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Subcommittee on Oversight and Investigations

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(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,<sup>1</sup> 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 In fact, as a percentage of new individual market enrollment during 2008, we rescinded only one-tenth of one percent of the policies that year.

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<sup>1</sup> 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.