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House of Representatives
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MEMORANDUM

October 12, 2010

To: Members of the Committee on Energy and Commerce

From: Chairmen Henry A. Waxman and Bart Stupak

Re: Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market

Since March 2010, the Committee has been investigating the extent of coverage denials and exclusions for pre-existing conditions in the individual health insurance market. This memorandum summarizes what we have learned in the investigation. We have found (1) the four largest for-profit health insurance companies denied over 600,000 individuals coverage because of pre-existing conditions in the three years before passage of health reform and (2) the number of coverage denials increased significantly each year.

The insurance company practices described in this memorandum are those that exist in today's market. In all likelihood, they would continue unabated in the absence of federal health reform legislation. One of the major benefits of the Affordable Care Act, which was signed into law on March 23, 2010, is a ban on the practice of denying coverage based on pre-existing conditions.

Key findings in our investigation are:

- **From 2007 through 2009, the four largest for-profit health insurance companies, Aetna, Humana, UnitedHealth Group, and WellPoint, refused to issue health insurance coverage to more than 651,000 people based on their prior medical history.** On average, the four companies denied coverage to one out of every seven applicants based on a pre-existing condition. One of the four companies maintained a list of over 400 medical diagnoses that triggered a permanent denial of health insurance coverage to applicants.
- **From 2007 through 2009, the number of people denied coverage for pre-existing conditions increased at a rapid rate.** The number of individuals denied coverage by Aetna, Humana, UnitedHealth Group, and WellPoint increased from 172,400 in 2007 to 257,100 in 2009, an increase of 49%. During the same period, applications for enrollment increased by only 16%.

- **From 2007 through 2009, Aetna, Humana, UnitedHealth Group, and WellPoint refused to pay 212,800 claims for medical treatment due to pre-existing conditions.** In some cases, the companies offered health insurance to individuals with pre-existing conditions, but used medical riders to exclude coverage or increase deductibles for the pre-existing conditions. In the case of one of the companies, nearly 15% of the company's customers in the individual market in 2010 had policies with riders limiting coverage or increasing deductibles for certain medical conditions.
- **Each company had business plans that relied on using pre-existing conditions to limit the amount of money paid for medical claims.** In one document, executives devised a plan for "strategic growth" in the individual market that identified areas of opportunity to be "improved pre-existing exclusion processes, tighter condition and large claim review, [and] tighter underwriting guidelines." Other internal corporate documents show that insurance company executives were considering practices such as lengthening the look-back period, assessing separate deductibles specifically for identified pre-existing conditions, denying payments for prescription drugs related to pre-existing conditions, linking additional claims to pre-existing conditions exclusions, and narrowing the definition of prior creditable insurance coverage.

The Affordable Care Act signed into law by President Obama prohibits the use of pre-existing conditions to deny coverage or claims. For children, this provision becomes effective for policies issued on or after September 23, 2010. For everyone else, the ban on the use of pre-existing conditions takes effect on January 1, 2014. As a result, health insurance companies will no longer be able to deny coverage to people due to their medical history. The companies also will not be permitted to exclude medical coverage for treatments related to pre-existing conditions, and they will not be allowed to charge higher premiums based on covering individuals with pre-existing conditions.

I. PURPOSE AND METHODOLOGY OF THE INVESTIGATION

While most Americans receive health insurance coverage through group plans sponsored by their employers, millions of people who cannot obtain health insurance through their employers and do not qualify for government programs such as Medicare or Medicaid can obtain health insurance only through the individual market. In 2008, approximately 15.7 million adults under 65 received their health care coverage through individual health insurance policies.¹ In the individual health insurance market, companies screen applicants for pre-existing medical conditions prior to providing insurance coverage. Health insurance companies use information about pre-existing conditions to deny insurance coverage outright, charge higher premiums, or exclude coverage for medical claims related to the pre-existing conditions.

In early 2010, before passage of the Affordable Care Act, we initiated an investigation into insurance company practices relating to pre-existing conditions. On March 2, 2010, the Committee wrote the four largest for-profit health insurance companies – Aetna, Humana,

¹ Kaiser Family Foundation, *Health Insurance Coverage in America, 2008* (Oct. 9, 2009).

UnitedHealth Group, and WellPoint – to request information about rejection of insurance coverage and denial of claims related to pre-existing conditions in the individual health insurance market.² Collectively, these four companies covered 2.8 million people in the individual health insurance market in 2009.³

The Committee sought documentation on the insurers’ practices related to pre-existing conditions, including “internal communications, including e-mail, to or from senior corporate management” and “presentations to senior corporate management.”⁴ The Committee also requested information on the total number of denials of medical claims payments and the rejection of health insurance coverage due to pre-existing conditions over the last five years.⁵ All companies voluntarily provided the information requested. In total, the Committee received over 68,000 pages of documents from the companies.

This memorandum is based on the information and documents provided to the Committee. It provides new insights into how the largest for-profit health insurance companies used pre-existing conditions to deny coverage and claims. Without passage of the Affordable Care Act, the practices described in the memorandum could have continued unchecked.

II. FINDINGS

A. Coverage Denials

From 2007 to 2009, the four largest for-profit health insurance companies, Aetna, Humana, UnitedHealth Group, and WellPoint, refused to provide health insurance coverage to more than 651,000 people based on their prior medical history.⁶

² Letter from Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, to Angela Braly, President and Chief Executive Officer, WellPoint, Inc., Stephen Hemsley, President and Chief Executive Officer, UnitedHealth Group, Michael McCallister, President and Chief Executive Officer, Humana, Inc., and Ronald Williams, Chairman and Chief Executive Officer, Aetna (Mar. 2, 2010).

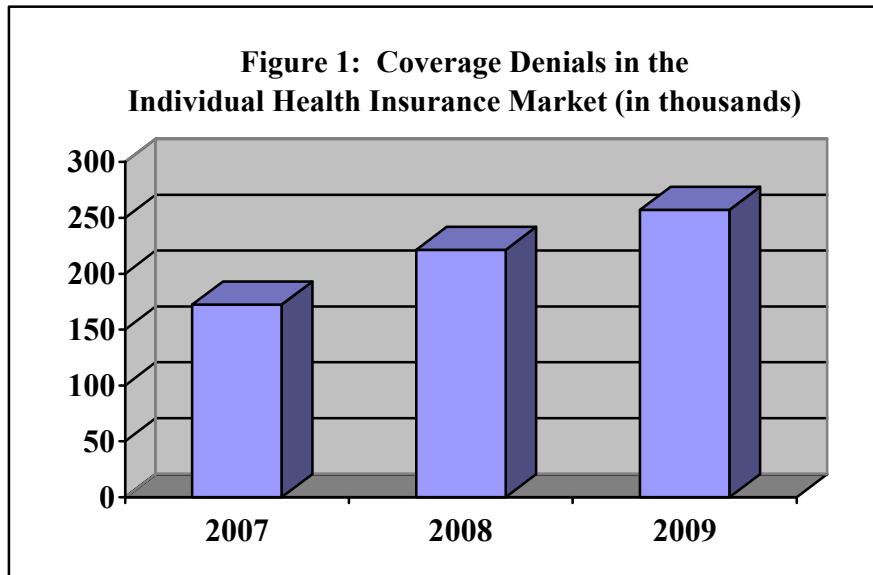
³ National Association of Insurance Commissioners, *Individual and Group Comprehensive Major Medical by Legal Entity* (Apr. 7, 2010).

⁴ Letter from Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, to Angela Braly, President and Chief Executive Officer, WellPoint, Inc., Stephen Hemsley, President and Chief Executive Officer, UnitedHealth Group, Michael McCallister, President and Chief Executive Officer, Humana, Inc., and Ronald Williams, Chairman and Chief Executive Officer, Aetna (Mar. 2, 2010).

⁵ *Id.*

⁶ Letter from Counsel, Aetna, to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 26, 2010); Letter from Counsel, Humana, Inc., to

A year-by-year analysis shows a significant increase in the number of coverage denials each year. The insurance companies denied coverage to 172,400 people in 2007 and 221,400 people in 2008. By 2009, the number of individuals denied coverage rose to 257,100.⁷ Between 2007 and 2009, the number of people denied coverage for pre-existing conditions increased 49%. During the same period, applications for insurance coverage at the four companies increased by only 16%. See Figure 1.



A significant percentage of applicants for insurance were denied coverage for pre-existing conditions. In 2007, these four insurance companies denied coverage to 11.9% of applicants; and in 2008, they denied coverage to 13.8% of applicants. By 2009, Aetna, Humana, UnitedHealth Group, and WellPoint denied health insurance coverage to 15.3% of their applicants in the individual market due to pre-existing conditions. On average, the four companies denied coverage to one out of every seven applicants based on a pre-existing condition.

The actual number of coverage denials is likely to be significantly higher than reported by the companies. The companies do not report as denials individuals who are discouraged from applying for coverage by insurance agents because of their pre-existing conditions. A document

Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 12, 2010); Letter from Counsel, UnitedHealth Group, to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 19, 2010); and Letter from Counsel, WellPoint, Inc., to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 12, 2010).

⁷ *Id.*

from one company states that one-third of its applicants do not obtain coverage because of pre-existing conditions.⁸ This estimate may reflect the actual denial rate when individuals who are discouraged from submitting formal applications are taken into account.

In addition, one of the four companies provided information to the Committee from only one of its subsidiaries, which represents only 32% of the company's individual health insurance business.⁹

The documents reveal that the health insurance companies denied individuals insurance coverage based on an extensive list of medical conditions. One of the companies maintains a list of 425 medical diagnoses that it used to decline health insurance coverage permanently to many applicants.¹⁰ These diagnoses include common conditions, such as pregnancy, angina, diabetes, and heart disease.¹¹ A recent Families USA study found that 57.2 million people under the age of 65 suffer from at least one diagnosed condition that could put them at risk for denial of coverage based on pre-existing conditions if they tried to purchase individual health insurance as a new subscriber.¹²

For certain medical conditions, companies routinely denied health insurance coverage without an internal review. In 2006, one of the companies distributed an inter-office memorandum that included a list of medical categories that "no longer require a review for declination."¹³ A set of 14 categories followed, including:

- "Any applicant who is a surgical candidate."
- "Any female applicant currently pregnant."
- "Any female applicant who has been treated for infertility within 5 years."
- "Any applicant with a BMI [body mass index] of 39.0 or greater."¹⁴

The insurance companies declined coverage for applicants of all ages due to pre-existing conditions. Although young people generally enjoy better health, the companies routinely

⁸ *Articulating Health Care Value Strategy for Individual Business* (Jan. 6, 2009).

⁹ National Association of Insurance Commissioners, *Individual and Group Comprehensive Major Medical by Legal Entity* (Apr. 7, 2010).

¹⁰ Underwriting Guide concerning health products (undated).

¹¹ *Id.*

¹² Families USA, *Health Reform: Help for Americans with Pre-Existing Conditions* (May 2010).

¹³ Inter-Office Memorandum from [redacted] to Distribution (Aug. 29, 2006).

¹⁴ *Id.*

denied health insurance coverage for individuals under the age of 30. Internal correspondence shows that in some instances “[f]or . . . plans for individuals, between 9 and 10 percent of individuals between the ages of 18 and 30 are declined coverage during the application process.”¹⁵

B. Claims Denials

In some instances, health insurance companies offer insurance to individuals with pre-existing conditions, but add riders to their policies denying payment for claims relating to those conditions or imposing additional deductibles. This was a practice commonly used by the four companies. From 2007 through 2009, Aetna, Humana, UnitedHealth Group, and WellPoint refused to pay 212,800 claims for medical treatment due to pre-existing conditions.¹⁶

The four companies denied 67,200 claims in 2007 and 74,650 in 2008. In 2009, the four health insurance companies refused to pay over 70,900 medical claims of individuals they insured due to pre-existing conditions.¹⁷

One company excluded treatment or assessed additional deductible charges for 14.7% of its customers in the individual market.¹⁸ The top four riders used by this company excluded coverage or increased deductibles for Caesarean deliveries, back disorders, psychiatric or psychological disorders, and outpatient treatment for cholesterol issues.¹⁹

C. Business Plans

Documents obtained by the Committee show that the companies’ business plans included using pre-existing conditions to limit the amount of money paid for medical claims. Executives at one company, for example, devised a plan for “strategic growth” in the individual market that would

¹⁵ E-mail from [redacted] to [redacted] (Aug. 28, 2007).

¹⁶ Letter from Counsel, Aetna, to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 26, 2010); Letter from Counsel, Humana, Inc., to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 12, 2010); Letter from Counsel, UnitedHealth Group, to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Mar. 19, 2010); and Letter from Counsel, WellPoint, Inc., to Henry A. Waxman, Chairman, Committee on Energy and Commerce, and Bart Stupak, Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce (Aug. 31, 2010).

¹⁷ *Id.*

¹⁸ E-mail from [redacted] to [redacted] (Feb. 8, 2010).

¹⁹ *Id.*

“[r]e-position all new customer segment’s pricing, products, and risk profile to gradually enhance profit profile of the book and . . . ultimately improve[e] price levels.”²⁰ Areas of opportunity included: “improved pre-existing exclusion processes, tighter condition and large claim review, [and] tighter underwriting guidelines.”²¹

At another company, executives identified key issues confronting the individual market. One document states: “Lack of attention to risk management, decreased ability to use pre-existing claim denials and rescind policies, and maternity policies have led to first year loss ratios climbing from less than 50% five years ago to over 65% today.”²² To lessen the company’s financial losses, a senior executive recommended that the company should “[e]nsure Pre-existing condition[s] are administered effectively to the extent allowed by law.”²³

In one training presentation to insurance brokers, executives at a third company explained: “Insurance is a Gamble.”²⁴ The training materials included the following statements about the company’s approach to the health insurance business:

- “Because U.S. insurance has such high maximum limits, selling insurance is like gambling.”
- “When we sell someone an insurance policy, we are betting that their total medical costs for the year will be less than they paid us in premiums.”
- “We try to ‘win’ our bets by accurately assessing their medical risk and charging the right premiums.”²⁵

The documents received by the Committee indicate that prior to passage of health reform, the insurance companies were considering ways to expand the use of pre-existing conditions to avoid paying for a broader class of medical claims. Internal corporate documents show that high-level executives considered practices such as:

- *Increasing the look-back period on pre-existing conditions:* When an individual applies for health insurance, the company will “look back” at the applicant’s prior medical history for a certain period of time to identify pre-existing conditions that could provide a justification to deny coverage. State laws govern the length of the look-back period. According to documents obtained by the Committee, it appears that in July 2009, executives at one insurer held a meeting during which they discussed lengthening the

²⁰ *Consumer Segment 2010 – 2012 Strategy Round 1* (Mar. 20, 2009).

²¹ *Id.*

²² *[State] 2010 Plan Information for Board Presentation* (Jan. 2010).

²³ *Id.*

²⁴ *The Importance of Insurance, and Your Role in Helping People Get It* (undated).

²⁵ *Id.*

look-back period for pre-existing conditions.²⁶ In a presentation circulated in advance of the meeting, the company's look-back guidelines were compared to the maximum legal limits in each state.²⁷

- *Assessing separate deductibles specifically for identified pre-existing conditions:* In a presentation concerning risk assessments in the individual health insurance market, executives at another company were provided a “[p]re-ex opportunity overview.”²⁸ Among a number of “additional potential opportunities [that] should be examined,” the presenter highlighted “the introduction of condition specific deductibles” as a future improvement to be considered.²⁹
- *Denying payments for prescription drugs related to pre-existing conditions:* Executives for a third company have recently introduced a project to withhold insurance reimbursement for prescription drugs if the medication is used to treat pre-existing conditions. A presentation in January 2010, explained: “We are proposing a pilot that enforces any medications used to treat pre-existing conditions be excluded for all members that do not have prior creditable coverage, as per Policy specifications.”³⁰
- *Linking additional claims to pre-existing conditions exclusions:* During an internal evaluation of the individual business, executives at the fourth company discussed “[c]ontrol[ing] cost by conducting Pre-Existing Condition Investigations.”³¹ As part of this dialogue, executives emphasized the importance to “[l]ink related claims to Pre-Existing Condition investigations” and “[i]dentify claims that should be linked to a Pre-Existing Condition investigation.”³²
- *Narrowing the definition of prior creditable coverage:* Prior creditable coverage is a period of past health insurance coverage that can shorten the length of time a new insurer can exclude insurance coverage of pre-existing conditions. Internal documents reveal that executives at one of the companies considered changing “the definition of prior creditable coverage to exclude prior individual coverage.”³³

²⁶ E-mail from [redacted] to [redacted] et al. (July 23, 2009).

²⁷ *Id.*

²⁸ [Redacted] *Claim Accuracy and Risk management assessment* (undated).

²⁹ *Id.*

³⁰ E-mail from [redacted] to [redacted] (Jan. 5, 2010).

³¹ E-mail from [redacted] to [redacted] et al. (Nov. 10, 2005).

³² *Id.*

³³ E-mail from [redacted] to [redacted] (Apr. 27, 2009).

III. EFFECT OF HEALTH REFORM

The Affordable Care Act, which was enacted on March 23, 2010, will significantly reform insurance company practices relating to pre-existing conditions.

Effective January 1, 2014, insurance companies in the individual market will no longer be allowed to deny policy enrollment based on a person's health status, including pre-existing conditions.³⁴ Additionally, the Act will bar health insurers from charging higher premiums to people who have pre-existing conditions. By 2014, health insurance companies selling coverage in the individual market will be allowed to set their rates based only on geography, whether the plan covers an individual or family, age, and tobacco use. Insurance companies will no longer use medical histories to calculate premium rates.³⁵

For children, these reforms are effective earlier. The law prohibits pre-existing condition claims exclusions for children under the age of 19 for new policies starting in September 2010.³⁶

In addition, the Affordable Care Act established a new Pre-existing Condition Insurance Plan administered by the Department of Health and Human Services. This temporary program provides health insurance to individuals who currently are unable to obtain insurance due to their medical history. Enrollees must have been uninsured for at least six months due to a medical condition and be a United States citizen or reside legally in this country. This insurance plan will exist until the Act's comprehensive pre-existing condition reforms go into effect in 2014.³⁷

IV. CONCLUSION

Our investigation examined practices concerning pre-existing conditions in the individual health insurance market. The investigation has revealed that from 2007 through 2009, the four largest for-profit health insurance companies, Aetna, Humana, UnitedHealth Group, and WellPoint, denied health insurance coverage to more than 651,000 people based on their prior medical history. During the same period, the four companies refused to pay 212,800 claims for medical treatment related to pre-existing conditions. Internal company documents show that this increasing use of pre-existing conditions to deny or limit coverage would have continued unabated if Congress had not passed health reform legislation.

³⁴ The Patient Protection and Affordable Care Act, Pub. L. 111-148 § 1201 (2010).

³⁵ *Id.*

³⁶ *Id.* at § 1255.

³⁷ *Id.* at § 1101.