance, so I am curious, how would you fix at least that part of the process? Anyone want to tackle that?

Ms. RADDATZ. I would just state that the insurance company at the time you apply for insurance and you disclose your doctors, they should be the ones that have to do the investigations. If they don't do the proper investigation at the time you apply, they shouldn't have the right to go back years later. You know, there is a 2-year window for the insurance companies by which they can do their investigations. No, that is wrong. They should have to investigate before they give you your insurance. They have all the opportunity to investigate then. You disclose your doctors, let them get the records, let them look at and comb the records at that time. Why are they doing that later on when people—

Mr. WALDEN. When you have a big claim.

Ms. RADDATZ. Pardon me? Absolutely. I mean, if that isn't intentional, what is? They want to save money and wait until you have claims before they spend the investigative money to do what they should do at the beginning. So all this time they haven't done their job. They are taking the consumer's money and the consumer thinks I am insured, but I am not insured and that is not right. That law needs to be changed.

Mr. WALDEN. Ms. Beaton, do you want to comment on that?

Ms. BEATON. Yes. Just like myself, I asked could I have a physical. I wanted to have a physical for insurance and they said no, we don't do that. So I even offered to let them have a physical on me, which to me that would be a good thing. You know, that way if there is anything they don't want, they don't have to take you.

Mr. WALDEN. We have that in Medicare, I think.

Ms. BEATON. They don't do that at all, so they don't want to spend the money for a physical to give it to you to rule you out then so you don't get your hopes up and think you have insurance.

Mr. WALDEN. OK.

Ms. HORTON. I completely agree with what Ms. Raddatz said, and I just wanted to add, you know, after this practice happens, which hopefully we are going to stop it from happening in the first place, but then when your physicians write letters on your behalf and aid you in appealing to these insurance companies, the fact that they give no weight whatsoever to what these physicians who have been treating you for years say, it is totally unconscionable.

Mr. WALDEN. I was reading through some of those examples of people who, you know, were rescinded and their physician says the patient would have no idea of this, it is a note I put in the file I never shared with them, and that doesn't seem right. Would it be helpful—and I realize I have run over my time here, but would it be helpful if there were also—it seems like there is yes and no columns on these forms. Given that I don't think any of you are physicians, would it be helpful if there maybe was an unsure, don't know column as well that you could check which then I would think if I am the insurer would cause me to go ah, there may be something here I should look at further. Because, I mean, the insurers, if you read through their testimony, they make the case that look, it is a very small percentage, although it is a very painful percentage—I am just telling you what they are telling us—small percentage. If we did everyone, it would slow down people getting access to insurance, blah, blah, blah. And so they are saying, you know, we go investigate those where we have cause or an issue. That is something we will get into on the next panel. But, you know, there is this notion that is a very small segment of the population and so, you know, to get people covered they go this direction.

Ms. HORTON. I don't believe that it is a very small segment of the population. I believe that they send anyone who sends in a claim to this post-claims underwriting department, and I have heard many people who formerly worked, you know, at insurance companies talk about these secret, you know, specific units that are designed to find errors or omissions or whatever you want to call them in people's records so that they can go back and save money.

Mr. WALDEN. And I think we actually get some of that testimony from our final witness from Georgetown that says it may be a small percentage but it is perhaps a big percentage of the claim costs.

Ms. RADDATZ. And I would just like to say, those are the people you know of. There are many people out there who lose their insurance and then go on Medicaid, go on welfare, go without insurance. You are not aware of who those are. Those are their numbers. Those aren't the consumer's numbers. We don't really know how many people are out there, and you know what? I don't care if there is just the three of us. That is too many. One too many who dies because an insurance company cancelled their insurance is one too many.

Mr. WALDEN. Ms. Beaton, any final comment? I just wondered if you had any final comment on that point. It is OK if you don't.

Ms. BEATON. I am real hard of hearing. What did you say?

Mr. WALDEN. I just wondered if you had any final comment.

Ms. BEATON. Oh, I just agree with both of what they said and I know so many people in my cancer group that I wish could be here to talk to you, that you wouldn't believe their stories. So it is common practice and you will never know how common it is, and when they hire nurses to investigate who sit there their whole shift doing nothing but review medical records looking for things to get rid of people, and that just shows you right there.

Mr. WALDEN. Indeed. Thank you very much.

Thank you, Mr. Chairman, for your indulgence.

Mr. STUPAK. Thank you. I ask unanimous consent that a statement from Rosa DeLauro, Member, be placed in the record.

[The information was unavailable at the time of printing.]

Mr. STUPAK. Let me just ask a question. You know, we have focused sort of on what happened to you three as we should and rightfully so but, you know, we found close to 20,000 cases in looking where there were rescissions over the last few years from three insurance companies here who will be testifying on the next panel, like a spouse gets in a bicycle accident and had some fractured bones and they denied it because her husband had back surgery. What bearing that had on the lady's fractures is beyond me. But that is what we are seeing. But Ms. Beaton, one thing I want to ask you, in your testimony you stated, and I am going to quote now, that you "live with fear every day of my insurance company." What are you afraid your insurance company might do?

Ms. BEATON. Without a doubt, some day they will cancel me. Some day Mr. Barton won't be there to protect me, and you know, I am young and they will find something to get rid of me. Somehow I won't have insurance. Some day I will be—out of Blue Cross and Blue Shield's record they will find a way to get rid of me, and coming here today I think will just about maybe do it.

Mr. STUPAK. So if your lost your insurance, you are afraid you would never get insurance from another company since you have been rejected once?

Ms. BEATON. If I lost my insurance what?

Mr. STUPAK. Are you afraid you would not be able to pick up another individual health insurance policy?

Ms. BEATON. I am uninsurable. The only way I could ever get insurance, through being a registered nurse I could go back to work in a hospital and be covered under a group. They could not deny you that way. I have done a lot of research about that. But as far as the individual policy, for the rest of my life I am uninsurable.

Mr. STUPAK. Because of your preexisting condition?

Ms. BEATON. Because of my cancer. Once you have cancer, you are uninsurable forever.

Mr. STUPAK. Thank you.

I apologize, Mr. Deal, I didn't see you there, but 5 minutes for questions.

Mr. DEAL. That will teach me to wear a light-colored suit. Thank you, Mr. Chairman, and I just simply wanted to express my appreciation to the witnesses for coming today. Certainly none of us condone abuses within the system, and you have pointed out some of those that appear to be in that category, and I know that it took a great deal of effort on your part to come and we appreciate your

courage and we appreciate your time that you have devoted to it. I do not have any questions of you. I think your testimony speaks for itself.

Thank you, Mr. Chairman. I yield back.

Mr. STUPAK. Well, that was pretty quick. Well, let me thank this panel for their testimony, their heartfelt testimony, and thank you for shedding some light on this and bringing a human face to a very serious problem. Thank you all for coming and thank you for your testimony.

I would now like to call up our second panel of witnesses. On our second panel, we have Don Hamm, who is the chief executive officer of Assurant Health; Mr. Richard Collins, who is the chief executive officer at Golden Rule Insurance Company, which is owned by United Health Group; Mr. Brian Sassi—am I saying that right?

Mr. SASSI. Sassi.

Mr. STUPAK. Sassi, who is president and chief executive officer at WellPoint Incorporated, and Ms. Karen Pollitz, who is the research professor at Georgetown University Health Policy Institute. Welcome, all our witnesses. It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under the rules of the House to be advised by counsel during your testimony. Do you wish to be represented by counsel during your testimony?

Mr. HAMM. Yes, if necessary.

Mr. STUPAK. Mr. Hamm, you would?

Mr. HAMM. Yes, if necessary.

Mr. STUPAK. OK. So if any time during the questions if you want to get advice from counsel, just let us know and we will allow you. Counsel can't testify but they can advise you. Mr. Collins?

Mr. COLLINS. No, sir.

Mr. STUPAK. Mr. Sassi.

Mr. SASSI. No, sir.

Mr. STUPAK. Ms. Pollitz.

Ms. POLLITZ. No.

Mr. STUPAK. So you are already standing. Let us raise your right hand and we will take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative. They are now under oath beginning with your opening statement. You have 5 minutes for an opening statement. You may submit a longer statement for inclusion in the record. Mr. Hamm, if you don't mind, I will start with you, start from my left and go to our right.

TESTIMONY OF DON HAMM, CHIEF EXECUTIVE OFFICER, ASSURANT HEALTH, ASSURANT; RICHARD COLLINS, CHIEF EXECUTIVE OFFICER, GOLDEN RULE INSURANCE COMPANY, UNITEDHEALTH GROUP; BRIAN A. SASSI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CONSUMER BUSINESS, WELLPOINT, INC.; AND KAREN POLLITZ, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

TESTIMONY OF DON HAMM

Mr. HAMM. Chairman Stupak, Congressman Walden, members of the subcommittee, I am Don Hamm, president and CEO of Assurant Health. I welcome this opportunity to participate in the hearing today. It is through dialog like this that we can continue to address one of the most challenging issues of our time, providing health insurance coverage for all Americans.

We appreciate that this subcommittee and Congress are committed to finding the right ways to address health care reform. 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 because risk is shared among all. I passionately believe that all Americans must have access to high-quality, affordable health care regardless of their income or their health status, and I am proud to lead a great company that provides health coverage to individuals and families in 45 States. People need our products and we are proud to provide them to thousands of Americans.

Individual medical insurance is portable and belongs to each consumer. In these uncertain economic times, individual medical provides benefits to a growing population who do not receive employee-sponsored health coverage. That is why individual medical is so important. We work hard to ensure our health questions include simple, easy and straightforward language. A correct medical history is necessary so we can fairly assess the health risk of each applicant. The vast majority of people complete the enrollment form accurately. The underwriting process depends on this information and we rely upon consumers' disclosures. People applying for individual insurance are given multiple opportunities to verify, correct and complete the information they provide. They are given 10 days to notify us of any inaccurate information or to reject the coverage.

As Assurant Health, we are acutely aware of how our coverage affects people's lives. It is a responsibility we take very seriously. Unfortunately, there are times when we discover information that was not disclosed during the enrollment process, and when this information is brought to our attention, we ask additional questions to determine if the information would have been material to the underwriting risk we assumed. Accurate risk assessment keeps rates lower for all.

Assurant Health does not want to rescind coverage. We are in fact in the business of providing health care coverage. We regret the necessity of even a single rescission. The decision is never easy, and that is why we follow a fair and thorough process that includes a number of careful reviews. Here is how our system works. When

we become aware of a condition that existed prior to the application date and that information was not disclosed, a senior underwriter reviews the omitted information to determine if it was material to the underwriting decision. Then the underwriting manager verifies the analysis. If the omission was not material, the review is complete. If the omission was material, the underwriter makes a recommendation to a review panel, which includes at least one physician. This review panel evaluates the information and makes a decision. The amount of the potential claim is never disclosed to the underwriters or to the review panel. The decision to rescind is only made when the undisclosed information would have made a material difference to the underwriting decision based on our guidelines. The consumer is given the opportunity to provide additional information before coverage is rescinded. This information is evaluated and a decision is made. If the consumer is dissatisfied with the decision, we provide multiple opportunities to appeal, which now includes an option to request a medical review by an independent third-party company.

Rescission affects less than one-half of 1 percent of the people we cover. Yet it is one of many necessary protections for affordability and viability of the individual health insurance in the United States. Assurant Health supports the principle that everyone in the United States deserves affordable health care and we see reform of our Nation's health care system as a shared responsibility between doctors, consumers, health insurers and policymakers who collectively can deliver effective solutions to provide coverage for all Americans, and that is why at Assurant Health we will continue to participate in efforts to reform and improve health care in America. Thank you.

[The prepared statement of Mr. Hamm follows:]

TESTIMONY OF



ASSURANT
Health

DON HAMM
PRESIDENT AND CEO
ASSURANT HEALTH

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

ON

INDIVIDUAL HEALTH POLICIES

JUNE 16, 2009



Testimony of Don Hamm
Assurant Health
June 16, 2009

Chairman Stupak, Ranking Member Walden, and Members of the Subcommittee, I am Don Hamm, President and CEO of Assurant Health.

I welcome the opportunity to participate in this hearing. It is through dialogue like this that we can achieve the goal we all share – providing health care coverage for all Americans.

We appreciate that Congress and the Members of this Subcommittee are committed to finding the right ways to address health care reform. 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 because risk is shared among all.

I passionately believe that everyone must have access to high-quality, affordable health care regardless of their income or health status. I am proud to lead a great organization that provides insurance coverage to individuals and families in 45 states.

People need our products, and we are proud to provide them.

Assurant Health is the brand name for individual medical insurance products underwritten and issued by Time Insurance Company and John Alden Life Insurance Company. We have been in the health insurance business for a long time. In fact, Time Insurance is one of the nation's oldest health insurers.

Assurant Health is headquartered in Milwaukee, with offices across the country. There are almost 2,500 employees on the Assurant Health team and our products are offered through more than 150,000 local insurance agents.



Individual Medical Insurance

Assurant Health understands the importance of health care coverage. More than 17 million Americans are covered by individual medical insurance.

Participation in the individual insurance marketplace is voluntary. Consumers decide when to purchase insurance and have a broad spectrum of alternatives.

Individual medical insurance is not dependent on employment, but rather, is portable and belongs to each individual. In these uncertain economic times, individual medical insurance provides increasingly important benefits to a growing number of people who do not receive employer-sponsored health care coverage.

Under the current system, all insurance companies must thoroughly analyze risk through the underwriting process before they offer coverage. Without doing so, the cost of coverage for all insurance would increase. Insurers rely on the accuracy of the medical information gathered through the enrollment process to make coverage decisions and to appropriately price and manage the risk they accept.

The Underwriting Process

Under the current system, where purchasing health care insurance is voluntary, people applying for coverage are asked about their medical history and status. Insurers seek information about medical treatment, visits, medications and symptoms.

Assurant Health's enrollment questionnaires are written in simple, easy-to-understand, straight-forward language so that people can easily and accurately report their medical history. If the questions on the application are answered accurately and completely, then we are able to assess the health risk and determine whether to offer coverage and at what price. Risk is pooled and prices are set based on the overall risk posed by the population of people that qualify for coverage.



Testimony of Don Hamm
Assurant Health
June 16, 2009

The vast majority of people fill out the enrollment form completely and accurately and we rely upon that information when determining whether to issue coverage. That is why we do not, as a matter of course, request medical records on each applicant who applies. To do so would be unnecessarily intrusive, limit access to health coverage by delaying issuance, and significantly increase administrative costs for all policyholders.

When we become aware of incomplete or inaccurate health information on the enrollment form, we inquire further. If additional review is needed, we ask the applicant for clarification and we may also request medical records from treating physicians in appropriate circumstances. Applicants often have immediate need for protection and we try to make our underwriting process as efficient as possible.

Assurant Health provides people with multiple opportunities to review their enrollment forms for accuracy and completeness. Once an offer of coverage is made, we mail the insurance contract and enclose a copy of the enrollment form. We remind customers that we have relied on the information on the enrollment form and ask that they read and review it for accuracy and completeness. We point this out both in a short cover letter and on the first page of the contract itself. The consumer is given 10 days to notify us of any inaccurate information or to reject the coverage.

Review Process

Unfortunately, there are times when we discover that an applicant did not provide complete or accurate medical information when we underwrote the risk. When this information comes to our attention, a senior underwriter reviews it to determine if it would have been material to the underwriting decision. A different underwriting manager then verifies the analysis. If we determine that the omission was not material, the review is complete and we do not rescind the coverage.



Testimony of Don Hamm
Assurant Health
June 16, 2009

If the omission was material, the underwriting manager makes a recommendation to a review panel, which includes at least one physician. This panel evaluates the information and makes a decision. The amount of the potential claim is never disclosed to the underwriters or review panel.

The decision to rescind is made only in cases where the undisclosed information would have made a material difference to the underwriting decision based on our guidelines.

The consumer is given the opportunity to provide additional information before coverage is rescinded. This information is evaluated and a decision is made.

If the consumer is dissatisfied with the decision, we provide multiple opportunities for appeal, which now include the option to request a medical review by an independent, third-party company.

If the rescission review process determines that the omitted information is material, Assurant Health attempts to avoid rescission by offering other options. For example, many people are offered an exclusionary rider for the previously undisclosed condition, so that the coverage otherwise continues in effect. Even if the application would have been declined had the accurate information been known when we underwrote the risk, Assurant Health does not rescind coverage for the entire family, but rather, offers to "reform" the coverage so that other family members can maintain their health insurance coverage.

Rescission is rare. It affects less than one-half of one percent of people we cover. Yet, it is one of many protections supporting the affordability and viability of individual health insurance in the United States under our current system.



Testimony of Don Hamm
Assurant Health
June 16, 2009

Health Care Reform in the United States

Assurant Health supports the principle that everyone in the United States deserves access to affordable healthcare regardless of their income or health status.

We see reform of our Nation's healthcare system as a shared responsibility between doctors, consumers, health insurers and policy makers – who collectively can develop effective solutions to provide coverage for all citizens.

Americans deserve a better health care system and that is why Assurant Health continues to participate in efforts to improve health care in the United States.

Thank you.

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Don Hamm
Assurant Health
President & CEO

Don Hamm became President of Assurant Health in September 2002 and Chief Executive Officer in January 2003. Don has a long history with the company. Starting in 1982, he served as Chief Information Officer while also heading up health operations and the Small Group department. He then worked as a principal with William M. Mercer, a consultant with Tillinghast Towers Perrin and Vice President of the Southeast Region for Blue Cross/Blue Shield of Wisconsin. He rejoined Assurant Health in 1999 as Senior Vice President and Chief Financial Officer.

Don has a bachelor's degree in actuarial science from Drake University and a master's degree in health care management from the University of Wisconsin – Milwaukee (UWM). He is a Fellow in the Society of Actuaries (FSA), a member of the American Academy of Actuaries (MAAA) and a Fellow of the Life Management Institute (FLMI).

Don serves on the Executive Committee of America's Health Insurance Plans (AHIP) and is active in the community, serving on the board of the Milwaukee Symphony Orchestra and the Greater Milwaukee Committee. He is also an advisory council member of the UWM School of Business and has served as the Co-Chair of the Health Division for the United Way Workplace Giving Campaign from 2006 through 2008.

Mr. STUPAK. Thank you, Mr. Hamm.
Mr. Collins, your opening statement, please, sir.

TESTIMONY OF RICHARD COLLINS

Mr. COLLINS. Good morning, Chairman Stupak, Ranking Member Walden, members of the subcommittee, thank you for inviting me to testify today. My name is Richard Collins. I am the CEO of Golden Rule Insurance Company. We are a UnitedHealth Group business that sells health insurance policies to individuals and their families. Golden Rule has been offering this important coverage for over 60 years. We seek to offer innovative and affordable products to meet the diverse health care and financial needs of our customers.

In our current health care delivery system, the individual insurance market operates primarily for families who do not have access to group insurance or government benefit programs. We have long advocated that our country needs comprehensive reform that includes modernizing our delivery system, tackling the fundamental drivers of health care cost growth, strengthening employer-based coverage, and providing well-targeted support for low-income families. To be effective, we believe the modernization of the individual market needs to contain all the following elements.

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

Until comprehensive reform is achieved, we believe 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 for rescissions and terminations of policies would cease to exist. Our company mission is to improve the health and well-being of all Americans. In the individual market, we accomplish this by covering as many consumers as possible with quality health insurance. We also work to keep our products affordable to accomplish our mission because the primary barrier to access is affordability. We understand that we have a responsibility to treat all of our policyholders fairly and I assure you, we take this responsibility very seriously.

Unfortunately, for a variety of reasons, some people choose not to purchase individual health insurance until they have a significant health event. This decision not only has enormous physical impact and financial impact on these families but raises the cost of health care for everyone. As you know, the practice of rescission

has long been recognized by the laws of virtually every State. Rescission is uncommon but unfortunate and a necessary recourse in the event of material and at times intentional or fraudulent misstatement or omission on an insurance application. Under our current system, failure to act on these cases is fundamentally unfair to those working families that play by the rules because it would severely limit our ability to provide quality and affordable health insurance. In the rare event that we determine it is necessary to rescind coverage and after a thorough investigation of the facts and in compliance with State laws and regulations, we follow practices and procedures designed to ensure a fair and transparent process for the individual. And as I indicated, our use of rescission is rare. Less than one-half of 1 percent of all individual insurance policies in 2008 were terminated or rescinded and in each case the affected customer was afforded the right of appeal.

In conclusion, we look forward to working with this committee, the Congress, State and federal regulators to continue to expand access to affordable health insurance coverage in the individual market. Thank you.

[The prepared statement of Mr. Collins follows:]



UnitedHealth Group

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Testimony of

Richard A. Collins

Chief Executive Officer of Golden Rule Insurance Company

Before the

House Energy and Commerce Committee

Oversight and Investigations Subcommittee

On

June 16, 2009

**TESTIMONY OF RICHARD A. COLLINS
BEFORE THE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 16, 2009**

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

Golden Rule has been offering this important coverage option for more than 60 years. We seek to offer innovative and affordable products that meet the diverse health care and financial needs of our customers.

In our current system of health care delivery, the individual insurance market operates primarily for families who do not have access to group coverage or to government health benefit plans. Unfortunately, for a variety of reasons some individuals choose not to purchase private health insurance until they have a significant health event. This decision not only has an enormous physical and financial impact on these individuals and their families, but raises the cost of health care for everyone.

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

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

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

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.

Our company mission is to improve the health and well being of all Americans. In the individual market we accomplish this by covering as many consumers as possible with quality health insurance. We also work to keep our products affordable to accomplish our mission. We have a responsibility to treat all of our members fairly and I can assure you we take this responsibility very seriously.

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

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

In the rare event that we determine it is necessary to rescind coverage after a thorough investigation of the facts and in compliance with existing state laws and regulations, we follow practices and procedures designed to ensure a fair and transparent process for the individual. And, as I indicated, our use of rescission is rare. Less than one half of one percent of all of our individual insurance contracts in 2008 were terminated or rescinded. And in each case the affected customer was afforded the right to appeal.

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

Mr. STUPAK. Thank you.
Mr. Sassi, your opening statement, please.

TESTIMONY OF BRIAN SASSI

Mr. SASSI. Thank you, Chairman Stupak, Ranking Member Walden and members of the committee for inviting me to testify before you today. I am Brian Sassi. I am the president and CEO of the consumer division of WellPoint.

We take contract rescissions very seriously because we understand the impact these decisions can have on individuals and families. We have put in place a thorough process with multiple steps to ensure that we are as fair and as accurate as we can be in making these difficult decisions. I want to emphasize that rescission is about stopping fraud and material misrepresentation that contribute to the spiraling health care costs. By some estimates, health care fraud in the United States exceeds \$100 billion, an amount large enough to pay for covering nearly half the 47 million uninsured. Rescission is a tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the cost of those who do not. The bottom line is that rescission is about combating cost driven by these issues. If we fail to address fraud and material misrepresentation, the cost of coverage would increase, making coverage less affordable for existing and future individual policyholders.

I would like to put this issue in context. While most people who are under the age of 65 obtain health insurance through their employers, some 15 million Americans purchase coverage in the voluntary individual market. In a market where individuals can choose to purchase insurance at any time, health insurers must medically underwrite applicants for current health risk. If an individual buys health coverage only when he or she needs health care services, the system cannot be sustained. While we understand and appreciate that this is a critical personal issue, individual market rescission impacts an extremely small share of the individual market membership. In our experience, we believe that more than 99 percent of all applicants for individual coverage provide accurate and complete information. In fact, as a percentage of new individual market enrollment during 2008, we rescinded only one tenth of 1 percent of individual policies that year.

The issue of rescission in health insurance surfaced in the media in 2006 and 2007, generating the public concern that we are here talking about today. Our main point today is the same as it was then: a voluntary market for health insurance requires that we protect our members from costs associated with fraud and material misrepresentations. Otherwise the market cannot be sustained.

In response to the public concern over the practice of rescissions, in 2006 WellPoint undertook a thorough review of our policies and procedures. Following that review, WellPoint was the first insurer to announce the establishment of a variety of robust consumer protections that ensure rescissions are handled as accurately and as appropriately as possible. These protections include, one, creating an application review committee which is staffed by a physician that makes rescission decisions; two, establishing a single point of

contact for members undergoing a rescission investigation; and three, establishing an appeal process for applicants who disagree with our original determination which includes a review by an application review committee not involved in the original decision. And then in 2008, WellPoint was the first in the industry to offer a binding, external, independent third-party review process for rescissions.

We have put all these protections in place with multiple steps because we cover millions of Americans and want to be as fair and as accurate as we can be. Some have asserted that health insurers provide a systematic reward for employees regarding rescissions. This is absolutely not the case at WellPoint. I want to assure the committee that there is no WellPoint policy to either factor in the number of rescissions or the dollar amount of unpaid claims in the evaluation of employee performance or in calculating employees' salary or bonuses.

In response to policymaker interest in enacting consumer protections related to rescission, WellPoint is proposing a set of rescission regulations with new consumer protections, and I have outlined these in my written testimony to the subcommittee. In addition, the health insurance industry has proposed a set of comprehensive and interrelated forms to the individual health insurance market as a whole. The centerpiece of this proposal is the elimination of medical underwriting combined with an effective and enforceable personal coverage requirement. In other words, insurers sell to applicants regardless of preexisting conditions as long as everyone enters the risk pool by purchasing and maintaining coverage. This would render the practice of rescissions unnecessary. Our proposals are examples of how we are working to find common ground on these issues so that we can make quality, affordable health care available to all Americans.

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

[The prepared statement of Brian Sassi follows:]

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

United States House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

June 16, 2009
(Written Submission)

Thank you Chairman Stupak, Ranking Member Walden, Chairman Waxman and Ranking Member Barton for inviting me to testify before you today.

We take contract rescissions very seriously because we understand the impact these decisions can have on individuals and families. We have put in place a thorough process with multiple steps to ensure that we are as fair and as accurate as we can be in making these difficult decisions.

I want to emphasize that rescission is about stopping fraud and material misrepresentations that contribute to spiraling health care costs. By some estimates, health care fraud in the U.S. exceeds \$100 billion per year,¹ an amount large enough to pay for covering nearly half of the 47 million uninsured. Rescission is one tool employed by WellPoint and other health insurers to protect the vast majority of policyholders who provide accurate and complete information from subsidizing the costs related to fraud and material misrepresentations. The bottom line is that rescission is about combating cost driven by fraud and material misrepresentation. If we fail to address fraud and material misrepresentation, the cost of coverage would increase, making coverage less affordable for existing and future individual policyholders.

I would like to put this issue in context. While most people who are under the age of 65 receive coverage through their employers, some 15 million Americans purchase coverage in the voluntary individual market. In a market where individuals can choose to purchase insurance at any time, health insurers must medically underwrite applicants for current health risk. If an individual buys health coverage only when he or she needs health care services, the system cannot be sustained.

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

¹ Sparrow, Malcolm. *License to Steal*.

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

I know that the Committee has been hard at work on health care reform and that some of these discussions have focused on ways to combat fraud and abuse within the government run programs. The federal government has concluded that fraud contributes significantly to Medicare, Medicaid, and welfare costs, and the government has increased its efforts through audits and other anti-fraud initiatives to reduce fraud, waste and abuse in these programs. Our efforts to reduce fraud that contributes to spiraling health insurance premiums is no different. Contract rescission is a standard practice in all industries involving contracts, including the federal government and its programs, where contract law provides that when a party is induced into a contract by material misrepresentations, that party has a right to rescind the contract.

The issue of rescission in health insurance surfaced in the media during 2006 and 2007, generating the public concern we are discussing here today. Our main point today is the same as it was then: a voluntary market for health insurance requires that we protect our members from costs associated with fraud and material misrepresentations. Otherwise the market cannot be sustained.

In response to public concern over the practice of rescissions, WellPoint in 2006 undertook a thorough review of our policies and procedures. Following that review, WellPoint was the first insurer to announce the establishment of a variety of robust consumer protections that ensure rescissions are handled as accurately and appropriately as possible. These protections include: 1) creating a new Application Review Committee which includes a physician that makes rescission decisions, 2) establishing a single point of contact for members undergoing a rescission investigation, and 3) establishing an appeal process for applicants who disagree with our original determination which includes a review by an Application Review Committee not involved in the

initial decision. And in 2008, WellPoint was the first in the industry to offer a binding, external, independent third-party review process for rescissions.

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

Some have asserted that health insurers provide a systematic “reward” or job performance recognition for employees regarding rescissions. This is absolutely not the case at WellPoint. While we did respond to the Committee’s request by providing rare references to rescissions contained in two performance reviews from 2003, this does not reflect any policy, and I want to assure the Committee that there is no WellPoint policy to factor either the number of rescissions or the value of claims not paid in the evaluation of employee performance or when calculating employee salary or bonuses.

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

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

- A requirement that allows an individual to purchase a policy he or she would have been eligible for had he or she included the appropriate information on the application.

In addition, the health insurance industry has proposed a set of comprehensive and interrelated reforms to the individual health insurance market as a whole. The centerpiece of this proposal is the elimination of medical underwriting combined with an effective and enforceable personal coverage requirement. In other words, insurers would sell to all applicants, regardless of preexisting conditions, as long as everyone enters the risk pool by purchasing and maintaining coverage. This would render the practice of rescission unnecessary.

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

Mr. STUPAK. Thank you.
 Ms. Pollitz, your opening statement, please.

TESTIMONY OF KAREN POLLITZ

Ms. POLLITZ. Thank you, Mr. Chairman, members of the committee. I am Karen Pollitz and I study private health insurance and its regulation at Georgetown University. Thank you for holding this hearing today. Health insurance rescission is a serious issue of utmost importance. In addition to the devastation that it visits on people, the problems explored today can teach us lessons that will be important for health care reform.

The individual market is a difficult one, as we all know, and because it is small and voluntary and vulnerable to adverse selection, there has been a lot of resistance to enacting a lot of incremental reforms to govern practices in this marketplace. However, with the enactment of HIPAA in 1996, the Congress did act to apply one important rule broadly to all health insurance including individual health insurance, and that is the rule of guaranteed renewability. Prior to HIPAA, individuals and small employers who bought health insurance and then made claims would sometimes have their coverage cancelled and HIPAA sought to fix that by requiring, and I quote "except as provided in this section, 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. Only narrow exceptions to guaranteed renewability are permitted and with respect to policyholders' behavior, the policy can be renewed or discontinued only if the individual moves out of the service area, fails to pay their premium or commits fraud."

Congress relies on States to adopt and enforce HIPAA protections and the federal government is supposed to directly enforce when States do not. As States implemented HIPAA, they adopted the guaranteed renewability rule but other conflicting provisions in State law remained unchanged. In particular, laws governing so-called contestability periods continue to permit insurers to engage in post-claims underwriting and to rescind policies or deny claims based on reasons other than fraud and failure to pay premiums. State laws create a window, usually two years, when claims made under a policy can be investigated to determine whether they may be for a preexisting condition. After the period of incontestability, a policy can be rescinded or a claim denied only on the basis of fraud, but during the window, if a claim is submitted by a new policyholder, the original application for coverage is reinvestigated, and if any, even unintentional, material misstatement or omission is discovered, consumers may lose their health insurance. That conflicts with HIPAA.

Now, clearly, when it comes to post-claims underwriting, protection against fraud is important but there is evidence that some insurance companies are not nearly as careful as they should be in their initial medical underwriting and rely instead on post-claims underwriting to catch their mistakes later. Applications for coverage may ask broad, vague or confusing questions, use technical terms and make it very difficult for consumers to answer accurately and completely, or other follow-up that should occur in the

initial underwriting may not. For example, if a 62-year-old submits an application indicating absolutely no health problems or health history that application may be considered and coverage issued without any further investigation at the time of application. Market competition and profitability create pressures on medical underwriters to do their jobs more quickly and cheaply. However, if medical underwriting is allowed in health insurance, it has to be completed upfront before coverage is issued. The recent subprime mortgage scandals where banks issued mortgages without adequate screening of consumers' financial status offers an analogy. When insurers issue medical underwritten coverage without carefully screening an applicant's health status and rely on post-claims investigations to avoid incurring a loss, consumers are vulnerable. How extensive is this problem? It is hard to say. The industry has offered its own estimates but official data are lacking, and that is troubling. The federal government has not kept track of this issue. At a hearing of the Government Oversight Committee last year, a witness for the Bush Administration testified that she had not acted on press reports of inappropriate rescissions or even looked into them. She did not appear to be aware of conflicts in current State law and she testified she had only four people on her staff who worked part time on HIPAA private insurance issues.

In conclusion, Mr. Chairman, this investigation into health insurance rescission has trained a spotlight on an important question. If the Congress enacts a law or an entire health care reform proposal, how will you know if that law is being followed? It is fundamentally important that along with federal protections for health insurance, you also enact reporting requirements on health insurers and health plans so that regulators can have access to complete and timely data about how the market is working in order to monitor compliance with the law. Congresswoman DeLauro has introduced a bill to create a federal office of health insurance oversight that establishes such reporting requirements on insurers and that appropriates resources so that the federal government and State insurance departments together can carry out those responsibilities. I hope the Congress will follow her leadership and make adequate oversight and enforcement resources part of health care reform.

[The prepared statement of Karen Pollitz follows:]



GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE

Statement of

**Karen Pollitz, Research Professor
Georgetown University Health Policy Institute**

**Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

June 16, 2009

Good morning Mr. Chairman and Members of the Committee.

I am Karen Pollitz, a Research Professor at the Georgetown University Health Policy Institute, where my colleagues and I study private health insurance and its regulation.

I applaud you for holding this hearing and for the investigation into rescission that preceded it. Rescission of health insurance coverage is a serious issue of utmost importance. It merits close scrutiny not only because of the devastation that coverage loss can cause for individuals, but also for broader lessons that can be learned as you embark on comprehensive health care reform.

Background information about individual health insurance

Rescission is just one problem facing individual health insurance market today. Other problems and weaknesses have been well documented.

In our dynamic system of health coverage, the health insurance status of individuals can change frequently. On average, two million Americans change or lose health coverage each month.¹ Particularly in this economy as layoffs sever access to job-based health coverage, people desperately need 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 or an offer of coverage with surcharged premiums or limits on covered benefits. Medical conditions discovered in the course of medical underwriting may be permanently excluded from coverage.²

Coverage under individual policies is typically far less than that provided under employer sponsored group health benefit plans and is often inadequate. Individual health insurance policies are characterized by high cost sharing and the exclusion or limitation of key benefits such as prescription drugs, maternity, and mental health care.³ Coverage in this market is also inefficient with administrative costs accounting for 30 percent or more of premiums, compared to 7 percent for large group health plans.⁴

Rates of turnover in the individual market are also very high. Most policyholders remain enrolled less than two years.⁵ Understandably people who rely on this market while they are between eligibility for job-based or public plans will leave as soon as they can rejoin other subsidized coverage. However, individual market insurers also engage in other practices to discourage people from staying as they age and their health status declines. For example, age rating can surcharge premiums for older policyholders by a factor of three to five, sometime even more. Durational rating applies surcharges at renewal for tenure; healthy policyholders can evade these surcharges by applying for new coverage and re-submitting to medical underwriting, but that option won't work for people who have become sick. Many insurers will also periodically introduce new products on the market and slow or cease marketing of older policies. This is sometimes described as

closing a block of business. Once older products no longer have a steady influx of new, healthy policyholders, the average health status of enrollees rapidly decreases and their premiums begin to spiral, eventually forcing them to drop or decrease coverage.

Making the individual health insurance market work better has, admittedly, presented a daunting challenge. This unsubsidized voluntary market is vulnerable to adverse selection. Many states have been reluctant to apply market reforms, such as guaranteed issue and community rating, to the individual market in the same way that these rules are more often applied to small group coverage. To date, Congress also has declined to apply many incremental reforms to the individual market. However, with the enactment of the Health Insurance Portability and Accountability Act of 1996, Congress did act to apply one important rule broadly to the individual health insurance market – guaranteed renewability.

Federal law guaranteed renewability requirement

Problems of individuals and small employers who had health coverage cancelled in the wake of expensive claims for medical care were widely reported in the 1980s and 1990s.⁶ This was a clear threat to health security that people expected from their insurance coverage. During the health care reform debate of 1993-1994, President Clinton's plan provided for guaranteed renewability of all health insurance, as did counter proposals put forth by many others.⁷ Calls for guaranteed renewability continued after that national health care reform debate concluded, and in 1996, the protection was included in the federal minimum requirements established for all health insurance by HIPAA. For individual health insurance policies, HIPAA requires

“Except as provided in this section, 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.” [emphasis added] Public Health Service Act § 2742(a)

A narrow and specific list of exceptions to guaranteed renewability requirement is enumerated in the law. An insurer may nonrenew or discontinue individual health insurance coverage based only on one or more of the following reasons: (1) nonpayment of premiums, (2) fraud, (3) the insurer discontinues a policy for all policyholders or exits the individual market altogether, (4) the policyholder moves outside the plan's service area, and (5) in the case of certain association coverage, the policyholder ceases membership in the association.⁸

State laws inconsistent with federal standard

Congress relies on States to adopt and enforce protections at least as strong as federal minimum standards established in HIPAA. Federal fallback enforcement is provided for when states fail to meet this standard.

As States implemented HIPAA they generally adopted the guaranteed renewability rule. However, other conflicting provisions in state law remained unchanged. (See examples in Table 1.) In particular, laws governing so called “contestability periods” continue to

permit insurers to engage in post claims underwriting and to rescind policies or deny claims. State laws regulating incontestability periods create a window - usually two years - when claims made under a policy can be investigated to determine whether they

Table 1. Examples of State laws governing guaranteed renewability and post-claims underwriting

State	Guaranteed Renewability	Incontestability period
AZ	A health care insurer may nonrenew or discontinue the health insurance coverage of an individual in the individual market only for one or more of the following reasons: ...The individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage. A.R.S. § 20-1380(B)(2)	After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period." A.R.S. § 20-1346(A)
CA	[Health insurance shall be renewed or continued in force except] for fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual...Cal Ins Code § 10273.6(b)	After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred ... Cal Ins Code. § 10350.2(a)
CO	A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons: ...Fraud or intentional misrepresentation of material fact on the part of the... individual with respect to individual coverage... C.R.S. § 10-16-201.5 (1)(b)	After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... C.R.S. § 10-16-202(3)
FL	An insurer may non-renew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following: 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. Fl. Stats. § 627.6425 (2)(b)	After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred ... Fl. Stats § 627.607
GA	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. O.C.G.A. § 33-29-21	After two years from the date of issue of this policy and in the absence of fraud, no misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... O.C.G.A. § 33-29-3(a)(b)(A)
MI	...Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact. MCL § 500.2213b (3)	After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... MCL § 500.3408 (a)
PA	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. 40 P.S. § 1302.4	After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred ... 40 P.S. § 753 (A)(2)
TX	[Health insurance shall be renewed or continued in force unless] the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy... 28 TAC § 3.3038(c)(2)	After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary. V.T.C.A., Insurance Code s 1201.208

may be for a pre-existing condition. After the period of incontestability, a policy can be rescinded or a claim denied only on the basis of fraud committed by the policyholder when s/he applied for coverage and was medically underwritten. During this window, however, the fraud-only standard does not apply. Instead, a process of “post-claims underwriting” may be conducted and if any, even unintentional, material misstatement or omission is discovered, consumers may lose their health insurance, despite federal law protections.

Post-claims underwriting

Every health insurer has internal policies and procedures for post-claims underwriting investigations. In general, insurers maintain a list of health conditions and diagnosis codes or other reasons that can trigger a post-claims underwriting investigation. If a new policyholder makes a claim for care related to something on the list, her original application may be pulled for further scrutiny to determine whether information related to the claimed condition was disclosed at the time of application, or whether information about that condition – or any other aspect of her health status at the time of application – may have been misstated or omitted.

How the underwriting process and investigations are handled varies by carrier. Some insurers conduct the initial underwriting process very thoroughly, asking specific questions of applicants, conducting telephone interviews to follow up on information, and even checking medical records and claims that the applicant may have made in the past if they were previously covered by that carrier. All health issues identified during this process are dealt with at the time of application. For example, if the applicant is found to have high blood pressure, she may be offered a policy with a ten percent premium surcharge applied on the basis of that condition. If she accepts that offer and enrolls, her claims related to the high-blood pressure will then be paid.

Other insurers, by contrast, do not underwrite applicants as thoroughly. Underwriting questionnaires sometimes ask broad, vague, or confusing questions that may be difficult for consumers to answer accurately and completely. For example, the application might not ask specifically about high blood pressure, instead asking about “cardiovascular” conditions, which might cause some people with low health literacy skills to misunderstand the question. Even if an application appears unusually “clean” – for example, one submitted by a 62-year-old indicating absolutely no health problems or health history – some insurers might accept that application and conduct no further investigation before coverage is issued, knowing that if a problem has been overlooked, it will be caught later in a post-claims investigation.

Market competition and profit concerns create pressure for medical underwriters to do their job quickly and cheaply, and to rely more heavily on automated systems instead of individual follow up. However the process is conducted, however, if medical underwriting is allowed in health insurance, it should be completed up front, before coverage issued. The recent subprime mortgage scandal – where banks issued mortgages without adequate screening of consumers’ financial status – is analogous. When insurers

issue medically underwritten coverage without carefully screening an applicant's health status and rely on post-claims investigation to avoid incurring a loss, consumers are vulnerable.

Certainly, post-claims investigations will sometimes uncover instances of health insurance fraud. In other reported cases, however, consumers never suspected the coverage they had purchased was anything but secure, and they were devastated when, instead of having claims paid, their health insurance rescinded or terminated.⁹

How extensive is this problem?

Representatives of the insurance industry have testified that rescission is rare and occurs in less than one percent of policies.¹⁰ Even if this estimate is accurate, it is not necessarily comforting. One percent of the population accounts for one-quarter of all medical bills. The sickest individuals may be small in number, but they are the most vulnerable and most in need of coverage.

In addition to a lack of official data on rescissions, there also are not good data on the number of new policyholders who become subject to post-claims investigations or on the other possible outcomes of those investigations, including policy termination, policy "reformation," or imposition of a pre-existing condition exclusion.*

We don't have this information because health insurance industry medical underwriting standards and practices are proprietary. Insurers compete intensely on their ability to avoid risk. Yet, the stakes for people could not be higher. Access to timely and quality health care is directly related to access to health insurance. It is troubling to not know how frequently the problem of health insurance rescission applies, or who is harmed.

At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the Agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.¹¹

Lessons for health care reform

As Members of this Committee undertake broader reform of the health care system, health insurance rescission offers an instructive case study. Consumers will not be helped if the federal government enacts additional rules and protections, but provides no resources to monitor compliance.

* When a policy is "reformed" the original offer of coverage is changed to retroactively impose a premium surcharge, coverage exclusion, or benefit limit.

Under HIPAA, the federal government relies primarily on states to adopt and enforce health insurance protections at least as protective as federal minimum standards. However, at the state level, limited regulatory resources are also an issue. In addition to regulation of health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent. State regulators necessarily focus primarily on licensing and solvency.¹² Dedicated staff to oversee health insurance and, in particular, health insurer compliance with HIPAA rules are limited. Enforcement of consumer protections is often triggered by complaints.

Complaints-based enforcement is not sufficient; the sickest patients are most vulnerable to problems and may not always have the wherewithal to complain. Instead, more proactive monitoring and enforcement is needed. The black box of health insurance must be made transparent. Health insurers should be required to report regularly on market trends and practices – enrollment, disenrollment, claims payment and denials, and so on – so that regulators can easily track how and where people are covered and how well health insurance protection works. Legislation has been introduced by Representative DeLauro and Senator Rockefeller to establish an Office of Health Insurance Oversight at the Department of Health and Human Services.¹³ The bill provides for detailed reporting of data by health insurers and authorizes additional resources for both the new federal Office and for state insurance departments so that consumer protections can be adequately monitored and enforced.

Mr. Chairman, your investigations have shown that at least one important consumer health insurance protections guaranteed by federal law has not been completely implemented and is not always followed, and people are hurt as a result. With health care reform, Congress will enact further important consumer protections and appropriate hundreds of billions of dollars for health insurance subsidies. As you do this, it will be important to also provide adequate resources for oversight and enforcement at both the federal and state level.

Notes

- ¹ Short, P, Graefe, D. and Schoen, C, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," The Commonwealth Fund, November 2003.
- ² Collins, S., et.al., "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006. See also Pollitz, K., Sorian, R., Thomas, K., "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Henry J. Kaiser Family Foundation, June 2001.
- ³ Gabel, J., et.al., "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs Web Exclusive*, April 17, 2002, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.172v1.pdf>
- ⁴ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," December 2008.
- ⁵ Kaiser Family Foundation and ehealthinsurance, "Update on Individual Health Insurance," August 2004.
- ⁶ See, for example, "A Call for Action" U.S. Bipartisan Commission on Comprehensive Health Care, September 1990.
- ⁷ See for example, Associated Press, "US Governors Propose Universal Health Insurance," February 1, 1993. See also description of Senator Dole (R-KS) proposal in "Health care assault on the middle class," *The Washington Times*, July 26, 1994.
- ⁸ Public Health Service Act §2742(b)
- ⁹ Girion, L., "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, November 9, 2007. See also testimony of Heidi Bleazard, Committee on Oversight and Government Reform, July 17, 2008. See also testimony of Kevin Lembo, Connecticut State Health Care Advocate, Committee on Oversight and Government Reform, July 17, 2008.
- ¹⁰ Testimony of Stephanie Kanwit, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.
- ¹¹ Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.
- ¹² National Association of Insurance Commissioners, *2007 Insurance Department Resources Report*, 2008.
- ¹³ H.R. 2427 and S. 1050.

Mr. STUPAK. Thank you, and thank you all for your testimony. We will go to questions.

Mr. Sassi, let me ask you this because you threw a bunch of statistics at us, but I was just looking at the State of California alone, and it seems to me if I remember correctly, in July of 2008 Anthem Blue Cross, which is a subsidiary of WellPoint, paid a \$10,000 fine and had to reinstate 1,770 rescinded policies, and in February of 2009 once again California Anthem Blue Cross, again, one of your subsidiaries, had to pay a \$15 million fine and reinstate over 2,300 rescinded policies, and then another settlement, \$5 million and another 450. So it seems like in the last year you have had to reverse 4,500 rescissions and pay a fine of \$30 million just in one State. Is that true?

Mr. SASSI. I don't believe the numbers are exactly accurate, but the premise is accurate. The issue of rescission first surfaced in the media, particularly in California, I believe, in 2006 and 2007, and shortly thereafter one of our regulators initiated an audit, issued audit findings. We disputed the majority of those findings, and our response is appended to that audit report. The regulator subsequently did change—

Mr. STUPAK. Well, according to California Department of Management and Health, in July of 2008, last year, July 17, 2008, you entered into an agreement with California to—

Mr. SASSI. Yes. We—

Mr. STUPAK [continuing]. Over 1,700 people and, what, a \$10 million fine, and in February 2009, California Department of Insurance also put out a release indicating that you paid a \$15 million fine and had to reinstate 2,300 people. So according to my math, that is just over 4,000 and \$25 million in fines, right?

Mr. SASSI. Yes, I think there wasn't a \$15 million fine to the Department of Insurance. Irregardless of that, you know, companies enter into settlement—

Mr. STUPAK. Let me ask you this—

Mr. SASSI [continuing]. Agreements for a variety of reasons.

Mr. STUPAK. Let me ask you this, and I will ask all three of you. Why don't you just vet these policies before you ever collect the premium? Why don't you just go through these policies and make sure there is no problems with it before you insure the people? Only one State requires you to do that, and that is Connecticut, right?

Mr. SASSI. Chairman, we do investigate the applicants. We have very rigorous underwriting requirements. As we review an applicant's application, we rely on the applicants to be truthful in completing, and our experience has shown that over 99 percent of applicants are truthful in completing their applications.

Mr. STUPAK. So when do you do the—

Mr. SASSI. We rely on that.

Mr. STUPAK. When do you do the investigation then? Why are we getting this post-underwriting going on? Why does that occur?

Mr. SASSI. Well, I would contend that we don't participate in post-claim underwriting.

Mr. STUPAK. Really? Well, let me ask you this—

Mr. SASSI. If there is a situation where either a pharmacy claim was received or a pre-authorization for a hospital stay is received

or a claim that is received that would hit either a specific diagnosis that could lead to potential fraud, that would trigger an underwriter to investigate.

Mr. STUPAK. Well, let me ask you this. In the book right there, and I believe it is tab number 11, that is our document. You gave us—WellPoint provided the committee with a list of conditions that automatically lead to an investigation post underwriting, OK? And for WellPoint, the list of conditions that trigger rescission investigation includes diseases ranging from heart disease and high blood pressure to diabetes and even pregnancy. So what do these conditions have in common that would cause you to investigate patients with these conditions for a possible rescission? You have 1,400 different conditions which would trigger, according to your documents, which will trigger an investigation.

Mr. SASSI. Chairman, an investigation does not mean that a rescission actually occurs. For example, in 2008, there were over 16,000 investigations triggered. Ninety-two percent of those were dismissed and no action was taken.

Mr. STUPAK. Right, but why do you have 1,400 different conditions which trigger an investigation? What is the common theme amongst these 1,400 that would trigger an investigation?

Mr. SASSI. I would say there is no common theme other than these are conditions that had the applicant disclosed their knowledge of a condition at the time of initial underwriting, we may have taken a different underwriting action, and so that is what the investigation really is about, is to determine did the applicant have the condition, did they know about the condition—

Mr. STUPAK. Well, I thought you said you did pre-screening before, you screened them before.

Mr. SASSI. We do, but in many of these—

Mr. STUPAK. Why would you have to go back? If you screened them before and there wasn't a problem, then why would you have a list of 1,400 different conditions that trigger an investigation? If you pre-screen, if your pre-screening is good, you wouldn't need a list of 1,400, would you?

Mr. SASSI. But unfortunately, there are those among us that are not truthful in completing their application.

Mr. STUPAK. So in the 1,400 different areas they lie? The applicants lie? Or is it a cost issue? These are 1,400 expensive areas, aren't they?

Mr. SASSI. Rescission is not about cost. A pharmacy claim that is \$20 could trigger something.

Mr. STUPAK. Sure, if it is for a certain condition, right? Heart disease?

Mr. SASSI. No, not necessarily.

Mr. STUPAK. All right. My time is up. Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman.

I would just like to ask each of the companies present, is it your company's policy to deny coverage to any applicant that discloses that he or she has had previous policies rescinded? You heard some of the witnesses today say look, once I get rescinded, no company is going to write me again on an individual policy. Is that correct, Mr. Sassi.

Mr. SASSI. I am personally unaware of that policy.

Mr. WALDEN. Mr. Collins.

Mr. COLLINS. Sir, we do have that question on our application but I am not aware as to whether or not what the underwriting guidelines are so we ask if you have been rescinded or declined by another carrier.

Mr. WALDEN. But you don't know what happens with that information?

Mr. COLLINS. No, sir. I imagine it triggers an investigation but I don't know if there is an underwriting policy that is directly linked to that that is a black and white policy.

Mr. WALDEN. Mr. Hamm.

Mr. HAMM. Yes, we would not provide coverage in that situation.

Mr. WALDEN. So do you ever look to see if a rescission—the circumstances around another company's rescinding of a policy before you just—I mean, if they check the box and say yes, I was rescinded in the past—

Mr. HAMM. Our underwriting guidelines are that we would not issue that policy.

Mr. WALDEN. Wow. Mr. Collins, is that your underwriting? Can somebody tell you if that is your underwriting policy too?

Mr. COLLINS. I don't know, sir, but I would be happy to get back to you with an answer on that.

Mr. WALDEN. And Mr. Sassi, is that your company's policy?

Mr. SASSI. Again, I am not aware of the policy. I would be happy to research it and provide a response for the record.

Mr. WALDEN. You obviously sat here and heard the testimony of the prior witnesses, and some of the information we have seen indicates there are mistakes made in rescinding policies, at least from our standpoint, and I think you have settled some cases along those lines. After hearing that testimony, do you think it should be your company's policy to just not issue a private insurance policy to somebody who had been rescinded by another company? Should that be the policy of your company?

Mr. SASSI. Well, as I stated for the record, I am not aware that that is a company policy.

Mr. WALDEN. And I stipulate that. Should it be?

Mr. SASSI. I think that is a factor that should be considered.

Mr. WALDEN. But I am hearing, at least from Mr. Hamm, that it is your company's policy that if they were rescinded by another company, it is a no go coming to your company. That is correct, right? I heard you correctly. Mr. Collins, once you find out whether it is or not, do you think it ought to be?

Mr. COLLINS. Well, sir, I think we should investigate the circumstances.

Mr. WALDEN. I do too. I mean, if somebody did lie on a prior form, that is one thing. If they are truthful on your form, though, should that—because they made a mistake in the past, should they never be forgiven? They never have a shot at health insurance again? I mean, let us take Ms. Horton's case. You heard her situation. You heard her fear. So she will never get offered coverage again. Is that right?

Mr. SASSI. I agree, it should be something that should be investigated and considered.

Mr. WALDEN. Most of your company policies approve a decision to rescind if an applicant made any material misrepresentations or omissions in the application. I understand that. How does your company ensure the applicant was aware of the condition or notation found in his or her medical records? We have had some testimony along those lines and we have seen some in some of the files where they say, you know, my doctor never told me that, and we have letters from physicians who say that is correct, I make notes all the time in the medical files, I didn't tell the patient that. Where is the balance here, Mr. Hamm.

Mr. HAMM. We have a very fair and thorough process of determining if there was a material misrepresentation. The process involves several layers of review and a review panel including a medical doctor, and in that process we gather all the available information with respect to a person's use of medical services including medical records as well as the information on their application and we will do detailed research and look at each situation based on the facts, make a determination whether there was a material misrepresentation when the policy was underwritten.

Mr. WALDEN. So do you look at the case files? Do you look at the medical records? Do you communicate directly with the physician?

Mr. HAMM. We will communicate when it is necessary.

Mr. WALDEN. Well, but to determine the material misrepresentation. I mean, what happens in a case where the physician says I never told the patient that?

Mr. HAMM. It is difficult to speak of a hypothetical situation, it depends on the facts of each time, but I can tell you that we would not rescind a policy if the applicant was not aware of the condition.

Mr. WALDEN. Mr. Collins.

Mr. COLLINS. Sir, we afford the customer the right to appeal and we accept statements and information from the customer and their physicians with regards to the circumstances of the rescission, and we would take that into account. I think that fair-minded people would say that if an individual did not know of a condition that was noted in the medical record, then that would not be grounds for a rescission normally.

Mr. WALDEN. Mr. Sassi.

Mr. SASSI. We also have a thorough process when we initiate a rescission investigation. We do reach out to the member and share with them the information that we do have and ask them to provide us with any comments or other relevant information, and all of that information is used in making a recommendation, and all that information is provided to our application review committee that actually makes the rescission decision. We would not rescind a member that we could determine did not know of their condition.

Mr. WALDEN. And Mr. Hamm's company I know a week and a half or 2 weeks ago started this third-party independent review opportunity, correct?

Mr. HAMM. That is correct. We recently implemented that.

Mr. WALDEN. And I commend you for that. I think that is a good move.

Mr. Collins and Mr. Sassi, do you have a similar sort of independent review panel that an insured could go to and make their case?

Mr. COLLINS. No, sir, we do not have an independent review panel.

Mr. WALDEN. Do you plan to go that route? Is that something you are thinking about?

Mr. COLLINS. It is under consideration but we haven't made that decision, sir.

Mr. WALDEN. Mr. Sassi.

Mr. SASSI. Congressman, we were the first insurer to implement an independent third-party review and we implemented that in July of 2008.

Mr. WALDEN. OK, so last July. All right. My time is expired. Thank you, Mr. Chairman.

Mr. STUPAK. Well, thanks. On that third-party review, that was because California made you do it, right?

Mr. SASSI. No, absolutely not. It was not a requirement.

Mr. STUPAK. Because in your opening statement, you said you had announced robust consumer protections, so I want to know what is the difference between announcing implementation, I wanted to see if you had implemented those robust consumer protections. Have you implemented those robust consumer protections you mentioned in your opening statement?

Mr. SASSI. Yes, absolutely. In my written testimony to the subcommittee, we have outlined ten recommendations. We have implemented eight of those ten recommendations.

Mr. STUPAK. So eight of the ten are there. OK.

Mr. Hamm, you said you would not reject or rescind a contract for a policyholder if the policyholder had no knowledge of it. Well, that is the Raddatz case. That was our last case. That was Otto Raddatz. He didn't have any idea he had gallstones and an aneurysm, and your company rejected him.

Mr. HAMM. Mr. Chairman, I would really like to comment on that case, but due to privacy concerns I am not able to, but I can tell you that in situations when we uncover that the individual was not aware of the condition, we would not go forward with the rescission.

Mr. STUPAK. But do all your clients or policyholders have to get a hold of the attorney general of their State to get it done? I mean, that is what Raddatz had to do and you denied him twice.

Mr. HAMM. We have a very detailed appeals process. In fact, after the three levels review and the entire committee voting for a rescission, we notify the customer. We give them 15 days. We delay the rescission, giving them an opportunity to respond back to us with additional information, and when it does come in we have a different underwriter look at the appeal and they may appeal as many times as they would like.

Mr. STUPAK. Raddatz only had 2 or 3 weeks to get his stem cell—

Mr. HAMM. We go through the process as fast as possible.

Mr. STUPAK. And I apologize again, Mr. Deal. I didn't see you there. You have to change the color of your suit. I will go to you for questions, please.

Mr. DEAL. I am going to have to remind the chairman, Georgia was the fourth state admitted to this union when Michigan was

still Indian territory. We don't need to be overlooked. Thank you, though. We didn't win that argument, though.

Normally, we are confronted here with the question of, do we need new federal legislation, and the gentlemen from the insurance industry have all uniformly told us that if we will pass a federal mandate of having everybody mandatorily in the insurance pool, that all of these problems will go away. What I find interesting, Ms. Pollitz, is that you brought up a question that nobody has seemed to answer. In your testimony, you point out that in 1996 the HIPAA provisions required that in individual health insurance policies, that not only is it a guarantee of renewability, but you say continuation in force. Now, do you interpret that phrase to mean the non-cancellability that we have been talking about here, and if so, if that is what the law that has been in place since 1996 means, why are we having this discussion?

Ms. POLLITZ. Well, I am not sure if I can answer that second question, but I think I should say I am not an attorney, I just read English, and the words say continue in force, and the only exceptions among the ones we are talking about today are fraud, and that is inconsistent with what these other kind of post-claims underwriting guidelines or provisions that are in State law provide for, which say that fraud is the only defense or the only reason for canceling after a 2-year period so that essentially new policyholders can't ever quite be sure if they are really covered. The insurance industry kind of gets a do-over and gets to look again, and any material omission, whether—material just means it matters. It doesn't mean that it was fraudulent. It doesn't mean—it just means that it matters to the insurance industry. That can become the basis for challenging coverage. Sometimes coverage is rescinded, sometimes it is terminated going forward. Some insurers won't rescind a policy because they don't want to get an argument with doctors and hospitals who may already have been paid to try to get that money back and so they will just cancel the policy going forward. But with respect to cancellation and rescission, I think the Congress spoke on this in 1996—

Mr. DEAL. And none of the five exceptions to that fit the discussions here unless it is elevated to the level of fraud.

Ms. POLLITZ. That is correct.

Mr. DEAL. And I would ask the entire panel, are you aware of any court interpretation or any question that has ever been raised as to the applicability of this section 2742(a) of the Public Health Service Act as it relates to the issue we are talking about here today as to whether or not it in fact does preclude cancellation for whatever we might call it, whether we call it post-review underwriting?

Mr. HAMM. Congressman, may I speak to that?

Mr. DEAL. Yes.

Mr. HAMM. This is a legal issue but I don't believe that rescission is considered a non-renewal.

Mr. DEAL. Well, but it doesn't just stop when it says "shall renew." It says "or continue in force." I guess if you read that phrase "or continue in force" to mean the same as renew, then it would actually be a redundant phrase, which the law generally

does not favor redundancy. Has this ever been challenged? Does anybody know if it has ever been raised before?

Mr. COLLINS. I have no knowledge, sir.

Mr. DEAL. Well, let me go then to the second part of my question, and that is, we then go to the States having their statutory periods, generally 2 years as has been pointed out, for review, but Mr. Hamm, you pointed out that under your policies, I believe you said that you give the potential customer 10 days to review the application and to notify the company of any errors in 10 days to just say we don't want to have the policy in effect. Are there any States that currently have in place a period of time for insurance companies to mandatorily review for these kinds of misstatements, in other words, review the medical records within a given time other than the 2-year period? Do any States have a shorter time frame?

Mr. HAMM. I am not aware of that. We comply with all applicable State statutes, and I think it is almost all States we have a 10-day free look where we send the customer a copy of their application, remind me that they are attesting to the accuracy of it, ask them if they have any questions or changes, and then as part of the policy, in the welcome letter we reinforce the importance that we receive all the disclosed information appropriately.

Mr. DEAL. If, though, something was going to be rejected based on information that was in an application or information in the medical records that we for whatever reason have not disclosed, it seems to me that 2 years is a rather lengthy period of time, and in practical application, it seems that even in that 2-year period it takes some other triggering mechanism to institute the review, that there is no normally dictated review of the applications unless something triggers it or brings it to your attention. Should there be a time frame shorter than this 2-year period and should there be a review that takes place prior to a triggering act taking place?

Mr. HAMM. Let me clarify that we do not post-claims underwrite. We ask information of every single applicant to the company, and 88 percent of the time we receive additional information from them and we ask them to fully disclose all their information. It is only when we are aware subsequently that there was some information that was omitted or inaccurate that we would investigate whether a rescission should be made.

Mr. DEAL. But that would be that triggering act and you wouldn't know about that unless something by way of a pharmaceutical being prescribed or an office visit in the doctor's office or a hospitalization.

Mr. HAMM. That is correct.

Mr. DEAL. What I am asking is, just as you give the policyholder 10 days to review the application to figure out if it is correct, should there be a comparable, maybe longer, obviously I think longer, period of time in which the company without some triggering act should be required to review the applications and say hey, we think there is something wrong or ask for additional information rather than waiting until people get in a posture where they probably are uninsurable at the time the issue is raised?

Mr. HAMM. It is something to discuss and give some thought to.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Burgess for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and that last point of Mr. Deal's I think is an excellent one and likely would have eliminated the problem for at least one of the three witness that we had in front of this morning.

Let me just ask Mr. Hamm, Mr. Collins, Mr. Sassi, you were here and you heard the testimony this morning of the three individuals who testified. What do you think after hearing that? Is that something that—and again, I am coming at this from the perspective of someone who supports the individual insurance market. I was a customer of the individual insurance market at one time. I may be again in the future. I recognize the value that you bring, and I want you to be able to continue to do the type of business that you do but you heard the opening comments of the chairman of the subcommittee this morning. There is a move afoot to do things in a way that would be very difficult for you to business in the future and I for one would not like to see that happen, but tell me what your impressions are after hearing the testimony that you heard this morning.

Mr. HAMM. I would be glad to respond to that, Congressman, and I have to say, I really felt bad. You know, I have a lot of empathy for the people that are impacted, and I know in my own life I have dealt with the cancer and I just have a lot of empathy and concern for the people and it is my hope that there will be changes made, that this will no longer be necessary. It is just that today when we have a voluntary system of insurance where people choose, we have to collect information up front to underwrite, and if we didn't have that process, then people would wait until they had a health condition before applying for coverage and the rates would be much, much, much higher than they are today. I chaired a group that put forth reform proposals, and in our proposal we suggest that the country should move toward a guarantee issue environment with no preexisting conditions being excluded as long as everyone is required to participate. If everyone participates, then there is no need for rescission and the price would not increase for those currently covered.

Mr. BURGESS. You brought that up. What do you do with the segment of society that is just not going to participate? I mean, there will be—that segment of society will exist whether it is the individuals who are in this country without the benefit of a Social Security number, whatever that number is, 10 million, 12 million, people who just don't comply. We live in a free country and they don't like mandates. Look at the people who don't comply with the mandate of the IRS right now knowing the penalties that are out there waiting for them if they get caught, so people are perfectly willing to fly beneath the radar. What then? Will these people be rated on whether or not they had a preexisting condition or are they just absorbed then by the larger taxpaying public who does play by the rules and pays their bills on time?

Mr. HAMM. We believe that the requirement to purchase insurance should be enforced. We believe that those who don't have the means should be subsidized, and we would look forward to working with Congress to find a solution that is workable for all Americans, but I believe every American must have access to high-quality

health care. We have to work together to find out how we can make that happen.

Mr. BURGESS. Well, you and I will fundamentally disagree on that point, and I think the approach that was taken by Congress in the development of the Part D program in Medicare for all the faults initially rolling it out, creating problems that people actually want that are actually useful for people will be a better way of going about that. The coverage rates for prescription drugs amongst seniors now is in excess of 90 percent with a very high satisfaction rate, and clearly in my mind, at least, that is a better strategy than simply layering another mandate on the American people or the employers of America. But I don't disagree with you that something needs to happen, and let me just take this to a different level, and again, I want to pose this question to all three and I really would like an answer from all three on this.

If there were a system of universal coverage without government intervention in the marketplace, is there a better way to accomplish our goal of universal coverage without that excess market manipulation by the government? Insurance companies have used adverse selection methods to deny or cancel policies in the individual market. Apparently it happens also in other markets. To the extent that this has been allowed in law, the business interests almost dictate those actions, yet some of us have argued that if we let the market work, you can make an innovative product for all. So here is my question. Will you today publicly and clearly commit right now that regardless of what happens in Washington, whatever decision that we reach on health reform, that you will design a product for all populations regardless of claims history but also economic status? And I would like an answer to those questions individually, a product for all populations regardless of claims history and all populations regardless of economic status. Mr. Hamm, why don't you go first and then we will just go down the row.

Mr. HAMM. I am having a little difficulty following your question, sir. If I may understand specifically what you are asking?

Mr. BURGESS. Regardless of what we do, whether we do an individual or business mandate, employer mandate, maybe we don't do a mandate at all, but you have it within your power to design a product so that all populations regardless of claims history could be covered. Would you be willing to do that?

Mr. HAMM. In the current system, that would not be feasible. We need to have an environment where all Americans are required to participate before we could give those assurances.

Mr. BURGESS. So you would not be willing to alter business practices if there were a way to do that to provide coverage for a greater segment of the population, even with a claims history?

Mr. HAMM. If the reforms proposed by AHIP are adopted, then we would be very glad to participate in the system, but it is necessary that all participate. When it is a system where people choose, we need to have the process of assessing risk at the time of the application.

Mr. BURGESS. With all respect, the reforms proposed by AHIP are not going to happen. You are going to get a plan as your chairman outlined here this morning.

Mr. Collins, can I get you to answer briefly? Would you be willing to design such a product?

Mr. STUPAK. Briefly. We are going to have votes here.

Mr. COLLINS. Sir, I would respectfully have to agree with Mr. Hamm that a guarantee issue product that would fit all people at affordable prices is economically practically impossible. What I would suggest is that HIPAA also creates alternative coverage mechanisms for each and every State, so each State is supposed to have a high-risk pool or an alternative coverage mechanism, and these high-risk pools have been woefully underfunded so one of the things that could be done right now today is to increase the amount of funding going into those high-risk pools so that people that have serious health issues and are otherwise uninsurable in the individual market have a place to go that is affordable and affords them the care that they need.

Mr. BURGESS. And on the issue of high-risk pools, I think the private sector is going to be required to make a contribution to that as well and that you all in the private sector, whether it be group insurance or individual market, there must be a product that is available to everyone regardless of their claims history. Yes, they may require a federal subsidiary. Yes, they may require a State subsidiary, and yes, the private sector may have to bring something to the table as well.

Mr. Sassi, let me ask you—

Mr. STUPAK. All right, that is it. Last question, Mr. Burgess. You are just going on.

Mr. BURGESS. Let me ask you then just to answer the question—

Mr. STUPAK. Last one.

Mr. BURGESS [continuing]. I posed to the others. Regardless of the claims history and the population, would you be willing to make a product available?

Mr. SASSI. I have to agree with my colleagues here that in the current voluntary individual market, we could not guarantee issue policies where people could jump in and out of the insurance market. We have had experience of States that have implemented guarantee issue without an effective, enforceable personal coverage mandate, and unfortunately, that has resulted in significant cost increases that have to be borne by others in the individual market. So the answer would be no.

Mr. BURGESS. Mr. Chairman, you have been very generous with your time. Again, I would just stress that this is going to take creative thinking outside the box. I don't think you are going to get what you want in the AHIP proposal. You are going to get more something that looks like what the chairman outlined to you at the beginning, and I would urge you to think creatively about this problem because this is the difficulty that leads us to where we are here today, and I can't help you—

Mr. STUPAK. OK, questions or speeches are over.

Mr. BURGESS [continuing]. If you are not willing to move on this issue, and thank you, Mr. Chairman. I will yield back.

Mr. STUPAK. We hope the chairman's, not my plan, but our side plan does work. We do hope that. I won't argue it with you now. That is for another hearing.

Maybe we can get another round in. We are going to have votes here in a few minutes. Now, each of you provided to the committee information that relates to certain medical conditions that automatically trigger an investigation into possible grounds for rescission. Mr. Sassi, I left off with you. You had 1,400 different conditions that automatically trigger an investigation. Mr. Hamm, on behalf of Assurant, there are 2,000 conditions that trigger an investigation that you provided to the committee. These include breast cancer, ovarian cancer and brain cancer. Why does cancer trigger an investigation?

Mr. HAMM. What triggers the investigation—

Mr. STUPAK. No, why does cancer trigger an investigation?

Mr. HAMM. I will answer. What triggers the investigation are the types of medical conditions of a chronic nature where there is a high probability that the condition would have preexisted at the time of the application. It is not based on the cost of the claim. It is based on the medical condition. In fact, the people that make the rescission decision are not aware of the cost of the claim. It is all about—

Mr. STUPAK. If it is the medical condition, then before you sign them up, why don't you get all the medical records? Why don't you find it then? Why do you wait until there is a claim?

Mr. HAMM. If we were to receive all the medical records at the time of application, that would delay the process significantly, delaying people's access to health care, and would add a tremendous amount of cost to the product. The vast majority of applicants provide all the information that is asked for at the time of application.

Mr. STUPAK. So it is a cost issue? It is too costly to get the medical records?

Mr. HAMM. It would add to—yes, it would add to the premiums that our customers would pay by a significant amount.

Mr. STUPAK. So what does it cost, \$40 to get medical records?

Mr. HAMM. I am not familiar with the cost but I would also delay the process.

Mr. STUPAK. But isn't it better to delay the process to make sure a person is insured as opposed to pulling them when they are going through cancer like Mr. Raddatz?

Mr. HAMM. The vast majority of our customers provide the appropriate information.

Mr. STUPAK. So did Mr. Raddatz but you still denied him coverage, right?

Mr. HAMM. I unfortunately cannot comment on that particular case.

Mr. STUPAK. Mr. Collins, in asking the same question of United, you insisted that you also use a computerized system to identify cases to automatically investigate for possible rescission but there is no one at your company who knew how the computer decides which files should be reviewed. So is it the case that United has put the decision of which patients will have their health care treatment interrupted by a rescission investigation in the hands of a computer that no one understands?

Mr. COLLINS. No, sir, that is not true. I haven't really been privy to the discussions between my staff and your staff on this issue. We have been trying to come to an understanding about how to

best provide the data in a format that is easily understandable, but let me just say—

Mr. STUPAK. Can you tell us what conditions the computer considers for a possible rescission investigation?

Mr. COLLINS. No single factor is used in our process to trigger an investigation so we look at—the system looks as it is screening claims that come in at the effective date of the policy, the effective date of the procedure, the severity, the type of service and the diagnosis code. Those are all factors that go into the algorithm that pulls cases out for screening.

Mr. STUPAK. Well, the algorithm, no one from your company could tell us. Will you commit to us today to produce whatever witnesses or documents are necessary to explain your algorithm, your computer selection process? Could you do that? Will you commit to do that?

Mr. COLLINS. Yes, sir. We are—

Mr. STUPAK. We are still trying to figure it out.

Mr. COLLINS. We are trying to put it in a format that would be acceptable to the committee, sir.

Mr. STUPAK. Dr. Pollitz—Professor Pollitz, do you see a common thread here among the conditions? You have 1,400 conditions, 2,000 conditions and a computer that it can't explain that does rescission. Why do you think they have all these rescission?

Ms. POLLITZ. I think the common thread is that if somebody makes a claim for anything serious in their first year, there is an opportunity to go back and review the entire transaction to see if it is going to be withdrawn. I think that is just the common transaction, and I think it is not consistent with your federal law, and whatever else you may do going forward—

Mr. STUPAK. But as to the HIPAA law, basically we leave it up to the States, and HIPAA has to be enforced by the federal government, CMS, right?

Ms. POLLITZ. That is correct, the ultimate enforcement.

Mr. STUPAK. So the value of the law only depends on the enforcement of the law?

Ms. POLLITZ. Yes, it does, and there is a fine of \$100 per day per affected individual for noncompliance with the law that can be levied.

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

Mr. HAMM. I would not commit to that.

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

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

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

Mr. SASSI. No, I can't commit to that. The intentional standard is not the law of the land in the majority of States.

Mr. STUPAK. Well, do you think it is fair to rescind somebody for an innocent mistake?

Mr. SASSI. Well, I think applying a knowing standard is a much more objective and—

Mr. STUPAK. Well, our first panel, none of them had any knowledge of it and they were all rescinded, right?

Mr. SASSI. I am sorry?

Mr. STUPAK. Our first panel, none of them knowingly made a misrepresentation but they were all rescinded, their policies from Ms. Beaton all the way down to our witnesses there. They weren't material misrepresentations, right?

Mr. SASSI. It is our policy if we determine that the applicant did not know about a specific condition, we would not rescind.

Mr. STUPAK. So like Ms. Horton there, you wouldn't have rescinded her?

Mr. SASSI. I can't speak to the specifics of Ms. Horton's case. I am not familiar with the specifics. I am sorry.

Mr. STUPAK. Mr. Barton for questions, please.

Mr. BARTON. Thank you. I want to thank our witnesses for being here. This is a difficult situation. But I listened when you all answered Chairman Stupak's question about unintentional omissions, and to your credit you were honest that you would reserve the right to still rescind some of these policies. Doesn't it bother you that people are going to die because you insist on reviewing a policy that somebody took out in good faith and forgot to tell you that they were being treated for acne? Doesn't that bother you?

Mr. HAMM. Yes, sir, it does, and we regret the necessity that that has to occur even a single time, and we have made suggestions that would reform the system such that that would no longer be needed.

Mr. BARTON. Well, you know, I haven't heard your opening statements, I glanced at them, and I haven't heard the first round of questions. We understand the need to verify that people are telling the truth. We are not asking you guys, the insurance industry, to automatically take somebody's word for it. I mean, I understand that. But when I see advertisement after advertisement about be a part of the family and we treat you like, you know, our own family, and then somebody who doesn't have group coverage takes out an individual policy and runs into some situation where they have a health care issue that requires a major claim early in the policy, if they operate in good faith in taking out the policy and you approve them, I really don't think it is good business practice to go back and try to figure out a way to rescind that policy. If nothing else, it is a false trade practice, truth in advertising, and one of the beauties of our Constitution is a little thing called federal preemption. We have the authority on this committee to preempt State law if it is interstate commerce. Now, we can't preempt State law in intrastate commerce but we can in interstate commerce, and I don't think there is one vote on this committee for the practice of retroactively reviewing a policy to try to rescind it if you have a woman like my constituent, Ms. Beaton, who discovers that she has breast cancer or you have somebody who needs a stem cell transplant or even the young lady from California who just needed some blood work done. We will back you up on fraud and misrepresenta-

tion but I don't think you are going to get a vote at all on rescissions that are not material to the claim being processed. I don't know that that is a question. That is just a statement. If you would like to comment on that, I would certainly like to give you the opportunity to do it.

Mr. STUPAK. No one cares to answer?

Mr. HAMM. I would just reinforce that rescission would only occur when the information was material to the initial—if the information was material to the underwriting decision, only in that case.

Mr. BARTON. Mr. Chairman, I am going to yield back. I mean, I would—

Mr. STUPAK. Could I follow up on that?

Mr. BARTON. Sure.

Mr. STUPAK. Well, if it is material to the representation—let me ask you this. In your policy, Mr. Hamm, it states, and it is question number 14 on your questionnaire, your enrollment questionnaire. Now, tell me how you get a misrepresentation. Within the last 10 years—this is what it says—because you said Assurant Health's enrollment questionnaires are simple, easy to understand, straightforward language, so people can easily and accurately report their medical history. So your question says, within the last 10 years, has any proposed insured had any diagnosis, received treatment for or consulted with a physician concerning phlebitis, TIA, cystitis, lymphadenopathy, glandular disorder. So tell me, what is TIA?

Mr. HAMM. I am not aware. I believe—

Mr. STUPAK. If you don't know what it is, how would anyone filling out your application know what it is? So there is grounds to deny them right there. You don't even know what it is and neither do I. How about phlebitis or lymphadenopathy? How about lymphadenopathy? What is that?

Mr. HAMM. I don't know the answer to those questions.

Mr. STUPAK. Do you sincerely believe that an average applicant would know what these words mean if you don't know and I don't know?

Mr. HAMM. Sir, I believe that is an application that is not currently used at this time. I would like to—

Mr. STUPAK. It is last year's application. Yes, it is last year's application. Have you changed the application in the last year?

Mr. HAMM. I am sorry, sir. I didn't hear you.

Mr. STUPAK. It is last year's application. Did you change it in the last year?

Mr. HAMM. I am not aware if we have changed that application.

Mr. STUPAK. So far as you know, that is your current application?

Mr. HAMM. But I believe that our current application asks questions back to 5 years, so the 10-year might be different than what we issue today. I would need to—

Mr. STUPAK. Well, it is the same questions, TIA, right, that you don't know what it is and—

Mr. HAMM. I do not know what that is.

Mr. STUPAK. Mr. Deal.

Mr. BARTON. Mr. Chairman, I do have one question.

Mr. STUPAK. Sure, Mr. Barton. I took your time. I will yield to you.

Mr. BARTON. This is a hypothetical but I just want to figure out what the answer is. I had a mild heart attack 3 years ago, so I now take six different medications every day and I am going to probably have to take those medications for the rest of my life. I am covered under a group plan, Blue Cross/Blue Shield of Texas and it is available to every federal employee who lives in Texas, and my coverage has been good. I have never had a problem. But let us say I quit the Congress and I go into business for myself and I try to get a private health plan like Ms. Beaton got when she switched jobs from being a nurse and went into business for herself. On the application, I have to list the medications that I am taking, the fact that I had a heart attack, give the doctor, the time, the location, but I broke my leg playing football in high school. I got a 250-pound fullback ran over a 150-pound linebacker. I was the linebacker. Now, if I forget to put on my application with your companies that I had the small bone in my left leg broken playing football in 1967, but I do put all my medications and my history of my heart attack, the fact that I omitted breaking my leg in 1967, is that a grounds to rescind my claim, my policy later on under your policies right now that your companies issue? I admit to my big problem, tell you the medications, all the stuff but I just flat forget that I broke my leg and was treated by a doctor paid by the Waco Independent School District in 1967.

Mr. SASSI. Congressman Barton, our underwriting guidelines really kind of dictate that but it is my understanding of how our underwriting guidelines work is that since that condition would not be material in our initial underwriting decision because it happened so far in the past and was of a non-serious nature, that that would not have factored into the underwriting decision.

Mr. BARTON. And I understand you might cover me because of my heart attack. I understand that. It would be totally within your company's right to say Congressman Barton had a heart attack in 2004 or 2005, therefore we can't issue him a policy. I understand that. My question is really about my leg injury from way back when. If I don't disclose that, does that disqualify me potentially on down the road? Mr. Collins?

Mr. COLLINS. Sir, the application is looking for information going 10 years back so that—

Mr. BARTON. So that would not be material?

Mr. COLLINS. That would not be material.

Mr. BARTON. Mr. Hamm.

Mr. HAMM. The same answer as Mr. Collins.

Mr. BARTON. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Deal for questions, please.

Mr. DEAL. Thank you, Mr. Chairman.

We are talking her in the private insurance market and I believe, Mr. Sassi, you said that somewhere in the 15 million range. Is that correct?

Mr. SASSI. Correct.

Mr. DEAL. To you three gentlemen, do you also have policies that extent to ERISA-type coverage plans?

Mr. SASSI. Yes. WellPoint insures one in nine Americans. The vast majority of our members are covered under ERISA plans.

Mr. DEAL. Mr. Collins.

Mr. COLLINS. Yes, sir, the majority of our membership are also in group insurance plans which are covered under ERISA.

Mr. DEAL. Mr. Hamm.

Mr. HAMM. The majority of our policies are individual. However, we do have some customers that are under ERISA.

Mr. DEAL. Does the same problem pertain in the ERISA marketplace as in this private insurance marketplace? Ms. Pollitz, you indicated you think it does.

Ms. POLLITZ. There is rescission in the small group market. It operates a little bit differently because that is a guaranteed issue market, but a similar process if a claim is submitted during the pre-X period. It is largely the eligibility of the members of the group and the family members of the group that will be reinvestigated to see if there is any way that the people who made the claim shouldn't have been on that policy in the first place.

Mr. DEAL. But the State periods like 2 years do not apply because it is an ERISA plan?

Ms. POLLITZ. Well, your pre-X rules are also much tighter in the small group market so Congress has said these questions about 10 years ago, 5 years ago, those don't matter in the small group market. You are only allowed to apply—an insurer is only allowed to apply preexisting condition for something that was actually treated or diagnosed in the six-month window prior to coverage taking effect. So anything that happened before that isn't even allowed to be considered, and if the person coming into the policy had prior group coverage, that gets credited against the pre-X so that can't be considered either. So it is mostly eligibility, and I have seen—

Mr. DEAL. I am going to try to be real quick here and I apologize for cutting you off. With regard to what needs to be done, in the event we don't get the major reform that you all have been talking about, anybody else is talking about, in the event it becomes something of trying to narrow a time window in which insurance companies have the right to review medical records, would it not be feasible that if we had electronic medical records that that would facilitate a more timely review? I would assume common sense would say that it would. Ms. Pollitz, do you foresee that consumer protection groups would oppose making those kind of personal medical records available for insurance companies to review in a timely fashion so that we would not hopefully have these situations to develop?

Ms. POLLITZ. They are already available for review.

Mr. DEAL. Well, we don't have the extent of electronic medical records that we all hope we will have.

Ms. POLLITZ. But the privacy rules that you have in force today under HIPAA say that medical underwriting is a permissible reason for disclosure of medical records.

Mr. DEAL. You would see no reason that anybody would raise that issue?

Ms. POLLITZ. It is already permitted under current law.

Mr. DEAL. The last thing, and this is more of a comment than anything else, I think the issue that Dr. Burgess discussed with

you about those who are now being excluded because of preexisting conditions, et cetera. I think we all know that our high-risk pools are not effectively operated and certainly nonexistent in States like mine, for example. I think we need to be looking at a policy where we would maybe take those funds that are available for high-risk pools, some of which are not being utilize, put them into an environment in which we could perhaps with the sharing of some of those costs with the insurance industry bring these individuals into the pool with the additional revenue that would be available from federal sources. I just simply suggest that something we all need to be thinking about in my opinion. Thank you, Mr. Chairman. I yield back.

Mr. STUPAK. Mr. Burgess, do you want to question now or do you want to come back after votes? We only have 5 minutes, so I am going to have to hold you tight.

Mr. BURGESS. OK. You know me. I can be really brief.

Mr. STUPAK. I have never seen it yet, but go ahead if you want to try.

Mr. BURGESS. I will just ask all three of you briefly, you know, you have heard the discussion of the public option plan. What is your opinion of that?

Mr. HAMM. I oppose the public plan option.

Mr. BURGESS. Mr. Collins.

Mr. COLLINS. Sir, I believe that with the reforms that have been proposed, that we can make the market work much better without a public plan.

Mr. BURGESS. And Mr. Sassi.

Mr. SASSI. We also oppose a public plan. We also feel that—

Mr. BURGESS. I don't want to be the one to have to break this to you, but the reality is, you are very likely to get a public plan. You are not likely to get the deal that was struck by AHIP down at the White House. I mean, I think you can see the handwriting on the wall. I would urge you to think outside the box on this one. There are ways that we can solve this problem without going to a public plan, in my opinion, and without leaving so many people uninsured, without leaving so many people fall through the cracks, as we heard this morning. Clearly the situation as it stands right now is unstable. It is untenable. We can't continue it. But you guys have got to be able to come to the table with some innovative thinking on how we provide coverage to that segment of the population that is particularly vulnerable and needs the coverage. We don't need to turn the whole system on its head just to cover that 10 or 15 percent that is right now left out but that is what we are going to do if you don't help us with this, and the fallback position, I promise you, is a government-run plan and that is what you are going to get if we don't work together on this issue, so I appreciate you all being here today. Mr. Chairman, I appreciate the extra time and I am going to yield back.

Mr. STUPAK. OK, so you didn't have a question on the subject of today's hearing. OK. In all fairness to WellPoint, I said in my opening statement—and if you care to comment, please do. I said in my opening statement in the committee investigation, WellPoint evaluated employee performance based in part on the amount of money its employees saved the company through retroactive rescissions of

health insurance policies. According to the documents obtained by the committee, one WellPoint official was awarded a perfect score of five for exceptional performance based on having saved the company nearly \$10 million through rescissions. Do you care to comment on that? I think it is fair to give you an opportunity to comment on it.

Mr. SASSI. Thank you, Chairman. During the process of collecting information requested by this committee, we did uncover two performance appraisals from 2003 that were isolated to one area within California that included one line each referring to retro savings and a dollar amount. They were in the context of a part of the performance appraisal with other metrics and they were part of a more comprehensive performance appraisal that was, I think, five to seven pages long. I reiterate my statement that WellPoint does not have a policy, it has not been our policy to systematically reward associates for performing rescissions, for tracking the number of rescissions or the dollar amounts.

Mr. STUPAK. But didn't both of those employees receive bonuses, somewhere between \$600 to about \$6,000, I think the range was?

Mr. SASSI. My understanding is that those associates received within the average compensation that all WellPoint associates received for that given time period.

Mr. STUPAK. OK, so it is not the reviewers, all your employees—OK. With your profits, I guess you could give bonuses.

All right. That concludes our hearing for today. The committee rules provide that members have 10 days to submit additional questions for the record. The record book has already been submitted for the record. We will redact any business proprietary or anything that relates to privacy concerns or is law enforcement-sensitive, so that will be entered into the record.

That concludes our hearing. I thank all of our witnesses for coming, and that concludes this subcommittee hearing.

[Whereupon, at 1:35 p.m., the subcommittee was adjourned.]

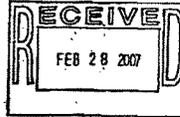
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[REDACTED]
[REDACTED]
[REDACTED] IN [REDACTED]

February 1, 2007

[REDACTED]
Anthem Blue Cross and Blue Shield
12464 La Grange Road
PMB 134
Louisville, KY 40245-1901



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Dear Ms. [REDACTED]:

I am responding to your letter dated January 25, 2007 and in reference to my ID# [REDACTED].

In reviewing the question of my height and build in the original application, there was clearly a typo in the original application. My thought is perhaps my agent mistyped my written application as he took care of filling out the on-line application for me.

My height and build is (and was at the time of my application) height: 5'10"; and weight: 275 pounds. I hope this provides the needed clarification.

Sincerely,
[REDACTED]
[REDACTED]

11010

Individual Misrep Claims >= \$2,500.00 or Drugs >= \$500.00
 or Abuse Charges for Drugs >= \$500.00 in a 30-Day Window

08/14/20

Subs-Mbr ID	Claim ID	Subs-Mbr Name	Prod ID	Group ID	Orig Eff Date	Charged	
[REDACTED]	[REDACTED]	[REDACTED] (MI)	h/o broken leg with rod insert	APSI0227	00060020	05/01/2006	57,405.34
[REDACTED]	[REDACTED]	[REDACTED]		APSI0227	00060020	05/01/2006	57,405.34
Misrepresentation Claims						57,405.34	
Code Description						57,405.34	
05/0200	04109	OTHER STREPTOCOCCUS				57,405.34	
05/0206	27800	OBESITY NOS				50.00	

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1/5/07 all claims are ITS from CT+MA with 5/06 → 5/06 dates

- [REDACTED] Medical Center - CT - Reg recs rec'd 1-18-07
- [REDACTED] - CT
- Surgical [REDACTED] - MA
- Cardiology [REDACTED] - CT
- [REDACTED] Health Services - CT
- [REDACTED] - KY - Reg recs

1/18/07 Records for [REDACTED] not requested, Weight on records from Meditate Medical Center show weight as 310lbs 2 wks after signature date (+95 lbs).

1/19/07 send SW per SK us to CTO - MUM
 Also reg recs from Haney at sometime. - MUM
 Address changed on facets - MUM

- 2/6/07 - Sent no pay letter to the Prot corporation - go
- 2/18/07 - Jo SWs for final decision. - MUM
- 2/21/07 - Per US Consultant received. Jo CTO for committee prep. - MUM
- 2/28/07 Received per Committee - MUM
- 3/19/07 spoke to agent - (He forgot to call me back last week) - no written app - he took information over the phone. He is supposed to send me an email stating this - go

11084

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810



March 15, 2007

CERTIFIED MAIL [REDACTED]

[REDACTED]
[REDACTED] IN [REDACTED]

ID#: [REDACTED]

COPY

Dear Mr. [REDACTED]

As stated in our letter of January 25, 2007 it has come to our attention that your application for the Blue Access policy, offered by Anthem Insurance Company, contains incorrect and/or incomplete medical information.

The application you completed asks the following question(s):

Section D- your build

The above question was answered incorrectly on your application. Had we known of your true build, coverage would have been declined.

Therefore, your coverage is rescinded. We intend to recover full payments made on claims submitted. All claims that are currently pending will be denied. Any premium fees paid will be refunded within approximately 30 business days, minus any amount that is applied toward claim payments that have been made for this member.

Please be advised that you will not receive a Certificate of Creditable Coverage since your policy has been rescinded.

- You have the right to appeal this decision. To initiate the appeals process, please forward your request for an appeal along with any additional information to the following address: Anthem Blue Cross Blue Shield, Appeals Department, P. O. Box 33200, Louisville, KY, 40232-3200. If you prefer, you may fax your appeal to [REDACTED].

09 / 24 / 2007

5/14 800-360

When the form and the Stamp are both used, you must also file a return, in accordance with the rules of the IRS and the local authorities.
© Copyright 2006 Blue Cross and Blue Shield Association
11008

Thank you for your attention to this matter. Should you have any questions, please call me at [REDACTED]

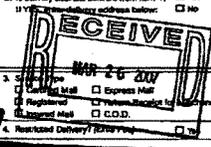
Sincerely,

[REDACTED]

Anthem Blue Cross and Blue Shield

Confidential notice: This message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited.

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SENDER - COMPLETE THIS SECTION	RECIPIENT - COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) [REDACTED] Date of Delivery 2/23/07</p> <p>C. Is delivery address different from 1? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. If Yes, is delivery address below 1? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. <input type="checkbox"/> Registered <input type="checkbox"/> Registered Agent <input type="checkbox"/> C.O.D.</p> <p>F. Restricted Delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>1. Article Addressed to:</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] IN</p>	
<p>2. Article Number (Transfer from service label)</p> <p>[REDACTED]</p>	

PS Form 3811, February 2004 Domestic Return Receipt 10258-02-00-1040

<p>U.S. Postal Service</p> <p>CERTIFIED MAIL - RECEIPT</p> <p>(Official Use Only, Not for General Circulation)</p> <p>OFFICIAL USE</p>	<p>Article Number</p> <p>Quantity</p> <p>Value</p> <p>Postage & Fees \$</p>
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[Redacted]

From: [Redacted]
Sent: Wednesday, April 25, 2007 12:14 PM
To: [Redacted]
Subject: RE: Speak now ltr

As discussed in the ARC today, this member will remain readnded.

Thanks,

[Redacted] btx

From: [Redacted]
Sent: Tuesday, April 24, 2007 10:51 AM
To: [Redacted]
Cc: [Redacted]
Subject: RE: Speak now ltr

[Redacted] please pull the file and reverse any decisions that may have been made on this account.

Thanks

[Redacted] Underwriting Manager
KY0302-A625

From: [Redacted]
Sent: Tuesday, April 24, 2007 6:05 AM
To: [Redacted]
Cc: [Redacted]
Subject: RE: Speak now ltr

If the agent did not send the app then we can't readnd. I need the get the agent's name so he can be contacted. His actions are not acceptable!

From: [Redacted]
Sent: Monday, April 23, 2007 7:12 AM
To: [Redacted]
Subject: RE: Speak now ltr

broker

[Redacted] Underwriting Manager
KY0302-A625

04/25/2007

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From: [REDACTED]
Sent: Friday, April 20, 2007 5:29 PM
To: [REDACTED]
Subject: RE: Speak now ltr

Captive or broker?

From: [REDACTED]
Sent: Friday, April 20, 2007 2:06 PM
To: [REDACTED]
Subject: RE: Speak now ltr

Yes you are correct

[REDACTED]
Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Thursday, April 19, 2007 4:12 PM
To: [REDACTED]
Subject: RE: Speak now ltr

So he submitted electronically with VS and never sent a copy of the application to the applicant to review? Am I understanding this correctly?

From: [REDACTED]
Sent: Friday, April 06, 2007 9:06 AM
To: [REDACTED]
Subject: FW: Speak now ltr

See below for further update

[REDACTED]
Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Friday, April 06, 2007 9:03 AM
To: [REDACTED]
Subject: RE: Speak now ltr

There is a note in the file dated 3/29/07 by [REDACTED] that says "Per [REDACTED] build is rescind either way- rescind per committee." The rescision was completed on 3/29/07, so should I still contact the agent? In my notes, I have that he said he since he took the application over the phone, he did not send anything to the member. I will try to get him to send me that in writing. I am sending him an email, I will copy you on it.

From: [REDACTED]
Sent: Friday, April 06, 2007 8:58 AM

04/25/2007

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To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Speak now ltr

Yes, and we need to know if he mailed a copy of the application to the applicant with the letter stating if anything is incorrect to let us know.

Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Friday, April 06, 2007 8:33 AM
To: [REDACTED]
Subject: RE: Speak now ltr

The agent never sent me anything. When I contacted him and finally spoke to him, he stated he did not have a paper application, that this was taken over the phone. I asked him to send me an email stating that and have never received it. I had to call him several times to even speak with him about this. Should I try again?

From: [REDACTED]
Sent: Friday, April 06, 2007 8:10 AM
To: [REDACTED]
Subject: FW: Speak now ltr

See below. Can someone get me an update?

Underwriting Manager
KY0302-A625

From: [REDACTED]
Sent: Thursday, April 05, 2007 7:00 PM
To: [REDACTED]
Subject: RE: Speak now ltr

What happened with this one?

Associate General Counsel
Mail Point: KY0301-A606
Tel: [REDACTED]
Fax: [REDACTED]

From: [REDACTED]
Sent: Thursday, March 01, 2007 1:24 PM

04/25/2007

11089

To: [Redacted]
Cc: [Redacted]
Subject: RE: Speak now ltr

I thought if the agent received a paper application they had to send us the paper application because we had to audit the paper against what was keyed. We need to go back to the agent and see if they have the paper application because we only have the on-line on Ultra.

[Redacted]
Underwriting Manager
KY0302-Aszb

From: [Redacted]
Sent: Thursday, March 01, 2007 1:08 PM
To: [Redacted]
Cc: [Redacted]
Subject: Speak now ltr

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Sarah,

In yesterday's committee meeting, a file was reviewed on [Redacted] whose weight was put on the application as 215lbs on 4/8/06 and we have records stating his weight on 5/8/06 was 310lbs. His reply to the speak now letter came in yesterday afternoon and he thinks that the agent may have mis-keyed his weight off the original written application. The member states his build at the time of the application was 5'10" 275 lbs. It was decided yesterday to rescind this member due to build. My question is, should we still rescind him based on the information in the speak now letter?

Thanks,

[Redacted]
Individual Underwriting
[Redacted]

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04/25/2007

11901



ISG Operations
220 Remington Blvd.
Bolingbrook, IL 60440
Fax: 1-630-679-4519

April 2007

[Redacted]
TX 758

Regarding: [Redacted]
ID Number: [Redacted]
Group Number: [Redacted]
Policy Effective Date: December 2005
UniCare Agent: [Redacted]

Dear [Redacted]

In reviewing the claims from East Texas Radiological Consultants for services rendered December 2005, we find there were material misrepresentations and omissions on your Application for UniCare Individual Enrollment signed November 2005. A copy of this application is enclosed for your review.

The application you completed disclosed the following medical history for yourself:

- Height 5 feet 4 inches and weight 160 pounds.

Based upon this history, you became enrolled effective December 2005. Subsequently, during a medical investigation, UNICARE requested and received medical records from Central Texas Digestive. Review of these records disclosed the following significant medical history for you:

- 10-2005 This patient follows-up in clinic with recurrent and intermittent episodes of nausea. There was considered that this was probably related to medications and all medicines were discontinued without improvement, so she resumed her Avandia, Nexium, and Teveten. Past Medical History: Notable for diabetes and hypertension.

Had this information been disclosed in the UniCare Individual Application Health History, Section 6 pages 3 and 4, our medical underwriting guidelines would have prohibited us from offering the enrollment as requested.

Your contract with us, consisting of the policy and the application, provides that we may rescind the policy if material health information is omitted from the application or misstated. Specifically authority for this action can be found under the Conditions of Application, Section 7, item #10, which states,

"I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed on this application is eligible for benefits if any information on this application is false, incomplete or omitted. UniCare may void all coverage from the original effective date of the agreement for such material misstatements or omissions."

In addition, Section 1, paragraph 6 of your UniCare Individual Policy states,

"IF WITHIN TWO YEARS AFTER THE EFFECTIVE DATE OF THIS PLAN, WE DISCOVER ANY MATERIAL FACTS THAT WERE OMITTED OR THAT YOU OR YOUR INSURED FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND THIS PLAN AS OF THE ORIGINAL EFFECTIVE DATE."

Because the medical history omitted from your application would have precluded us from issuing the policy as applied for, your current UniCare Policy will be retroactively canceled to the original effective date. All suspended claims will be denied. All claims paid in error will be adjusted. A check representing a full refund of all premium submitted, less the amount of any claims paid by UniCare will be processed and sent to you under separate cover within thirty (30) working days of the date you receive this letter.

Should you feel the information upon which our decision was based is erroneous or if you have any questions regarding UniCare's decision to rescind your policy, please submit your written concerns and all supporting documentation to my attention at the address noted above.

Sincerely,


Underwriting Services
UniCare Life and Health Insurance Company

Committee Review Date: 3/22/07	 UNICARE.	Committee Decision
State: Texas 90 Day Dates: 4/15/07		Rescind <input type="checkbox"/> No Retroaction <input type="checkbox"/> Retro Waiver <input type="checkbox"/> Retro Rate <input type="checkbox"/>
Member Name: [REDACTED]		
HCID Number: [REDACTED] MC Number: [REDACTED]		
Application Signature Date: 11/05 Effective Date of the Policy: 12/05 Plan: [REDACTED]		
Membership Information: Active Referral Source: Claims Date of Referral: 7/26/06		
Date claim received that was sent for review: 7/06 Diagnoses on Claim: Lump or Mass in Breast		
Medication Listed on IntelliScript: Levaquin, Advair, Albuterol, Prednisone, Zithromax, Norvase, Alprazolam, Prepac, Cipro, Diazepam, Promethazine, Phenazopyridine, Transderm Scopalamine, Visicol, Metformin Medication Listed on Reviewpoint: Prochlorperazine		
Application/Health Statement:		
• Height 5 feet 4 inches and weight 160 pounds		
Underwriting History:		
Approved Preferred		
Relevant Medical History Prior to Effective Date:		
Provider: Central Texas Digestive		
• 10/2005 This patient follows-up in clinic with recurrent and intermittent episodes of nausea. There was considers that this was probably related to medications and all medicines were discontinued without improvement, so she resumed her Avandia, Nexium, and Teveten. Past Medical History: Notable for diabetes and hypertension		
Relevant History Post Effective Date:		
Medical records/information received from [REDACTED] indicate the following history:		
• "I specifically asked the agent who signed me up for your insurance policy how to check the boxes of health questions, he stated if you are not on medication for any of the problems to check "NO." In 2005 I was not on medication for blood sugar or hypertension. I also check my blood sugar once or twice a month to make sure mine was not out of the normal range. Diet, exercise and awareness was controlling my blood sugar and blood pressure with out taking medication for either of these. I have never had nor has it been ordered to take a Glucose Tolerance Test which is the specific test needed for diabetics. In 2005 I also monitor my blood pressure checks. Diet and exercise was all that was needed to keep it in the normal range."		
Medical Underwriting Guidelines:		
• Diabetes and hypertension would have been decline per Complications Requiring Declination per MUG 250		
• Recommend no retroaction. Unable to prove intent of member. No response from agent to verify if this information was told to her.		
Other Medical History:		
None		
Health Questions Answered "NO" should be Yes:		
Sect 6 questions 3 and 13		
Revising Underwriter:		
[REDACTED]		

I was diagnosed with non-Hodgkins Lymphoma in September 13, 2004. I have been covered by an individual policy with Fortis Insurance policy # 0050553480-m since August 7, 2003.

I have been through chemo therapy and am being prepared for a stem cell transplant within 3-4 weeks. Dr Stiff at Loyola medical center in Maywood is my doctor for the procedure. I was called on the phone on April 18, 2005 and told that my insurance company was cancelling my coverage. I never received any written notification of this.

I called them and they faxed me the attached letter. (exhibit #1) 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. I disclosed kidney stones to them. I have not sought any treatments or medication ever for gall stones or blood clots.

I must have the stem cell transplant. It is a matter of extreme urgency that I receive my transplant in 3 weeks. I have had all the preliminary chemo and I am ready.

This is an urgent matter!
Please help me so I can have my transplant as scheduled.
Any delay could threaten my life.

I give you permission to discuss this matter with my sister, Peggy M. Raddatz. [REDACTED]
with Raddatz 4-21-05

April 15, 2005



FORTIS

Solid partners, flexible solutions[®]

Mr Otto Raddatz

[REDACTED]
[REDACTED] IL [REDACTED]

Re: Policy / Certificate Number [REDACTED]

Dear Mr Raddatz:

Through a series of medical questions on your July 8, 2003 application / enrollment form, we asked that your family's health history be completely and accurately disclosed for the purpose of determining insurability.

During the course of our consideration of your claim for benefits, we received information regarding Otto Raddatz's health history, which was reported to us by Dupage Medical Group. The information we received pertained to one or more medical conditions that were not disclosed on the application / enrollment form including, without limitation the following: abnormal abdominal CT scan showing atherosclerotic abdominal aorta with infrarenal aneurysm and cholelithiasis (gall stones). Specifically, we have discovered medical records dated from February 9, 2000 to March 13, 2000 that revealed this health history.

Unfortunately, this history came to our attention after a claim was submitted. Under the circumstances, we must reform coverage. Had our Underwriting Department been aware of this medical history at the time of application / enrollment form was approved, eligibility for insurance coverage would have been affected. Therefore, we will be removing Otto Raddatz from coverage based on the material misrepresentation with respect to one or more questions on the application / enrollment form, including without limitation the following: 18b 18c 24. Please refer to the copy of the application / enrollment form included with your policy / certificate.

We are enclosing an Amendment of Application that excludes coverage for Otto Raddatz from the effective date of the coverage. If you choose to accept the above Amendment of Application, please sign, date and return it to Fortis. The policy/certificate will remain in force for all other previously covered family members. If you choose not to accept and sign the Amendment of Application, you will leave us no alternative except to rescind the entire policy back to the effective date of August 7, 2004. In either outcome, Fortis will arrange for any appropriate refund of premium.

Fortis Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI
53201-3050
Telephone
1 800 800 1212

Fortis Insurance Company / Fortis Benefits Insurance Company / John Alden Life Insurance Company

We require receipt of the signed Amendment of Application within 30 calendar days from the date of this letter. The signed Amendment of Application should be faxed to my attention at 1-414-299-1266.

If you have any new information that may impact this decision, please submit this information in writing. However, if the amendment of application is not received within the specified time frame, we will proceed with the rescission of coverage regardless of the receipt of appeal information.

The above information was reviewed in accordance with Fortis Insurance Company's underwriting guidelines, practices and procedures. All of the Company's rights and defenses, whether or not specifically mentioned herein, are reserved.

Yours sincerely,

[Redacted Signature]

Senior Individual Medical Underwriter
1-800-800-1212 Extension [Redacted]
Facsimile: 1-414-299-1266

[Redacted]

Enclosures



OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

May 3, 2005

Fortis Health
501 West Michigan
P. O. Box 3050
Milwaukee, WI 53201-3050

Peggy Raddatz
RE: Otto Raddatz

Dear _____,

We are in receipt of your formal response dated April 29, 2005 regarding Mr. Otto Raddatz. I have also had discussion with an attorney for Assurant Health named _____ . According to Ms. Quataro, Mr. Raddatz's insurance is being rescinded based on the fact that he did not state on his application of July 8, 2003 the presence of an aortic aneurysm. After reviewing the records again and speaking to the doctor caring for Mr. Raddatz at the time the CT scan was done, it is clear that Mr. Raddatz had no knowledge of the aneurysm, which was found incidentally on a CT scan done in February of 2000 by Mr. Raddatz's physician, Dr. _____.

Dr. _____'s medical notes at no time state that Mr. Raddatz was informed of an aortic aneurysm or indicate that Mr. Raddatz was in need of follow-up care related to an aneurysm. Notations made by Dr. _____ on the CT report of February 11, 2000 state: "Have kidney stones come in tomorrow". Dr. _____, who is now retired from practice, informed me that he does not recall telling Mr. Raddatz of the aneurysm. The fact that it is not written in the medical records that further attention related to an aneurysm is needed is further evidence suggesting Mr. Raddatz was not told he had an aneurysm.

Our office believes that it is highly likely that Mr. Raddatz was not informed of his aortic aneurysm until he received notification from Fortis that his policy was being terminated. Mr. Raddatz saw a physician, Dr. _____, who had replaced Dr. _____, for the first time in four years in August 2004. As reflected in the notes of that visit, neither he nor the physician mentioned an aneurysm. Next, when he saw a hematologist, Dr. _____, after the CT scan of September 2004, Mr. Raddatz does not indicate in his initial history the presence of an aneurysm nor does Dr. _____ mention an aneurysm in his report to _____ . Again, this would again indicate that Mr. Raddatz was not told of an aortic aneurysm.

Furthermore, the fact that Mr. Raddatz never sought medical attention after his visits of February and March 2000, until he became symptomatic from his current illness, can be viewed

as further evidence suggesting Mr. Raddatz did not make any fraudulent statements or material misrepresentations on his enrollment form. As stated several times on the complaint forms filed with our office, Mr. Raddatz was unaware of the presence of the aneurysm. 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.

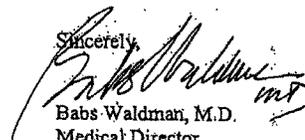
During this recent underwriting process, Fortis asserts that questions 18b, 18c, and 24 on the enrollment form were answered incorrectly. However, each of these questions is ambiguous, and they do not sufficiently elicit the level of detail you are purportedly seeking. These are also the kind of questions that are difficult for a lay person to answer, particularly with the degree of specificity and completeness that you are now saying was required of Mr. Raddatz. Indeed, Mr. Raddatz was clearly making no effort to withhold the fact that he had undergone a CT scan since he disclosed the fact that he had seen a Dr. [REDACTED] for kidney stones. Therefore, if the application is read as a whole, the information known to Mr. Raddatz was provided on his application.

We are stating that Mr. Raddatz's health insurance policy should not have been rescinded. Mr. Raddatz has been undergoing treatment under the reasonable assumption that he has medical coverage. He suddenly faces not only life-threatening illness but now the inability to afford the only treatment that may help him. The timing of rescinding Mr. Raddatz's insurance is such that he cannot possibly make other arrangements for coverage before it is too late. Clearly, Mr. Raddatz will die very soon without receiving the medical care that he needs. Our office is making every effort to assist this consumer, and we believe we have satisfied the guidelines as set forth by his policy by providing the above-mentioned information. In addition, we agree that each insured must be treated equally and fairly according to the guidelines set forth by their health insurance policy. However, many situations are not clear and in these situations, in the interest of human fairness, decisions should be made to best protect the consumer.

We greatly appreciate your continued review of this matter. We hope you will agree that we have adequately demonstrated that Mr. Raddatz did not know that he suffered from an aortic aneurysm. If our argument fails to meet the standard needed to reinstate his insurance policy, please provide our office with details of additional information that will be needed to reinstate his health insurance policy. We greatly appreciate your prompt and continued attention to this matter and would like a response by Friday, May 5. Thank you very much.

Dr. Babs Waldman, M.D.
Health Care Bureau Medical Director
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
Chicago, Illinois, 60601

Sincerely,



Babs Waldman, M.D.
Medical Director

Fax: [REDACTED]

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810



January 5, 2007

CERTIFIED MAIL [REDACTED]

[REDACTED]
[REDACTED], IN [REDACTED]

COPY

ID#: [REDACTED]

Re: [REDACTED]

As stated in our letter of December 8, 2006 it has come to our attention that your application for the Blue Access policy, offered by Anthem Insurance Company, contains incorrect and/or incomplete medical information. We have received and reviewed your December 18, 2006 letter of explanation and appreciate you allowing us the time to respond.

The application you completed asks the following question(s):

- 2. Has any person applying for coverage in the past 5 years had any diagnosis, consultation, treatment, testing or taken any medication or received follow up treatment or examination for:
 - a. Allergies, asthma, emphysema, bronchitis, chronic obstructive pulmonary disease, sleep apnea or other disease or disorder of the lungs or respiratory system?

The above question was answered "no" on your application. Had we known of your history of chronic obstructive pulmonary disease, coverage would have been declined.

Therefore, your coverage is rescinded. We intend to recover full payments made on claims submitted. All claims that are currently pending will be denied. Any premium fees paid will be refunded within approximately 30 business days, minus any amount that is applied toward claim payments that have been made for this member.

Please be advised that you will not receive a Certificate of Credible Coverage since your policy has been rescinded.

You have the right to appeal this decision. To initiate the appeals process, please forward your request for an appeal along with any additional information to the following address: Anthem Blue Cross Blue Shield, Appeals Department, P. O. Box 33200, Louisville, KY, 40232-3200. If you prefer, you may fax your appeal to (502) 889-3034.

1016 Rev1/02

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01/24/2007 13:03

HJ LAW OFFICE

██████████
Attorney at Law

Personal Injury & Estate Planning included in areas of practice

██████████
ANTHEM BLUE CROSS & BLUE SHIELD
P.O. Box 37810
Louisville, KY 40233-7810

COPY

IN RE: ██████████

Dear Ms. ██████████

On January 5, 2007, you wrote ██████████ advising him that Anthem Blue Cross and Blue Shield had rescinded his health insurance coverage because of his response to a particular question on his health insurance application as to whether he had any diagnosis, consultation, treatment or testing specifically for chronic obstructive pulmonary disease. He answered no because his physician, Dr. ██████████ and Dr. ██████████ nurse practitioner never used the term COPD or chronic obstructive pulmonary disease when discussing his history of cigarette smoking and the chronic problems that arise from tobacco usage in an appointment which preceded his application for health insurance.

I have enclosed a copy of a letter from Dr. ██████████ dated January 9, 2007 wherein he specifically indicates that he did not explain to ██████████ that he was describing COPD while discussing the chronic problems of tobacco usage with him. Neither Dr. ██████████ nor his nurse practitioner had any recollection that they ever actually sat down and talked with ██████████ about the diagnosis of COPD and that ██████████ may well be correct that it was mid year 2005 before that diagnosis was ever given to him.

For these reasons, we ask that Anthem reinstate his health insurance coverage retroactive to the date of rescission. I am also faxing a copy of this letter to the Anthem Blue Cross and Blue Shield Appeals Department seeking the above requested relief.

██████████ medical condition is grave and he is scheduled for surgery in less than two weeks. If he suffers any harm, whether financially or physically, from this denial of insurance coverage, he will most certainly seek the appropriate remedies in court.

Thank you for your consideration to this letter. If you would, please contact me upon receipt to discuss Anthem's response.

Very Truly Yours,

██████████
Enclosure

WLP0010334

		Committee Decision: Rescind <input checked="" type="checkbox"/> No Retroaction <input type="checkbox"/> Pending more info <input type="checkbox"/>	
Committee Review Date: May 2007	HCID#, NAME, Member Code, Plan: Individual KeyCare Preferred	Application Signature Date: December 2006	Effective Date of Policy: December 2006
Date Referral Received: April 2007			
Claim/Notification eliciting investigation: Claim for dx 311 (depression) was flagged on the portability query.			
Application/Health Statement: Clean application; weight of 170 and height 5'3"			
UNDERWRITING HISTORY Approved Level 1			
RELEVANT MEDICAL HISTORY PRIOR TO EFFECTIVE DATE:			
RELEVANT MEDICAL HISTORY POST EFFECTIVE DATE: Documented weight of 213 pounds and height 5'3" on January 2007 (See page 5 of the medical records)			
MEDICAL UNDERWRITING GUIDELINE(S): Maximum weight for her height is 193 pounds			
Health questions answered "no", should be "yes": Weight portion of the application was incorrect			
Reviewing Underwriter: _____			
Comments: We did not receive a response from Mrs. _____			
_____ _____			
_____ RVP Individual Underwriting East Region	_____ RVP, Medical Director	_____ Director, Medical Management	

Anthem Blue Cross and Blue Shield
Post Office Box 13647
Roanoke, Virginia 24018-3047



IMPORTANT INFORMATION ABOUT YOUR POLICY

April 2007

[Redacted]
VA

RE: ID No. [Redacted]

Dear Mrs. [Redacted]

I am writing to request your help in resolving a matter concerning your application for the Individual KeyCare Preferred program, your current health care coverage. The application includes questions about the medical history of the individual applying for coverage. Answers to these questions are evaluated along with any information obtained during the claims review process. Through this process, we learned that your history of psoriasis and hemorrhoids was not noted on your application. We also learned that you have a documented weight of 213 pounds on January 2007 which would indicate that the weight on your application is inaccurate. For your reference, I have enclosed a copy of your application.

Please clarify in writing why these conditions and lifestyle information were not included on your application, then send your letter to my attention by April 2007. Your written response is required for us to determine the future status of your contract with Anthem Blue Cross and Blue Shield. This review of your policy must be completed before any outstanding claims can be considered for payment. As explained in your policy, omitting important information from an application may result in cancellation of your coverage.

*****IMPORTANT NOTICE*****

If we do not receive a written response for our review by April 2007, your Individual KeyCare Preferred coverage will be cancelled retroactive to its original effective date.

- 2 -

Anthem Blue Cross and Blue Shield is a member of the Anthem Group of Companies. For more information, please visit us online at www.anthem.com.

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WLP0014292

05/11/2007 09:42 5488535034

ANTHEM RISK MGMT

PAGE 05

Anthem Blue Cross and Blue Shield
Post Office Box 13047
Reno, NV 89450-3047



Ms. [REDACTED] I appreciate your help as we work to resolve this matter. If you have any questions, our Member Liaison will be glad to assist you at [REDACTED]

Sincerely,

[REDACTED]

Underwriting Auditor

Enclosure

cc: File

- 2 -

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WLP0014293

Committee Review Date: 3/22/07 State: Texas 90 Day Date: 4/15/07		Committee Decision Rescind <input type="checkbox"/> No Retroaction <input type="checkbox"/> Retro Waiver <input type="checkbox"/> Retro Rate Up <input type="checkbox"/>
Member Name: [REDACTED]		
HCID Number: [REDACTED] MC Number: MC40 [REDACTED]		
Application Signature Date: 4/16/06 Effective Date of the Policy: 5/1/06 Plan: HSA 3 \$5000/\$10000		
Membership Information: Active Referral Source: MRU Date of Referral: 1/1/07		
Date claim received that was sent for review: 11/23/06 Diagnoses on Claim: Lump or Mass in Breast		
Medication Listed on Intelliscript: Tetracycline and Tobramycin Medication Listed on Reviewpoint: Boniva, Prometrium		
<u>Application/Health Statement:</u>		
<ul style="list-style-type: none"> Height 5 feet 4 inches and weight 185 pounds. 01-2002 Ovarian. Laproscopic removal 		
<u>Underwriting History:</u>		
Approved Preferred		
<u>Relevant Medical History Prior to Effective Date:</u>		
Provider: [REDACTED]		
<ul style="list-style-type: none"> 03-2005 Bone density-Osteopenia. Start Actonel. 03-2006 Meds: Actonel 		
<u>Relevant History Post Effective Date:</u>		
An offer letter for waiver 73U was sent on 2/16/07 with no response		
<u>Medical Underwriting Guidelines:</u>		
<ul style="list-style-type: none"> Osteopenia requires prescribed oral medications waiver 73U for 10 years would have been applied per MUG 733 Recommend to rescind due to no response to offer sent on February 16, 2007 		
<u>Other Medical History:</u>		
None		
<u>Health Questions Answered "NO" should be Yes:</u>		
Sect 6 question 27		
<u>Reviewing Underwriter:</u> [REDACTED]		
[REDACTED] Director Ind/Sm Grp Underwriting	[REDACTED] VP Medical Director	[REDACTED] VP & GM Ind /Sm Grp Unicare

Policy # [REDACTED]
APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

Proposed Insured: [REDACTED] Male Female
 Resident Address: [REDACTED]

1. Are any of your dependents to be covered under the policy/certificate? Yes No. If Yes, give details below.

Dependent's First Name	Relationship to You	Date of Birth	Dependent's First Name	Relationship to You	Date of Birth
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

2. Are you or is any family member (whether or not named in this application) an expectant mother or father? Yes No
 3. Have you or anyone named above been declined for insurance due to health reasons? Yes
 4. Have you or any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for less than the past 12 months? Yes
 5. Do you or any person named in Question 1 now have hospital or medical expense insurance that will not terminate prior to the requested effective date? Yes
 6. Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for any of the following: HIV infection, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? Yes
 Deductible: \$ 250 \$ 500 \$ 1,000 \$ 1,500 \$ 2,500 Requested Effective Date: [REDACTED]
 Months of Coverage: 1 MO. 2 MO. 3 MO. 4 MO. 5 MO. 6 MO.

STATEMENT OF UNDERSTANDING
 I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule at its Lawrenceville or Indianapolis Office with this application; (b) no benefits will be paid for a health condition that exists prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate which may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the postmark date affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule at its Lawrenceville or Indianapolis Office. I understand that the broker is only authorized to submit the application and collect premiums and may not change or waive any right or requirement.

Proposed Insured's Signature or Printed Name: [REDACTED] Date when you signed this application: [REDACTED]
 Licensed Agent or Broker (Printed Name): [REDACTED] Individual Producer #: [REDACTED]

Important Note: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.
 GR-AP-108-21 1/28/2007 - 11:25:51 AM Note: P.O. [REDACTED] 380-G-0807

UHG23949

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

To Continue Your Application for Coverage, You Must Become A Member Of FACT
Read and fill out the following FACT Membership Enrollment Form.

FACT MEMBERSHIP ENROLLMENT FORM

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues (\$20 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Short Term Medical Insurance to FACT.

X [Redacted Signature] x 11/28/2007 [Redacted Date]

If you wish to apply for association group insurance, please complete the application.

FACT ENR0 01M 0105

Payment Options: Must choose one

Single Payment: Check or money order \$ Amt. [Redacted] (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
For this method of payment, you must make check or money order payable to FACT. (EFT also available with online application)

Single Payment: Credit card \$ Amt. [Redacted] (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
For this method of payment, you must complete the Credit Card Authorization below.

Credit Card Authorization Visa MasterCard
I authorize FACT or Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

Account No. [Redacted] Expiration Date [Redacted]

Name on Credit Card [Redacted] x [Redacted] Phone No. [Redacted]

Address [Redacted] City [Redacted] State [Redacted] ZIP [Redacted]

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

Monthly Payment: Electronic Funds Transfer (EFT) \$ Amt. [Redacted] (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 nonrefundable application fee.) Additional monthly EFT payments will be \$20 less. For this method of payment, you must complete the EFT Authorization below.

Electronic Funds Transfer (EFT) Authorization
I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.
I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Void stamp: VOID

Routing No. [Redacted] Checking Account No. [Redacted]

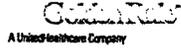
Financial Institution Name [Redacted] Address [Redacted] City [Redacted] State [Redacted] ZIP [Redacted]

Draft On [Redacted] Day [Redacted] Account Holder's Signature [Redacted] Date Signed [Redacted]

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date, or 2) up to 10 days after the due date.

11/28/2007 - 11:25:51 AM

07 [Redacted]



COPY

April 18, 2008

[Redacted]

Identification No: [Redacted]
Control No: [Redacted]
Claimant: [Redacted]
Insured: [Redacted]
Date: [Redacted]

When reviewing claims, we sometimes obtain medical records to help us resolve claim issues. As part of this routine process, we obtained medical information for you from [Redacted].

During our review of your information, we learned there was prior medical history that may have impacted our decision to provide you with health coverage. Therefore, we are sending your information to our Underwriting Department for review, and we will keep you informed as our review progresses.

You should continue to pay your premiums. However, these premiums will be conditional and may be returned to you if we determine that material misstatements were made in the application for insurance.

Golden Rule expressly reserves its rights under the policy, including, but not limited to, those under the Time Limit on Certain Defenses provision, the Preexisting Conditions provision, and the Incontestability provision.

After our review is complete, we will let you know if your coverage will be affected in any way.

Sincerely,

[Redacted]
Claim Department

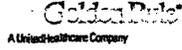
Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

07177886
[Redacted]

63

UHG23957

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules



COPY

May 2, 2008

[Redacted]

Identification No: [Redacted]
Claimant: [Redacted]
Insured: [Redacted]

Dear [Redacted]

Your request for benefits has been reviewed very carefully. We want to let you know the result of our review.

The Application for Coverage:

Before we can issue health insurance coverage, a customer fills out an application. We use the application to determine if we can offer coverage and rely on this information when we agree to provide coverage for a customer.

If the application is approved, a copy of it is attached and made part of the certificate. We do this so the customer can check the answers and let us know if any information is missing or incorrect. On the front of the certificate, it says "Check the attached application. If it is not complete or has an error, please let us know. An incorrect or incomplete application may cause your certificate to be voided and claims to be reduced or denied."

New Information From Our Review:

During our review, we requested and received medical records from [Redacted]. These medical records indicate that information was incorrect or missing from your application. This information would have changed the original decision to issue coverage.

According to the information we received, the answer to Question(s) 6 should have been "Yes" with respect to your medical history. The application should have also contained additional information in response to the question. A copy of the application is enclosed for your review.

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62429
www.goldenrule.com

07177886
[Redacted]

9

UHG23903

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

Page 2
May 2, 2008

Identification No: [REDACTED]
Claimant: [REDACTED]

The records we received noted that you were seen at [REDACTED] with a history of and treatment for alcohol abuse since at least November 28, 2006, up until at least January 19, 2007.

From November 28, 2006, up until at least August 16, 2007, it is noted by [REDACTED] of a history and treatment for hypertension.

How the New Information Affects Your Coverage:

If this information had been shown correctly on your application, our underwriters would have been unable to issue your coverage.

Now that we are aware of this information, we need to take the same action we would have taken if we had been aware of this information when you applied for insurance.

Your coverage has been voided. This means it is as though it had never been approved or issued. This also means:

- We will return all premium paid;
- We will not collect any more premium;
- We will not provide coverage or pay any claims; and
- We have no liability for any current or future claims.

There may be additional information that was missing or incorrect on your application. Golden Rule reserves the right to assert any other material misstatements as reason to void your coverage. By taking this action, we are not waiving any rights under the provisions of the certificate, including, but not limited to, the preexisting conditions provision.

Premium Refund:

Enclosed is a draft for payment of \$922.82 to refund all premiums paid for your coverage. This draft also includes membership fees for Federation of American Consumers and Travelers (FACT). Any premiums you may have paid recently will be refunded to you as soon as we receive and identify them. Please note that there is a release on the back of the premium draft. By cashing the premium refund draft, you are accepting our decision to void your certificate.

07177996 [REDACTED]

[Redacted]

Identification No: [Redacted]
Claimant: [Redacted]

Page 3
May 2, 2008

Please note that if the premium refund draft is not endorsed by the payee or if the release on the back is altered, Golden Rule will not pay the draft, you will not receive the funds, and your bank may charge you penalties or fees.

Your FACT Membership:

We will not continue to collect your FACT membership dues. As we explained above, your premium refund draft includes the membership fees we collected on behalf of FACT. We have not recovered this amount from FACT. You are still a member. If you wish to remain a member, you should arrange to send your membership fee directly to FACT. Their toll free number is 1-800-USA-FACT (1-800-872-3228), or you may write to them at:

FACT
Membership Service Office
P.O. Box 104
Edwardsville, IL 62025

Summary:

Since there is no coverage, for the reasons explained above, no present or future claims will be paid.

If you have additional information you believe would change our decision, please send it to us. We will review the information and reply to you promptly.

Sincerely,

[Redacted Signature]

Claims Review

Enclosure

07177886
1031275007001

02/01/2007 15:07 FAX

002

MICHIGAN

FACT MEMBERSHIP ENROLLMENT FORM

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and signing of Social dues (\$3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for Federation group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X

Date X

1/31/07

If you wish to apply for optional group insurance, please complete the application below.

FACT ENFO 0105

APPLICATION FOR INSURANCE

To be filled out personally by the applicant(s). PLEASE PRINT OR TYPE. Do not separate application pages.

1. Primary Applicant		2. Spouse	3. Dependent Children					
Name (Last, First, MI)	Special Status	Name (Last, First, MI)	Birth Date	Age	Sex	Height	Weight	
[Redacted] C.	INS OS	[Redacted] M.	[Redacted]	48	M	5-10	185	
[Redacted]		[Redacted]	[Redacted]	47	F	5-2	160	
3. Dependent Children		Name (Last, First, MI)		Birth Date	Age	Sex	Height	Weight
		[Redacted] L.	[Redacted]	18	F	5-2	99	
		[Redacted] M.	[Redacted]	15	F	4-11	97	

4. Primary Applicant's Address (P.O. Boxes are not accepted)

5. Phone Number: Home, Other, Business, Email Address

6. Hayer (if any)

7. Your Beneficiary: Name, Address, City, State, Zip, Age

8. Your Occupation: Sales, Date Hired: 1985, Total Annual Household Income

10. Primary Applicant's Mother's Maiden Name, Spouse's Mother's Maiden Name

Jan 27 2007 02:55:50 pm, 098-98-107-21 Primary Applicant's Initials, Spouse's Initials, Date 1/31/07, 122D-0908

INDY SUPPORT/ISSUE, FEB-0-2 2007, V. MAXWELL

09085412, REPS, 1007/10/170, PAGE: 02

UHG25321

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

02/01/2007 15:08 FAX

003

11. Requested Election Date: 2/1/07 Requested Health Class: Individual Tobacco (if question 32 is yes)
 Plan Includes Preferred Network: If not wanted, check here Preferred Standard Tobacco (if question 32 is yes)
 Network Name: Blue Cross

Copy Select \$ 600 \$ 1,000 \$ 1,500 \$ 2,000

HSA 100* \$1,050 \$ 2,100 \$ 300 (Saver 80 only)
 HSA Saver* \$1,800 \$ 3,600 Plan 100* \$1,000 (Saver 80 only)
 \$2,700 \$ 5,400 Plan 80** \$1,500 (Saver 80 only)
 \$3,600 \$ 7,200 Saver 80** \$2,500 \$5,000
 \$6,000 \$10,000 \$5,000

Term Life Benefit Preventive Care
 Supplemental Accident \$2,500 \$4,000 Maximum Maternity
 Prescription Drug Cost Paid in-Kind with Saver 80

12. Initial Payment With Application
 Check P.A.C. (EFT with on-line app. only) Credit Card

Operating Payments
 Monthly P.A.C. (EFT) Quarterly Direct Bill List Bill (exclude term)

FACT Sheet
 Base Premium Amount: \$ 3.00
 Term Life Benefit: Optional
 Preventive Care: Optional
 Supplemental Accident: Optional
 Maternity Benefit: Optional
 Prescription Drug Cost: Optional
 HSA Deposit: 325 Monthly Minimum (only with HSA)
 Total Monthly Payment: \$ 495.00 Quarterly Total Quarterly Payment: \$ 1,485.00
 One-Time HSA Set-Up Fee: \$ 0 \$ 0 only with HSA One-Time HSA Set-Up Fee: \$ 0
 One-Time HSA Identifying Rider: \$ 0 One-Time HSA Identifying Rider: \$ 0
 Initial Payment: \$ 495.00 Initial Payment: \$ 0

13. Within the last 60 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below. Yes No

Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (7) above the signature lines).

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	<u>YES</u>	<u>FEB.</u>

14. Will the term life benefit replace any existing life insurance? Company Name: _____ Policy #: _____ Yes No

15. Has any applicant ever had an application or policy voided, changed, postponed, issued, or changed (in extra premium, or had coverage modified (including medical exclusion items) by any insurer or its insurer? If yes, list name and give details. No

Reason: CONSUMER Action Taken: _____
 Date: _____ Reason for Action: _____

16. Has any applicant previously applied for, or been covered by, Golden Plan? No
 If yes, who? _____ Policy/Certificate #: _____

QRHAP-10741 Primary Applicant's Initial [REDACTED] Spouse's Initial [REDACTED] Date 1/21/07 122D-0606
 Jun 27 2007 10:56:40 pm

PAGE 88 FEB 01 2007 14:18 098085412 02/01/2007 11:53 03 GEOR

UHG25322

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

02/01/2007 15:08 FAX

003

COVERAGE INFORMATION

11. Requested Effective Date: 2/1/07 Requested Health Class: Private Standard Tobacco (if question 22 is yes) Tobacco (if question 22 is yes)

Plan Includes Preferred Network: If not wanted, check here

Member Name: 1111

Copy Select \$ 500 \$1,000 \$1,500 \$2,500

Copy Select \$2,000

Term Life Benefit Preventive Care (not Available with Copay Rider) Supplemental Accident \$2,000 \$4,000 Maximum Maternity

HSA 100* \$1,050 \$2,100 HSA 60** \$1,000 \$2,000 \$3,000 \$5,000 \$10,000

Plan 100* \$1,000 (Over 60 only) Plan 60** \$1,000 (Over 60 only) 60** \$2,500 \$5,000

Term Life Benefit Preventive Care Supplemental Accident \$2,500 \$4,000 Maximum Maternity Prescription Drug Cost (see contract with carrier)

12. Initial Payment With Application: Check P.A.C. (EFT with on-line app only) Credit Card

Outstanding Payment: Monthly P.A.C. (EFT) Quarterly Credit Bill (Use bill (include type))

FRCT Due \$ 3.00

Base Premium Amount + 435.00

Term Life Benefit + _____ Optional

Preventive Care + _____ Optional

Supplemental Accident + _____ Optional

Maternity Benefit + _____ Optional

Prescription Drug Cost + _____ Optional

HSA Deposit + _____ \$25 Monthly Minimum (only with HSA)

Total Monthly Payment = \$ 435.00

One-Time HSA Set-Up Fee _____ \$10 only with HSA

One-Time HSA Indemnity Rider _____

Initial Payment = \$ 435.00 Member check payable to TRACT

13. Within the last 60 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below.

Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced. (Use (7) above the signature lines)

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	YES	FEB.

14. Will the term life benefit replace any existing life insurance? Company Name _____ Policy # _____ Yes No

15. Has any applicant ever had an application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? If yes, list name and plan details. Yes No

Reason: _____ Action Taken: _____

Date: _____ Reason for Action: _____

16. Has any applicant previously applied for, or been covered by, Golden Rule? Yes No

If yes, when? _____ Policy/Certificate # _____

QR-AP-107-21 Primary Applicant's Initials [REDACTED] Date 1/21/07 1220-0606
 Jun 27 2007 02:56:50 pm

09085412

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UHG25323

Confidential Proprietary Business Information
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02/01/2007 15:09 FAX

004

CHANGING

17. In the last 24 months, has any applicant participated in either any type of motorcycle? Yes No
 If yes, please answer the following questions:

a. Name of applicant(s)?

b. Does the applicant have a valid motorcycle license?

c. Within the last 24 months, has the applicant had his/her license suspended or revoked?

d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details."

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS"

		Yes	No			Yes	No
18.	In any family member (whether or not named in the application) parent or an adoptive brother or sister?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of heart?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
19.	Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	a.	heart or circulatory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20.	Do you have an adoption pending?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b.	nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
21.	In the last 6 months, has any applicant been, or been advised to take, medication or received medical advice or treatment of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c.	digestive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
22.	Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d.	muscular or skeletal system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
a.	gallbladder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	e.	respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b.	pancreas or liver?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	f.	male or female reproductive system, including infertility?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c.	arms or spine?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	g.	urinary system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d.	kidney?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	h.	thyroid, breast, or other glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e.	eyes, ears, or nose?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26.	In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f.	mouth, throat, or jaw?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27.	In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 8 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a dry cough for one month or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
23.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
a.	high blood pressure?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29.	In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b.	chest pain?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30.	In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse, or any alcohol- or drug-related arrest?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c.	headache?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31.	Is any applicant currently or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? If yes, show who had how many drinks per week in "Medical History Details" (one drink equals 12 oz. of beer, 4 oz. of wine, 1 oz. of hard liquor).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d.	paralysis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32.	Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e.	arthritis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33.	List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f.	convulsions or epilepsy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
g.	elevated cholesterol?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
h.	sexually transmitted disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
i.	cancer?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
j.	diabetes or sugar in the blood or urine?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
k.	stroke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
l.	tumor, cyst, polyp, lump, or growth of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
m.	mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
24.	In the last 10 years, has any applicant:	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
a.	had a complicated pregnancy or delivery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
b.	been hospitalized, had surgery, or discussed surgery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				

Jan 27 2007 02:55:50 pm
 OPN-AR 10251 Primary Applicant's Initials [REDACTED] Date 1/31/07 122D-0606

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02/01/2007 15:08 FAX

004

CHIEF OF POLICE

12. In the last 24 months, has any applicant participated in driving any type of motorcycle? Yes No
 If yes, please answer the following questions:

a. Name of applicant(s)?

b. Does the applicant have a valid motorcycle license?

c. Within the last 24 months, has the applicant had his/her license suspended or revoked?

d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details"

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS"

		Yes	No			Yes	No
16.	In any family member (whether or not named in this application) pregnant or an expectant mother or father?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18.	Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	a.	heart or circulatory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20.	Do you have an adoption pending?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	b.	nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
21.	In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	c.	digestive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
22.	Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	d.	muscular or skeletal system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
a.	gallbladder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	e.	respiratory system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b.	pancreas or liver?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	f.	reproductive system, including	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c.	joint or spine?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	1.	male reproductive system, including	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d.	kidney?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	infertility?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
e.	eyes, ears, or nose?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	2.	female reproductive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f.	mouth, throat, or jaw?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.	urinary system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
23.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	4.	thyroid, breast, or other glands?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
a.	high blood pressure?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26.	In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b.	chest pain?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27.	In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a chronic cough for one month or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c.	headache?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d.	psoriasis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29.	In the last 12 months, has any applicant experienced a weight gain or loss of 16 pounds or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e.	arthritis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30.	In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency problem, or abuse, or any alcohol- or drug-related arrest?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f.	convulsions or epilepsy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31.	In any applicant currently, or in the last 5 years, have, a test of alcoholic beverages in excess of 14 drinks per week? If yes, show who and how many drinks per week in "Medical History Details" (one drink equals 12 oz. of beer, 4 oz. of wine, 1 oz. of hard liquor).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
g.	stomach ulcers?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32.	Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, state "Tobacco" in Question 11.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
h.	sexually transmitted disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33.	List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
i.	cancer?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
j.	diabetes or sugar in the blood or urine?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
k.	stroke?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
l.	tumor, cyst, polyp, lump, or growth of any kind?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
m.	mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
24.	In the last 10 years, has any applicant:	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
a.	had a complicated pregnancy or delivery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				
b.	been hospitalized, confined, had surgery, or discussed surgery?	<input type="checkbox"/>	<input checked="" type="checkbox"/>				

Jan 27 2007 02:05:50 pm
 GRI-AR-109-21 Primary Applicant's Initials [REDACTED] Spouse's Initials [REDACTED] Date 1/31/07 122D-0606

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Confidential Proprietary Business Information
 UnitedHealth Group
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2/01/2007 15:09 FAX

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FINANCIAL INSTITUTIONS ONLY - PLEASE PRINT NAME

I (we) hereby authorize FICT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification from me (or either of us) of its termination.

Routing No. _____
 Checking Account No. _____
 Include Voided BLANK checks

Financial Institution Name _____
 Address _____
 City, State, ZIP _____
 Dist. Ct. _____

By _____ (Date Signed) 1/31/07
 X _____

This insurance coverage is not designed nor restricted to employees provided insurance. This coverage does not comply with all your state's anti-employer group health insurance laws. Therefore, this plan cannot be used, now or at some future date, by you or an employer to provide insurance for employees.

(a) I am not employed by an employer with 2-50 employees; or
 (b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employee-provided insurance.

02-30-708

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any person who provides information to me in an effort to help me obtain insurance coverage, including insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

Golden Rule may also release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or ability to benefit on my (our) signed or signed this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X 1/31/07 at _____ City, State _____
 X _____
 Signature of Parent/Guardian (if you are a minor)

ALL INFORMATION TO BE OBTAINED AND DISCLOSED UNDER THIS AUTHORIZATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental condition about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X 1/31/07 at _____ City, State _____
 X _____
 Signature of Parent/Guardian (if you are a minor)

X _____
 Signature of Spouse (if to be enrolled)

Jan 27 2007 02:50:50 pm 5 -122D-0606 53

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UHG25328

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2/01/2007 15:08 FAX

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MEMBER'S AUTHORIZATION - ONLY PAYABLE BY DEPOSIT P.A.A.

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification from me (or either of us) of its termination.

Routing No. [Redacted]
Checking Account No. [Redacted]

Include Voided BLANK check

Financial Institution Name [Redacted]
Address [Redacted]
City, State, ZIP [Redacted]
Draft On [Redacted] 1/31/07 (Date Signed)
X [Redacted] (Signature of Account Holder)

This insurance coverage is not designed to substitute for any other provided insurance. This coverage does not comply with all your state's self-insured group health insurance laws. However, this plan contract is used, how may at some future date, by you or an employer to provide insurance for employees.

I certify that:
(a) I am not employed by an employer with 2-50 employees; or
(b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.
By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employee-provided insurance.

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any person...

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X 1/31/07 at [Redacted] [Redacted]
Signature of Power/Quarantee (if you are a minor)

employee, insurance company, consumer reporting agency or the Medical Information Bureau (MIB) having nonmedical information about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) signed to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, test result, or prognosis of any present or potential condition about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any asking or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X 1/31/07 at [Redacted] [Redacted]
Signature of Power/Quarantee (if you are a minor)

I (we) understand the following:
• A photocopy of this authorization is as valid as the original.
• I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule.
• I (we) may request revocation of this authorization, as described in Golden Rule's Notice of Information Practices.
• Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) signed to sign this authorization.
• The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regarding health insurance.

I have retained a copy of this authorization.

Jan 27 2007 02:52:50 am

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02/01/2007 15:10 FAX

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HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

By signing below, I acknowledge that:

- I wish to establish an HSA with Ebanco Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Ebanco Bank's Custodial and Deposit Agreement forms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Ebanco Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Ebanco Bank to provide information about my HSA, including my account number, to Golden Rule, and Ebanco acting on behalf of Golden Rule or Ebanco Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to credit and collect my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Ebanco Bank if I wish to have statements mailed to my home address.
- If I have filed out the information to request an additional debit card, I hereby request Ebanco Bank to issue a debit card on my account in the person indicated and I acknowledge I will be held for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

Signature of Primary Applicant
 Primary Applicant's Social Security Number _____

Per the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Have you, within the last 6 months, been covered under another health insurance plan? Yes No
 Has your spouse? Yes No

REQUEST FOR AN ADDITIONAL DEBIT CARD (OPTIONAL)

Authorized User's First Name _____ Middle Initial _____
 Last Name _____
 Date of Birth _____
 Social Security No. _____

155X-0000

IMPORTANT INFORMATION TO BE READ BY THE APPLICANT

Be sure to:

- read the current product brochure before completing the application for insurance.
- if you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Brokers must be licensed with Golden Rule in state where application is placed AND state where applicant resides.
- Coverage is not available if:
 - any family member is currently pregnant; or
 - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.

Note:

- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- P.O. Boxes are not accepted as a Primary Resident Address.
- Applications received by Golden Rule more than 15 days after the signed date will not be accepted.

Send the Application and Filled Form Packet to the address below.

Be sure to include the following:

- Health insurance quote.
- Initial payment check made payable to "FACT".
- P.A.C. subscription and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
 HEALTH APPLICATION
 Golden Rule Building
 7441 Woodland Drive
 Indianapolis, Indiana 46270-1719

Jan 27 2007 02:55:50 pm

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ES:IT / ARZ / TR / ZA PAGE 07

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UHG25330

Confidential Proprietary Business Information
 UnitedHealth Group
 Produced Pursuant to House Confidentiality Rules

02/01/2007 15:10 FAX

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HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

By signing below, I acknowledge that:

- I wish to establish an HSA with Esante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Esante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be used to open when my account is opened, along with Esante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Esante Bank to provide information about my HSA, including my account number, to Golden Rule, and Esante acting on behalf of Golden Rule or Esante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Esante Bank if I wish to have statements mailed to my home address.
- I have filled-out the information to request an additional debit card. I hereby request Esante Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

Signature of Primary Applicant _____
 Primary Applicant's Social Security Number _____

For the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Have you, within the last 6 months, been covered under another health insurance plan? Yes No
 Has your spouse? Yes No

REQUEST FOR AN ADDITIONAL DEBIT CARD (OPTIONAL)

Authorized User: _____ First Name _____ Middle Initial _____
 Last Name _____
 Authorized User: _____ Date of Birth _____
 Authorized User: _____ Social Security No. _____

155X-0806

PLEASE READ CAREFULLY: THE APPLICATION

Be sure to:

- read the current product brochure before completing this application for insurance.
- fill out the application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Becker must be licensed with Golden Rule in state where application is filed AND state where applicant resides.
- Coverage is not available if:
 - any family member is currently pregnant; or
 - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.

Note:

- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- P.O. Boxes are not accepted as a Primary Resident Address.
- Applications received by Golden Rule more than 15 days after the signed date will not be accepted.

Mail the Application and Filled Forms Packet to the address below.

Be sure to include the following:

- Health insurance quote.
- Initial payment check made payable to "FACT".
- P.A.C. authorization and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
 HEALTH APPLICATION
 Golden Rule Building
 7440 Woodland Drive
 Indianapolis, Indiana 46278-1718

122D-0806
 Copyright © 2006 Golden Rule Insurance Company

Jan 27 2007 02:56:50 pm

09085412

UHG25331

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

Golden Rule
A UnitedHealthcare Company

COPY

August 21, 2007

[REDACTED]

Identification No: [REDACTED]
Claimant: [REDACTED]
Insured: [REDACTED]

Dear [REDACTED]

Your request for benefits has been reviewed very carefully. We want to let you know the result of our review.

The Application for Coverage:

Before we can issue health insurance coverage, a customer fills out an application. We use the application to determine if we can offer coverage and rely on this information when we agree to provide coverage for a customer.

If the application is approved, a copy of it is attached and made part of the certificate. We do this so the customer can check the answers and let us know if any information is missing or incorrect. On the front of the certificate, it says "Check the attached application. If it is not complete or has an error, please let us know. An incorrect or incomplete application may cause your certificate to be voided and claims to be reduced or denied."

New Information From Our Review:

During our review, we requested and received medical records from [REDACTED]. These medical records indicate that information was incorrect or missing from your application. This information would have changed the original decision to issue coverage.

According to the information we received, the answer to Question(s) 21, 23g, 23i, 25a, 25e, 28, and 32 should have been "Yes" with respect to your medical history. The application should have also contained additional medical history in response to Instruction number 33. Medical history for you should have been reported under the section of the application called "Medical History Details -- For All Applicants." A copy of the application is enclosed for your review.

The records we received indicate that [REDACTED] advised you to have an electrocardiogram for myocardial ischemia on April 11, 2002, March 1, 2004, and May 26, 2005. The records also reveal that on March 1, 2004, and May 26, 2005, you were advised to have pulmonary function tests for chronic obstructive pulmonary disease, and to check for granuloma. On May 27, 2005,

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

09085412

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UHG25281

Confidential Proprietary Business Information
UnitedHealth Group
Produced Pursuant to House Confidentiality Rules

Page 2
August 21, 2007

Identification No. [REDACTED]
Claimant: [REDACTED]

your complete blood count was abnormal revealing an elevated red blood cell count, hemoglobin, and hematocrit. On October 25, 2006, [REDACTED] saw you for a cough and wheezing. You were advised to stop smoking and to have pulmonary function tests as well as a computerized tomography scan of the lungs. On November 30, 2006, you were started on Chantix to help you stop smoking.

How the New Information Affects Your Coverage:

If this information had been shown correctly on your application, our underwriters would have been unable to issue your coverage.

Now that we are aware of this information, we need to take the same action we would have taken if we had been aware of this information when you applied for insurance.

Your coverage has been voided. This means it is as though it had never been approved or issued. This also means:

- We will return all premium paid;
- We will not collect any more premium;
- We will not provide coverage or pay any claims; and
- We have no liability for any current or future claims.

There may be additional information that was missing or incorrect on your application. Golden Rule reserves the right to assert any other material misstatements as reason to void your coverage. By taking this action, we are not waiving any rights under the provisions of the certificate, including, but not limited to, the preexisting conditions provision.

Premium Refund:

Enclosed is a draft for payment of \$3148.56 to refund all premiums paid for your coverage. This draft also includes membership fees for Federation of American Consumers and Travelers (FACT). Any premiums you may have paid recently will be refunded to you as soon as we receive and identify them. Please note that there is a release on the back of the premium draft. By cashing the premium refund draft, you are accepting our decision to void your certificate.

Please note that if the premium refund draft is not endorsed by the payee or if the release on the back is altered, Golden Rule will not pay the draft, you will not receive the funds, and your bank may charge you penalties or fees.

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Page 3
August 21, 2007

Identification No: [REDACTED]
Claimant: [REDACTED]

Your FACT Membership:

We will not continue to collect your FACT membership dues. As we explained above, your premium refund draft includes the membership fees we collected on behalf of FACT. We have not recovered this amount from FACT. You are still a member. If you wish to remain a member, you should arrange to send your membership fee directly to FACT. Their toll free number is 1-800-USA-FACT (1-800-872-3228), or you may write to them at:

FACT
Membership Service Office
P.O. Box 104
Edwardsville, IL 62025

Summary:

Since there is no coverage, for the reasons explained above, no present or future claims will be paid.

If you have additional information you believe would change our decision, please send it to us. We will review the information and reply to you promptly.

Sincerely,

[REDACTED]
Claims Review

Enclosure

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UHG25283

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09/05/29 * PHONE CALL RECORDS - DATA REQUEST *

ID: [REDACTED] GRP: [REDACTED] PLN:FHCA35 NAME: [REDACTED]
 EFF:02/02/07 PD:02/02/07 STATUS:RES ISS/RES:
 CLMT: [REDACTED] DOB: / / EFF: / / STA: [REDACTED]
 RIDERS:
 BEN RDRS:PP0025 MDBNMI PPCVRX WALPLN NETAMD STDF10
 DX:
 PROC:
 IP: OP: DOS: NO GUAR: PREM: 4770.81 UR VEND:
 PRE X: CONTEST: MED NEC: R & C:
 FUND: TPA:* COLA:Y FAM:Y QUAL:N NT ACCT#:
 DED: MET: COINS1: TO COINS2: TO
 CALLER: [REDACTED] RELATE:INSURED/APPLCNT/OWNE RSN:EV
 PHONE: [REDACTED] PLAN NAME: AGY:V1
 TAKEN BY:29CJC TAKEN DATE TIME:20070829 08:41 CH:153
 RETRN BY:44088 RETRN DATE TIME:20070831 13:59 CH:L49

WANTS TO KNOW WHEN HIGH BLOOD COUNT WAS.
 WHY WE DROPPED WHOLE FAMILY INSTEAD OF HUSBAND.
 VER PHONE
 8/30/07 9:27 24887/180 - THIS REQUEST GOES TO ADJ THAT SENT LETTER PER
 HC00 TO 44KIM [REDACTED] F/RESPONSE TO CALLER - THX
 8/30/07 ROUTED TO WRONG AREA-CLAIMS. ROUTE TO THE CORRECT AREA. 004
 SORRY - TO 28058 F/RESPONSE TO CALLER PLS / THX
 LEFT MESSAGE -8/31/07-1:09

 INSURED CALLED BACK IN WANTING TO KNOW WHY THIS WAS REC FOR THE WHOLE
 FAMILY.... ADVISED THAT SOME WILL BE CALLING HER BACK..THNX 24776
 CALLED HER BACK TOLD HER COVERAGE WAS VOIDED TO MEDICAL HISTORY NOT ON
 APP--SHE SAID ELEVATED RED BLOOD COUNT--I TOLD HER THAT WAS ONLY ONE REASON
 SHE ASKED ME TO READ ALL OF THEM TO HER --TOLD HER I COULD NOT DO THAT DUE
 TO HIPPA LAWS--I TOLD HER OUR REASONS WERE DETAILED IN OUR 8/21/07 LETTER
 VOIDING THE COVERAGE--
 SHE ASKED ME TO NOT THAT SHE WILL ACCEPT DECISION BUT FEELS LIKE WE SHOULD H
 AVE GIVEN THEM A 30 DAY NOTICE PRIOR TO VOIDING PLAN. TOLD HER I WOULD NOT
 E THAT.

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UHG25481

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 UnitedHealth Group
 Produced Pursuant to House Confidentiality Rules

WELLPOINT

**2003 Strategic Performance Management
Part 1A**

For period of: 01/01/03 *to:* 12/31/03

Name: [REDACTED]

Job Title: Director, Group Underwriting

Salary Grade: 41

Prepared by: [REDACTED]

Prepared by Job Title: General Manager, Individual Services

Date: 2/26/2004

Page 1

**2003 Business Objectives & Performance Assessment
Part 2A**

No.	Objective	Metric	Weight (Number One to Hundred)	Results Achieved	Rating (Number One to Five)
1.	<p>Business Objectives: List Business Objectives and Metrics. Rater enters weight for each objective ensuring total weight for all objectives equals 100%. At the end of the performance period, Rater reviews Business Objectives & Performance Assessment, determines ratings for each objective, and then calculates the Overall Weighted Rating for Business Objectives. After entering Ratings and Weights, use the instructions below to calculate column totals and the Overall Weighted Rating for Business Objectives.</p> <p>Meet financial and enrollment targets</p> <ul style="list-style-type: none"> a) Maintain fit puppet b) Evaluate and review underwriting guidelines, policies and procedures and workflows to meet operational metrics and maintain financial stability. c) Evaluate and refine underwriting audit process to improve quality and financial stability. 		20	<p>Reduced departmental payroll from .7871 to .7480 while meeting/exceeding unit metrics.</p> <p>has streamlined the Underwriting workflows and processes to maximize production, improve service levels, while improving accuracy as evidenced by a reduction in inventory from 14,000 to 3,000, improved turn around times from 10 days to 24 hours, decreased FTE count from 101 to 90 resulting in a savings of \$900,000; reduced medical records requests from 42% to 28%, instituted electronic submission and retrieval of medical records which improved service levels from 15 days to 8 days, while retaining costs by \$1,400,000.</p> <p>Enhanced process workflows, partnering with claims and MKU, enabling the FQOT department to review 6039 claims that resulted in a Pre-Ex savings of \$1,366,503 and a Retro savings of \$9,855,564.</p>	5

Delete unused rows: Highlight Row(s), On Menu, Click "Edit" then Click "Cut"

0174701000114

WELLPOINT

2003 Strategic Performance Management
Section 1

For period of: 03/24/03 to: 12/31/03

Name: [REDACTED]

Social Security Number: [REDACTED]

Job Title: Underwriting Supervisor

Salary Grade: 37

Prepared by: [REDACTED]

Prepared by Job Title: Director of Underwriting & Individual Underwriting Policy

Date: January 29, 2004

RECEIVED
May 18 2004
HRD Central Filing

Page 1

2003 Objectives & Performance Assessment
Section 2

No.	Objectives	Results Achieved	Rating (Number One to Five)	Weight (Number One to Hundred)	Weighted Rating (Press "F8" key to calculate or recalculate if changes are made)
4.	Develop associate personnel to achieve desired levels of performance and increase member satisfaction.	effectively handles all the differing viewpoints within her IORT department. She has proven to be skilled in working through unreasonable demands. She has since developed a structure and department that is now her own. This team has achieved a high level of performance as evidenced by: <ul style="list-style-type: none"> --o Pre-ex claims savings of \$1,265,503 --o Retro savings of \$9,835,564 --o Reduction of claims inventory of 1200 down to 500. 	3	20	60.00
5.	Achieve budget goals regarding associate utilization and administrative costs.	has achieved budget goals by monitoring and rebidding her FTE's, OT FTE's and office supplies.	3	5	15.00

Delete unused rows: Highlight Row(s). On Menu, Click "Edit" then Click "Cut"



Your Health Insurance Reference Guide



AUTHORIZATION

Authorization might be required

Authorization — advanced review of planned treatment — is required before inpatient treatment, as well as outpatient surgery and other types of invasive outpatient treatment, which are listed under Utilization Review in your insurance contract.

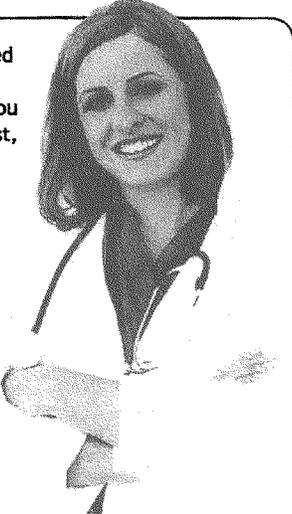
When authorization is required, ask your health care provider to initiate the process as soon as possible prior to the beginning of treatment.

The contact number for authorization is on the back of your insurance card.



Emergency surgery or hospital admission should never be delayed for authorization. However, your health care provider should call the authorization contact number as soon as possible during/following such emergency care.

No referrals are needed to obtain health care services. Even when you need to see a specialist, you may use any health care provider you choose.



May 6, 2005



FORTIS

Solid partners. Flexible solutions.

MR OTTO RADDATZ

[Redacted]
[Redacted] IL [Redacted]

Document: [Redacted]
Certificate: [Redacted]
Insured: Otto Raddatz
Company: Fortis Insurance Company, NAIC: [Redacted]
Your File: N/A

Fortis Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI
53201-3050
Telephone
1 800 800 1212

Dear Mr. Raddatz:

This letter is in response to your inquiry dated April 25, 2005 filed with the Office of the Attorney General for the State of Illinois. You expressed a concern regarding the decision of Fortis Insurance Company to rescind your coverage under the certificate due to material misrepresentation.

We are pleased to inform you that we will be overturning our original decision to rescind your coverage. As a result, any outstanding claims will be processed for payment according to the terms, conditions, provisions and limitations of your certificate.

If you have any additional questions, please contact Customer Operations at 1-800-800-1212.

Sincerely,

[Redacted Signature]

Individual Medical Underwriting Correspondent

cc: Office of the Attorney General - State of Illinois



OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

April 26, 2005

██████████
Chief Executive Officer
Fortis Health
P.O. Box# 3050
Milwaukee, WI 53201-3050

Re: Otto Raddatz

██████████ IL ██████████

Dear Mr. ██████████,

As Medical Director of the Office of the Illinois Attorney General, I have been asked to review the case of Mr. Otto Raddatz. Mr. Raddatz, who had been covered by State Farm for a number of years, completed an insurance application for Fortis in August 2003. On the application he indicated he had had nephrolithiasis and smoked, and he listed his physician from whom records could be obtained. His policy with Fortis began in August of 2003. In September of 2004, Mr. Raddatz unfortunately was diagnosed with non-Hodgkin's lymphoma, for which he has been undergoing treatment and is in his first partial remission. His prognosis is a matter of months if he does not go on to receive consolidation therapy. He has just finished an intense course of chemotherapy as part of that consolidation therapy that must be followed by an autologous hematopoietic cell transplantation (AHCT) within the next couple of weeks. The stem cell transplantation is necessary – indeed, life saving – as his bone marrow has intentionally been destroyed by the very aggressive chemotherapy given to treat his lymphoma. Mr. Raddatz will soon be completely pancytopenic if he does not receive a stem cell transplantation and receiving the autograft is his best chance of long term survival.

In the midst of this treatment, Mr. Raddatz received a call and a letter dated April 15, 2005 from Fortis stating his insurance is going to be rescinded as of August 2004 i.e. just prior to his diagnosis of Lymphoma. The reversal of Mr. Raddatz's insurance is being based on the fact that he did not include in his application of August 2003, the presence of two conditions that were incidentally found on a CT scan done in February of 2000 because of kidney stones: asymptomatic gallstones and a 3.5 cm abdominal aortic

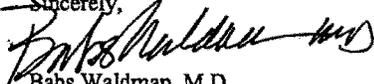
aneurysm. Neither of these conditions require treatment. To a lay person, neither of these asymptomatic conditions may rise to a level of awareness when filling out, or completing, an insurance application with very general questions. Mr. Raddatz should not be expected to view these two issues as significant, nor should he be expected to even remember their presence. He is asymptomatic from these and he has never had treatment for them. Basing retroactive denial of coverage based on this type of information is stretching the interpretation of insurance code beyond its intended boundary.

I find the behavior on the part of Fortis Health to be extremely troubling if not unethical. Clearly, there is no justification for rescinding this gentleman's insurance beyond avoiding the cost of his future treatment. The findings for which Fortis is rescinding/terminating Mr. Raddatz's coverage have absolutely nothing to do with his compelling diagnosis. To do rescind/terminate his policy at this point is not only devastating but probably fatal for Mr. Raddatz. In effect, by rescinding/terminating his coverage you are telling a dying patient that he cannot have the only treatment that can potentially save his life. Indeed, now that he is without insurance, the treating hospital will not proceed with the transplant unless Mr. Raddatz pays upfront.

Unfortunately, this is not the only complaint of this nature we have received. There seems to be a very distinct pattern in which Fortis rescinds insurance policies once claims have been made. The reasons for terminating insurance, such as Mr. Raddatz's, are not reasonably related to the diagnosis for which the claims are made. Often the conditions do not impact the consumer's health, nor might be expected to be thought of as significant by the consumer. Many conditions could have been dealt with by use of riders or exclusions. In the case of Mr. Raddatz there is life-threatening urgency. It is our hope that you will reinstate Mr. Raddatz's coverage and allow him to receive this life-saving treatment.

We expect a reversal of this most disturbing decision and need to hear ASAP as Mr. Raddatz needs to have this treatment within the next two to three weeks.

Dr. Babs H. Waldman, M.D.
Medical Director
Health Care Bureau
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
Chicago, IL 60601

Sincerely,

Babs Waldman, M.D.
Medical Director Health Care Bureau
[Redacted] Fax [Redacted]

Cc. Otto Raddatz
[Redacted]

or distribution is prohibited. If you are not the intended recipient, please contact the sender via E-mail and destroy all copies of the original message.

From: [REDACTED]
Sent: Monday, January 22, 2007 3:37 PM
To: [REDACTED]
Subject: research and fast response needed!
Importance: High

I just received a call from [REDACTED] with [REDACTED] Medical Oncology Head and Neck. She wanted to give me a heads-up on [REDACTED], who we rescinded on Jan 9, 2007 letter dated January 9, 2007. Per [REDACTED] because he no longer has insurance the surgeons scheduled to operate on his Stage III cancer this week have cancelled specifically due to his lack of insurance. [REDACTED] states there is a lawyer letter from [REDACTED] here as well as a retraction of medical record from [REDACTED] physician who counseled him regarding his COPD. Neither letter have I seen.

Have these letters been received by Appeals?

[REDACTED] CIFI
[REDACTED] fax

1/23/07
10:08 AM
1/23/2007

01/23/2007

