

Testimony of

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Mr. Chairman and Members of the Committee, thank you for the opportunity to be here today.

For 20 years, I worked as a senior executive at health insurance companies. During that time I saw how these companies confuse their customers and dump the sick to satisfy their Wall Street investors. Prior to the protections of the Affordable Care Act, Wall Street's dictates determined whether millions of American families would be offered coverage, whether they could keep it, and how much they would be charged for it.

For the last decade of my insurance career, I handled financial communications for one of the country's largest health insurance corporations. I worked closely with the CEO, the chief financial officer and the head of investor relations to be able to fulfill that responsibility.

The top priority of for-profit companies is to drive up the value of their stock. The stock price of the big for-profit insurers fluctuates based on their quarterly reports, which the CEO and other executives discuss every three months in conference calls with investors and analysts. On these calls, investors and Wall Street analysts look for two key figures: earnings per share, which is common to all companies, and the medical-loss ratio, or MLR, which is unique to the health insurance industry. As you know, the MLR is the ratio between what an insurer actually pays out in claims and

what it has left over to cover executive pay, underwriting, lobbying, sales, marketing, public relations, other administrative expenses, and, of course, profits.

Within the executive offices, there is a single-minded focus on being able to show investors and analysts that the insurer made more money during the previous quarter than a year earlier and that the portion of each policyholder's premium devoted to covering medical expenses was less than it was a year earlier.

To meet Wall Street's relentless profit and MLR expectations, insurers routinely dump policyholders who are less profitable or who get sick. This very committee found during a 2009 investigation that only three insurers had canceled the coverage of roughly 20,000 people over a five-year period, allowing those companies to avoid paying \$300 million in claims. To avoid paying almost a third of a billion dollars in claims, many if not most of those 20,000 people had to be seriously ill when their policies were rescinded.

Insurers also dump small businesses whose employees' medical claims exceed what insurance company underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether—leaving all the company's workers and their families uninsured. This practice is known in the industry as "purging." The purging of less profitable accounts through unreasonable rate increases helps

explain why the number of small businesses offering coverage has fallen steadily over the past several years.

Studies done by the accounting firm PricewaterhouseCoopers, which audits the books of many insurers and has authored numerous reports for their trade association, have shown how successful the insurers' expense management, rescission and purging actions have been in meeting Wall Street's MLR expectations. One PricewaterhouseCoopers study found that the average MLR in the insurance industry has fallen from approximately 95 percent in 1993 to around 80 percent today. In another study, it found that the collective MLRs of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. That translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients.

Another firm that does a lot of consulting work for health insurers, McKinsey & Company, noted in a 2007 report that the United States spent \$412 per capita on health care administration in 2003—nearly six times as much as other developed countries. McKinsey also found that 64 percent of the administrative costs incurred by private insurers in the U.S. is due to underwriting health risks and sales and marketing—costs that do not occur in most other developed countries. In other words, the term medical-loss ratio is largely unknown outside of the United States.

Part of my job when I worked in the insurance industry was to explain to the media every three months whether my company met Wall Street's profit expectations—and if it didn't, why not. I had to know what was influencing the MLR and what the company had done with the billions of dollars in premiums it received during the quarter from employers and individuals.

I came to know from personal experience that insurers almost always see sharp declines in their stock prices when they disclose that they spent more on medical care than investors expected. I'll never forget the day a few years ago when Aetna's stock price fell more than 20 percent on the day it admitted that its first quarter MLR had increased from 77.9% to 79.4%. Investors were so alarmed that they began selling shares of other insurers, too, believing that if the MLR was going up at Aetna, it was probably going up at its competitors as well.

When I handled financial communications for CIGNA, I knew as soon as I saw MLR numbers for a given quarter how busy my day would be when we announced quarterly earnings. If the company spent more on medical care than investors and analysts expected, my phone would be ringing all day long from financial reporters wanting to know why the MLR was going in the wrong direction—at least from Wall Street's perspective.

I might still be in my old job had I not come face to face with the real world consequences of that single-minded focus on pleasing Wall Street by constantly pushing the MLR downward.

In July of 2007, during a trip to East Tennessee to visit relatives, I read in the local paper about something called a 'health care expedition' that was being held a few miles across the state line at the Wise County, Virginia, Fairgrounds.

Thousands of people were expected to travel from as far away as Georgia and Ohio to this three-day event to get care from doctors and nurses and other caregivers who had volunteered their time.

Out of curiosity, I decided to go check it out. Nothing could have prepared me for what I saw when I arrived.

The parking lot was jam-packed. Many people were still in their cars and trucks, having slept in them all night. Others were lying on sleeping bags and inflated mattresses on the gravel.

When the fairground gates opened at 6 a.m., the place began to look like a refugee camp in a war zone. Enormous lines of people, many of them soaked from the rain that had been falling that morning, stretched out of view.

Some of those lines led to barns and animal stalls where doctors and nurses were treating patients. Many other people were being treated in open-sided tents. Dentists were pulling teeth and filling cavities, optometrists and ophthalmologists were checking eyes for glaucoma and cataracts, doctors and nurses were doing mammograms, and surgeons were cutting out skin cancers.

That day I realized that the folks in those lines were no different from me—they could have been my relatives or my parents' neighbors. I could tell from their faces that they were people with whom I shared cultural roots, but who hadn't had the good fortune to land a high-paying job as I had.

It was clear to me at that moment that my industry, with its obsession with the MLR and the bottom line, was one of the main reasons those folks at the fairgrounds had to go to such lengths to receive basic medical care.

Until that day, I had allowed myself to believe the insurance industry's characterization of them as deadbeats and shirkers. I could not have been more wrong. These people were not shirkers—our health care system had left them behind. They simply couldn't afford to get the care they needed.

Two-thirds of the 4,000 attendees at that health care expedition that weekend were employed. Most worked for small businesses that couldn't afford to provide

coverage for their employees. Undoubtedly, some of those small businesses had been purged by their insurers because an employee had gotten sick.

Many of those folks had tried to buy policies on their own, but like one-third of all people who try, they had been turned down because of pre-existing conditions.

Others had had their policies rescinded when they most needed them.

So, a few months later, I quit my job. I know now I've found my real calling, which is to explain to people—including Members of Congress—just how broken our health care system really is and how vulnerable we all are, how close we all are to joining the ranks of the uninsured because of insurers' short-term profit goals.

The provision of the Affordable Care Act that requires insurers to spend at least 80 percent of what we pay in premiums on our health care is one of the most important provisions of the law and one that must be preserved. In my view, Congress was more than benevolent to the insurance companies by allowing them to include spending on activities to improve the quality of care along with medical claims in computing their MLRs. Insurers had never done that before the law was passed. In addition, Congress exempted all taxes from the MLR calculation—a huge artificial boost to insurers' MLRs.

Some have suggested that Congress should now exempt insurance agent and broker commissions from the calculation too. And the bill introduced by Representative

Rogers would take that a step further by excusing all sales commissions, including payments to salaried sales staff, from the formula. To make it even easier for insurers to meet the law's requirement by exempting broker commissioners is precisely the wrong thing to do. I have spoken with agents who have seen their commissions reduced by insurers, and I am sorry they now have to find other ways to earn the same income as before. Many of them have, indeed, provided a valuable service to individuals and small businesses. But it is important to keep in mind that by accepting commissions from the insurers, agents and brokers are in a very real sense working for the insurers more than for those individuals and small businesses. Yes, many of them have gone to bat for their customers when they've had a dispute with their insurers, but their business model is antiquated and often not in the best interest of consumers. I believe it is time for agents and brokers to develop new business models and, while they're at it, develop a new value proposition for the people they theoretically serve.

It is important to note that even before the passage of the Affordable Care Act, insurers had begun taking steps to reduce broker commissions, which they viewed as too high to start with. Insurers are not being forced by the MLR provision of the law to reduce commissions: there are other levers on the administrative side or through reducing premiums. Basically, insurers have been choosing to reduce commissions to protect profits. I doubt you have heard of any insurers that have reduced the salaries of their CEOs and other top executives to meet the MLR requirements. You haven't and you won't.

Another thing to keep in mind as you consider legislation to exempt commissions from the MLR equation is that even if it were to be enacted, it is not likely to be of much help to agents and brokers now or in the future. If you think insurers would restore the commissions they've already reduced, you don't understand how insurers, under constant pressure from Wall Street, really operate. Exempting commissions would really only help insurers by making it easier for them to comply with the MLR provisions.

The proposed changes to the grandfathering provision are similarly misguided. By denying the Department of Health and Human Services the ability to enforce insurance reforms on current plans, the bill would take away important consumer protections, including the prohibition on lifetime limits and a ban on rescissions—a practice that lets insurers take away your coverage mid-year, usually after you've gotten sick. It would also prohibit enforcement of the rule that allows young people to stay on their parents' insurance plans until age 26. This week's Census figures show that this provision has already helped 500,000 young people get insurance. Why would Congress vote to take away their insurance?

HHS carved out reasonable limits on what plans could be grandfathered. A plan can maintain its grandfathered status until it changes its benefits or raises its cost too much. This proposal would remove those limits, so every plan is grandfathered, forever. This means that people will be locked into plans that don't have the

protections they are entitled to under the ACA, like preventive services without co-payments. Plans would also lose the guaranteed review of premium rates that increase by more than 10 percent, putting people once again at the mercy of health plans.

Repealing the grandfathering provision would be a gift to the insurance industry. As I learned during my years in that industry, another way insurers meet the profit expectations of their directors and investors is to constantly reduce the benefits in the policies they market and to shift increasing percentages of the cost of care from them to their policyholders.

If you ever listen to an insurance company's quarterly earnings call, you will hear executives and analysts use another obscure term is unique to the insurance industry: "benefit buydown." That euphemism describes the actions insurers and their employer customers take to cut benefits and shift additional out-of-pocket costs to consumers.

If Congress repeals the grandfathering provision of the law—which was intended to protect consumers from the effects of benefit buydowns—you will be guaranteeing that all Americans with private insurance will see continued reductions in benefits and cost shifting. While advocates of abolishing the grandfathering provision might claim that it is in the best interest of consumers, in reality it will make it easier for

insurers to meet their profit goals by enabling them to dump more and more of us into the ranks of the underinsured.

Thank you for giving me this opportunity to present my testimony.