

Practices in Health Care and Disability Insurance: Delay, Diminish, Deny, and Blame

By Peter Phillips and Bridget Thornton

*"I once tried to explain to a Norwegian woman why it was so hard for me to find health insurance. I'd had breast cancer, I told her, and she looked at me blankly. "But then you really need insurance, right?" Of course, and that's why I couldn't have it."
Barbara Ehrenreich, journalist and author*

Introduction

This study examines the historical circumstances that brought about our private health and disability insurance system in the US. We look at the organizational structures of private-for-profit and "non-profit" insurance companies that dominate the health care industry and the strategies these firms use to delay, diminish, and deny payment for health care and disability benefits for people across the country. We discuss the impact of delays and denials on patients and disabled individuals and the ways insurance companies deliberately create psychological doubt and self-blame among those who are legitimately entitled to benefits. We summarize the results of twenty extensive interviews with people who have experienced major difficulties in receiving payments of benefits and for health care service they expected from their insurance providers. We further examine the general lack of regulation, enforcement of existing laws and government motivation to meet the health and disability needs of all Americans, and the socio-economic power of the health insurance industry to dominate health care policy.

Health and disability insurance is an extremely large and profitable businesses. Increasingly, the health and disability insurance industry has come under scrutiny for mismanagement and blatant abuse of its policyholders. Michael Moore's top-grossing movie *Sicko* is one example of the growing concern surrounding health care in the US.

In 2002, the World Health Organization (WHO) put the cost of health care at 15.2 percent of US GDP (WHO 2006). WHO reports, "The health-care industry, including biopharmaceutical and medical device companies, now represents the third-largest sector among the 1,000 largest US firms, behind only energy and retailing." (See Appendix A)

In order to understand how insurance companies strategize to maximize profits and limit payouts for benefits, we examined the evolution of the industry and the socio-economic power base of the top health insurance companies in the US. The power of the companies to set national policies contrasts with the personal difficulties of the individuals interviewed, demonstrating a system-wide process of profit taking at the expense of fulfilling promises and of diverting money intended to pay for necessary health care goods and services.

The experiences of the people interviewed in this study are not necessarily representative of all encounters with health and disability companies in the US. We recognize that many people in this country have doctors who fight alongside their patients to demand payment for promised treatment. Because of the conflict of interest between health insurance company profits and necessary health care for all, millions of people in the US do not receive necessary health care and disability benefits, and suffer significant negative consequences. We believe that the twenty interviewees are representative of the general problems faced by an increasing number of US citizens.

Our interviewees were individuals, insured by seven different companies, whose experiential commonalities represent patterns of practices that should concern every American. Given the

upward trajectory of profits in the health and disability insurance industry, coupled with an historical lack of regulatory enforcement by federal and state government, we believe that the American people do not receive the health care they deserve, despite the generous amount of money spent on health services by taxpayers and consumers.

History of Health Insurance in the US

The United States has been slow to implement national social welfare programs compared to European countries. The creation of social welfare and rudimentary public health services with the Social Security Act of 1935 set the US on a path similar to what European countries had in place for several decades. With the Social Security Act, the US government instituted the Public Health Service to conduct, “investigation of disease and problems of sanitation,” yet national health care for all people has remained an elusive goal. (Social Security Act-Section 603-1935) Findings by the Public Health Service in 1938 reported widespread incidences of sickness and disability among the American people and closely linked these to poverty conditions. (Hirsh, 1939)

In 1965, President Johnson signed legislation for senior and low-income health care, Medicare and Medicaid, respectively. While the wealthy and upper middle classes have generally been able to afford necessary health care in the US, the bottom one-third of American society (one hundred million people) face limited access to necessary health care. This bottom one hundred million people, forty-seven million of whom have no health insurance whatsoever, are disproportionately people of color and single women with children. These inequalities of race and gender have led some researchers to conclude that racism and sexism have historically played a major role in US health care policy. (Quadagno 1994)

Throughout the 20th century, there has been a discussion around building a national health care system in the US. The National Conference on Charities and Corrections in 1911 called for the establishment of social insurance programs in the US including provisions against sickness and disability. (Hirsh, 1939) The American Association of Labor Legislation (AALL), founded by political economists of the American Economic Association in 1906, promoted state level laws for workmen’s compensation insurance and achieved coverage for federal employees in 1916, Longshoremen in 1929, and private employers in the District of Columbia in 1928. AALL was “largely responsible for the first health insurance movement in America by drafting the first American health insurance bills, but failed to secure passage in national or state legislatures.” (Domhoff, 1971, pp 175)

During the first half of the 20th century, the American Manufacturing Association and the US Chamber of Commerce intensely opposed attempts for national and state-level health care legislation. (Trattner 1989) Additionally, many physicians opposed national health insurance for financial and professional reasons, though this did not include all doctors. The American College of Surgeons supported pre-paid health insurance for hospitalization in 1934, but leaders in the American Medical Association generally opposed national health care efforts. (Thomasson, 2002)

The beginning of employer-sponsored health insurance plans started in the 1920s. At Baylor University Hospital in Dallas, local teachers paid six dollars per year for the guarantee of twenty-one days of hospitalization. In 1929, Blue Cross was the first organization to offer pre-paid health insurance. The American Hospital Association (AHA) supported similar plans around the country and eventually hospitals joined together in inter-hospital associations at a state level. Various states passed legislation that authorized tax-exempt status to Blue Cross and later Blue Shield, as well as freedom from the requirements of maintaining deep financial reserves that were legally required of most insurance companies. (Thomasson 2002)

During the 1930s and 1940s, the demand for professional medical services rose rapidly in the US with improvements in surgical techniques, anti-biotic sulfonamide drugs in 1935, and penicillin in 1946. During World War II, a wage freeze in many industries encouraged the addition of medical insurance plans as a way of attracting new workers to competitive industries.

Before World War II, only twenty private insurance companies offered health insurance plans in the US. This changed rapidly after the war and as private insurance companies began to compete with Blue Cross and Blue Shield groups plans by offering health insurance at lower rates to pre-screened healthy individuals. By 1958, pre-paid health insurance plans covered seventy-five percent of Americans. (Thomasson 2002)

The insurance industry in the US remains severely under-regulated at the federal level. Instead, each state adopts laws and regulations that govern insurance companies in their states. A national insurance company may adopt a business practice that one state deems legal while that same practice may be illegal in another state.

While countries around the world offer citizens necessary health care as a basic right, the US has not adopted the same philosophy. According to the Universal Declaration of Human Rights, health care is a vital right for every human being:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” (Adopted by the United Nations December 10, 1948, Article 25)

What is the best way to insure that all people in society have equal access to necessary health care regardless of income? Should Americans tie health care to employment or is it a basic right such as freedom of speech or voting? The Institute of Medicine estimates that as many as eighteen thousand Americans die prematurely each year because they do not have health insurance. (Institute of Medicine 2004) This figure does not include those who die prematurely each year because their insurers delay, diminish, or deny payment for promised benefits. Reports about people who die unnecessarily from services denied or delayed by insurance companies seldom receive broad coverage in the corporate media. This has led to a nation of people uninformed about how their ability to receive necessary health care and disability benefits is driven and controlled by the private insurance industry and how government regulations, regulators and insurance company interlocks affect the level of care and benefits they receive.

The number of Americans without health insurance is increasing — forty-seven million at last count, or some sixteen percent of the population. The cost of health insurance is rising two to three times faster than inflation, and unpaid medical bills is the number one cause of personal bankruptcy in the country. (Walter 2007)

How Health and Disability Insurance Companies Dominate State Health Policy

Richard Ericson, Aaron Doyle, and Dean Barry conducted the most extensive analysis to date of the structure of the insurance industry. Their book, *Insurance as Governance*, documents the historical interlocks between financial capital and government in setting the standards for a profitable insurance industry in both Canada and the US. (Ericson 2003) Ericson’s group conducted five years of research including extensive interviews with two hundred twenty-four people and numerous observations of insurance conferences, meetings, and internal documents. Their research led to a comprehensive understanding of the socio-political underpinnings and

structural deficiencies of the insurance industry. Ericson, Barry, and Doyle examined how the state (sociological term for government) operates in a partnership with insurance corporations in maintaining a profitable environment for capital growth and expansion. The state is dependent on taxation for continued operation; therefore, the maintenance of a positive business atmosphere is vital to the self-preservation of state interests.

Key determinations cited in *Insurance as Governance* include the following:

1. States betray their basic duty to serve the general public welfare by mobilizing private insurance corporations to establish regimes to serve collective well being.
2. States establish legal frameworks to minimize risk to capital/property holders, set standards for operations, provide capital, and support the conveyance of particular aspects of the public domain into private hands.
3. States see people primarily as consumers in support of private capital. The state conditionally grants rights for individuals based on their conduct in a variety of private, corporate, and quasi-public practices.
4. States increasingly support risk control for private capital from natural disasters, technological catastrophe, or civil unrest. States regulate individual behaviors to lower personal risks and protect health insurance/disability investments. States lower their risk using increased surveillance and law enforcement. Additionally, states collect data to build risk assessment information for private insurance companies.
5. Private insurance companies interlock with the state in the desire for preventive security, increased surveillance, risk minimization (such as state mandated seatbelt use), and acceptable profit producing regulations.

In summary, the state works in conjunction with health and disability insurance companies to maintain profitability first, encourage healthy behaviors by citizens second, and thirdly protect citizens from gross abuses by private firms when absolutely needed.

In order to understand the money and power connections of the health insurance industry, we look at the boards of directors of nine of the largest insurance companies and the affiliations of each member. (See appendix B) We found one hundred thirteen board members who held one hundred fifty past and/or present positions with major financial or investment institutions including such major firms such as J.P. Morgan, Citigroup, Lord Abbett, Bank of America, and Merrill-Lynch. These men and women sit on the boards of financial corporations commanding \$482.2 billion in annual revenues in the US. (Department of Commerce 2006)

Additionally, these board members have connections to some of the largest corporations in the world including General Motors, IBM, Ford, Microsoft, and Coca Cola. We found direct corporate affiliations among the one hundred thirteen health insurance directors to thirty-four corporations on the Fortune 500 list for 2007, which had a combined revenue of over 2.5 trillion dollars 2006.

The board members also held or hold eighty-two governmental or government-related positions. These positions range from members of the US House and Senate to Cabinet positions, Ambassadors, Governors, State Insurance Commissioners, and Democrat and Republican Parties posts that show a deeply embedded government-health insurance industry inter-connectedness. Three board members actually held positions in the Canadian government as well. Additionally, many board members were/are affiliated with influential policy organizations such as the

Trilateral Commission, Brookings Institute, US-China Business Council, US Chamber of Commerce, and The Business Roundtable. The board members of the major health and disability insurance firms in the US are a core element of the socio-economic-political elite in the US and uniquely positioned to dominate health care policy-making decisions for the American people.

Adding to their direct power in the government, major financial institutions, and across many industries in the US, the health insurance company directors also maintain some thirty direct connections to media organizations in the US ranging from local newspapers, radio, and TV stations to major corporations such as ABC, Washington Post, Cox Communications, and AOL-Time Warner. Thus, they are in a strong position to influence national media editorial policy and news reporting perspectives on key health and disability issues of the day.

Many of the board members have cross-affiliations with the nine companies we researched, whereby board members of one company serve on boards of other companies such as Wellpoint, Unum, Blue Cross-Blue Shield, and Kaiser Permanente, along with many connections to the pharmaceutical industry, health policy organizations, and hospitals.

These board members tend to hold industry-wide perspectives on protecting health insurance company profits, maintaining a healthy business environment for long-term economic growth, and insuring that any movement for expanded health care in the US will maintain their companies as the primary officiators.

Examples of this working partnership between the state and health and disability companies is evident in how successful the insurance industry has been in achieving legislation at state and national levels that protects their bottom line. The Employee Retirement Income Security Act (ERISA) of 1974 is a federal law governing pension plans. The courts have interpreted ERISA in such a way that it severely limits the redress available to individuals who obtain their healthcare or disability benefits through their employment. No matter how egregious the mistreatment, the courts interpret the ERISA preemption in such a way as to prevent punitive damages awarded to individuals. While some ERISA claims may be tried in state courts, federal law is usually applied. (Rosenblatt, 1999)

However, once an individual's complaint has been elevated to the federal level, further difficulty is encountered. The McCarran-Ferguson Act of 1945 forces litigation of insurance cases into federal court. It also exempts insurance companies from anti-trust laws. This allows companies to minimize expensive judgments granted by state courts. A person in federal court may not recover punitive damages, fines, late fees, or attorney expenses. If the court reverses a denial in favor of the customer, the company loses the amount of the claim, nothing more. Consequently, few people take their claims to federal courts. The insurance companies know that their loss, if the court rules against them, is negligible and act accordingly to retain maximum profits.

An internal memorandum from Provident, later purchased by Unum, reads:

“A task force has recently been established to promote the identification of policies covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. The advantages of ERISA coverage in litigious situations is enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of the benefit in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Fellon identified 12 claim situations where we settled for \$7.8 million in the

aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million”. (Provident Internal Memorandum 1995)

As one of our study participants, and a lawyer, stated:

“They (the insurance companies) know they’ve got ERISA on their favor. They’ll fight you to the death, to the bitter end because they got nothing to lose”.

ERISA puts the consumer at a severe disadvantage in the legal system. The insurance industry has legal teams that rival any industry in the country, with seemingly unlimited funds to engage in endless litigation. *Inside Counsel* reports that ten of the fifteen largest corporate legal departments in the US belong to insurance companies. (*InsideCounsel 2006*)

Insurance companies sell “peace of mind” and strive to convince the public that they are wise, trustworthy, reliable, and interested in their customers’ health and welfare. Some notable slogans and advisories by insurance companies include:

“Over 195 Years of Wisdom” – The Hartford; “Manage for Today, Plan for Tomorrow” – The Prudential; “Nothing is more important than the ability to be there when our customers need us most following a disabling accident or illness.” – Unum; “You are in good hands with Allstate” and “Like a Good Neighbor State Farm is there.”

Health and disability insurance companies maintain an ongoing lobbying effort in state capitals and provide continuing campaign support to both parties. According to the Center for Responsive Politics, the insurance lobby industry spends \$130,588,217 per year to influence state and federal politicians. (CRC, 2006 Lobby Database) The Foundation for Taxpayer and Consumer Rights reports, “The governor, the legislature, and political parties [in California] have received \$3,395,896 from the top five health insurers and their lobbying associations since 2001.” (Flanagan 2007)

Insurance industry-sponsored tort reform in the 1990s was supposed to curb the rate increases imposed by insurance companies and ostensibly lower the risk to insurers in the legal system by placing ceilings on the amount the insured could win in the courts. However, the results were the opposite. With individuals facing legal costs that often exceeded any possible settlement, insurance companies have successfully stalled the legal system.

In 2006, Sociologist Jared Barnes wrote, “Insurance rates have consistently increased since reforms were initiated. Since payments have been capped, insurance customers are having a very difficult time being awarded damages...The media hype and insurance public relations campaigns have poisoned voters’ minds. The only people benefiting from tort reform are the insurance companies.” (Barnes 2006)

The Revolving Careers between Business and Government

Individuals within the insurance industry and the state often have a revolving door career, and serving in positions within the industry, then government, or vice-versa. Revolving door connections undoubtedly have an effect on the state enforcement of insurance regulations. Cozy relationships tend to build between career-minded individuals on both sides of the state/private company regulatory fence. Many individuals, in both the state and private companies, see that the maintenance of close working relationships between regulators and the regulated as the building blocks for increased profits and personal career advancement.

Bill Gausewitz was a major player in Arnold Schwarzenegger's campaign for governor in his former position as Assistant Vice President of State Affairs for the American Insurance Association. After Schwarzenegger's election, the Governor chose him to serve as director for the Office of Administrative Law of California, which oversees and approves regulations, some of which dealt with the insurance industry. In the summer of 2007, California Department of Insurance (CDoI) Commissioner Steve Poizner chose Gausewitz as the Special Counsel to the Insurance Commissioner of California.

The former California insurance commissioner (1986-91), Roxanie Gillespie, moved into the private sector providing legal counsel to insurance companies at the law firm Barger and Wolen in San Francisco. Her biography on the Barger and Wolen website states, "Her past experience includes 13 years with an insurance company in various law and management positions, plus eight years as a regulator, and five as California Insurance Commissioner. Her expertise includes all aspects of insurance regulatory law. She has worked with a large variety of insurance organizations, from start-ups to long established giants in the insurance field."

During the first term of John Garamendi, California's first elected Insurance Commissioner, Gary A. Hernandez served as Deputy Insurance Commissioner and Chief of Enforcement, in charge of insurer enforcement and market conduct, fraud investigations and management of all failed insurers in California. He is now a partner at Sonnenschein, Nath & Rosenthal, a law firm representing the interests of many insurers, and is Chair of its Insurance Regulatory Group. He was also one of the chief negotiators for Unum, leading to its settlement with the CDoI in 2004 during Commissioner Garamendi's second term.

In another case in California, the former General Counsel of CDoI, Gary Cohen, left the department in July of 2007 to become Deputy General Counsel of Fireman's Fund Insurance, an Allianz subsidiary. Cohen was the same individual who initiated a CDoI investigation into Allianz's business practices.

Health and Disability Insurance Companies and the State Individualize Responsibility

The US has developed a system of health care wherein private insurance companies, both for-profit and non-profit, offer pre-paid insurance for medical services and disability benefits. Since just before World War II, employment has been the primary source for health and disability insurance for most Americans. However, for the millions unemployed or in jobs without health benefits, insurance policies can only be purchased as a personal/family plan directly from private companies. Insurance companies can exclude people with poor health or pre-existing conditions from enrollment or require them to pay exorbitant premiums.

Consequently, the provision of private health care goods and services in the US is remarkably different from other industrialized countries where single payer or nationalized health care systems provide medical care for all people.

In the US, not only is the state a key participant in protecting capital and profits in the health insurance industry, the state serves as cultural risk manager by encouraging an atmosphere of individual responsibility within the public. The state in cooperation with private insurance companies promotes attitudes that reinforce doubt, self-blame, and moral responsibility of the individual, while de-emphasizing the duty of insurers to pay for promised benefits, by increasingly linking illnesses and disease to personal lifestyle choices. Health insurance companies understand that an individual is less likely to demand expensive medical treatment for self-induced conditions or when faced with the prospect of accusations of fraud when an individual files a claim.

States and private insurance companies advocate individual responsibility for health care through a number of techniques. States pass laws that require certain behavioral changes by individuals that will tend to reduce overall health care demands. These include adherence to speed limits, the requirement of seat belts, mandatory vaccinations, health codes, non-smoking laws, and other health-related regulations. Additionally, states and private insurance companies coordinate public education efforts through schools and the media to encourage behaviors that will reduce health care demands. For example, tobacco education programs in schools have reduced smoking among teenagers. Such efforts benefit the health of the population. However, it is also clear that these efforts reduce insurance payouts as fewer smokers in society result in lower health care and disability claims and therefore, payouts by insurance companies. There is no evidence, clear or otherwise, that these lowered payouts have led to corresponding reductions in premium costs.

The functional result of these health care laws and educational efforts is to create a cultural climate of individualized responsibility for accidents, illness, sickness, and disease. This allows for the emergence of social-psychological assumptions in the health insurance system whereby providers, insurance companies, claims adjusters, health care providers, employers, and an individual's friends and family think in terms of what the individual may have done in the past that contributed or caused the health problem or disability. Therefore, instead of a health care insurance system that provides full service benefits to an individual regardless of contributing factors, we have a system that diminishes responsibility for services by the providers and refocuses the blame on the person in need of care. An insurance provider may deny or delay a liver transplant to an alcoholic or person with drug-related Hepatitis C, because those people have historically engaged in unhealthy behaviors. Most people assume that everyone is free to choose, although individual behaviors may be the consequence of societal problems such as poverty, domestic abuse, or untreated mental illness. Subjective value judgments within the health industry serve to deny necessary services to the people most impacted by poverty and social disadvantages.

While the public often views state-sponsored health and prevention education as important efforts toward the improvement of public health, there are other factors involved. Foremost for the state are the protection of private insurance capital and the lowering of costs for private health and disability insurance companies. Secondly, there are individual costs to people when companies delay, diminish, or deny payment of claims and services in the interest of profit. Insurance companies, operating in a culture of accusation, doubt, and blame, justify these practices by suggesting that customers are making false claims and are guilty of risky behavior.

A culture of blame provides an opportunity for private health and disability insurance companies to establish internal procedures that systematically limit care because patients, who blame themselves for their medical condition, are less likely to demand full benefits.

Blaming the Victim

Private health insurance companies reduce costs by treating each person's claim for health care or disability with suspicion of fraud. (Ericson 2003)

The CDoI claims that insurance fraud is ubiquitous. In a 2007 press release, Insurance Commissioner Steve Poizner claimed, "Unfortunately, fraud is a major cost-driver in the insurance system. These crimes impose a \$500 'fraud tax' on every man, woman and child in California. By attacking insurance fraud, we can stimulate our economy".

States, such as California, require insurers to have Special Investigations Units to identify and report on suspected insurance fraud – and there is a special multi-million dollar fund

to finance the investigation and prosecution of insurance fraud. The state projects most of its efforts toward fraud committed against insurers.

Inquiries to the CDoI regarding how these “fraud” figures were determined, uncovered the fact that they came from unverified insurance industry sources. Moreover, none of these figures included any amount for fraud committed by insurance companies. In fact, in a Backgrounder prepared by the CDoI for a Senate Committee on Banking, Finance & Insurance - Oversight Hearing: Department of Insurance - November 21, 2005, the Department acknowledged that there had been no prosecution of insurers for fraud. (*Senate Committee on Banking, Finance, and Insurance, Oversight, 2005*)

Built into institutionalized blame is the assumption that the basis for the health or disability claim is a mental condition, or a personal defect of the individual. One of our interviewees stated, “You are guilty until proven innocent”.

Over half of the twenty people interviewed in our study described feelings of personal responsibility for their condition or were told by doctors, nurses, or claims managers that the problem was their own fault.

A disabled lawyer said, “I submitted a lot of medical evidence including positive lab test and then having them come back and say that it is not unusual for these symptoms to be caused by psychiatric illness”.

A University of California graduate involved in an auto accident reported when asked if anyone had ever blamed him for his condition, “Yes, most definitely. I was asked to go through a variety of different physical examinations and was asked very personal information. They would ask questions about my past and ...like my experience with drugs and alcohol as well as previous jobs I had held. They really wanted to know as much as possible about me ...My insurance company kept on reiterating how the accident was my own fault and that I should be more understanding because I was at fault for the situation. This was very hard to deal with because even though it was my fault, I was in pain and needed help which was put on the back burner by the insurance company”.

At times, blaming can lead to serious consequences, as in the case of a young women suffering from severe back pain who eventually died. Her mother stated when asked about blame, “Over a six month period she saw six doctors and was told the pain was mental and given an antidepressant and narcotics. [I] never had an x-ray. [She was] diagnosed six months later with Ewings Sarcoma and died in four years. I as her mother felt personally responsible because I could have fought harder and she would still be alive”.

A disabled-school teacher said, “Patient blaming it’s called and [my HMO] is really good at it, blaming the patient. [They] blame your psychological state, meaning you have aches and pains and you’re depressed or something, they blame it on that. Anyway that they can blame the patient, they would. The doctor would pat me on the back and suggest counseling. The appeals nurse called me the B word”.

Another interviewee said, “I felt [my HMO] was calling me a nut case.”

An amputee with a Ph.D. talked about blame entering into her communications about her case, “Indirectly they did [blame] by the way the letters were written that were highly suggestive that I had somehow screwed up...they are trying to instill doubt, their letters were definitely intimidating. So when this happened I fell into a pretty significant depression”.

At times interviewees described how their employers joined in the blaming process. A disabled man with herniated disks from a car accident, said, “My employer questioned the extent of my injuries”.

A lumberyard worker talked about how he accepted self-blame, “My boss called me an idiot for not paying attention around the forklift. I felt like it could have been prevented you know, If I was more alert...this would have not happened. The insurance company made my case seem small and unimportant, like I should not ever bother with them. They said it was my fault and they were not responsible for the accident”.

A woman with severe neck and back disabilities described her dealings with [HMO] for depression related to her injuries, “they started coming up with borderline personality, [statements] because I’d go to the psychiatrist at [the hospital] and I’d say, ‘I need help, can you get these doctors to help me with this real injury that’s going on? I’m so depressed. I’m feeling suicidal. I can’t function. And then they put that in with your regular patient record [to use against me later].”

Other interviewee statements related to blame include the following from different individuals.

“I was treated like a criminal throughout the process. Details aside, it was devastating to me personally.”

“They blamed my disability on bringing this case against them.”

“They tried to turn my words on me at times to make it seem like it was my fault and not something worth filing.”

“I wanted to return [to work] before the doctor said I should and I ended up hurting myself again. After that, they were pressuring me to get back to work. They said it my fault the second time and that they were not responsible for that accident.”

The psychology of accusation, suspicion, doubt, and blame extends throughout the insurance industry. Auto insurance companies no longer describe a car wreck as an accident, choosing instead to use the word collision, thereby implying personal blame for the parties involved. (Ericson and Doyle, 2006) Health insurance companies have incorporated immediate suspicion into their systems. Insurance representatives expect people to exaggerate their symptoms in order to increase benefits to which they are not entitled. They then use this unsupported assumption to justify delaying, diminishing and denying payment for promised services or benefits.

Victims of the Health and Disability Insurance System

Over the course of three months, students in the Investigative Sociology (Spring 2007) class at Sonoma State University conducted face-to-face and e-mail interviews with twenty adults identified by consumer advocate groups as people who had experienced difficulties collecting benefits from health or disability insurance companies. These individuals did not know each other, but their common experiences demonstrate a growing trend within the insurance industry. Under the current system, companies choose between paying for promised benefits and maximizing profits.

Students transcribed the interviews word-for-word, which allowed us to do a comparative analysis of the twenty people based on common terms and quotes. The interviewees were men

and women from various socio-economic backgrounds, age groups, ethnicities, education, and levels of illness or physical disability. Each of the interviewees had experienced a problem with a disability or health insurance claim. We found consistent patterns of delayed service, diminished care, and denial of benefits in all twenty cases. The cases represented seven different health and disability insurance companies. We deleted the names of the companies from the interview quotes, as we believe that these practices are a system-wide problem with most all health and disability insurance companies involved.

As mentioned above, we uncovered psychological patterns of accusation and suggestion of fraud as well as blame placed on individuals for their own health and disability problems. Inducing self-doubt and frustration into a claimant's life is a way of psychologically encouraging a patient to terminate the pursuit of rightful benefits. Some of our participants suffered from severe disabilities and spent years fighting their insurance companies for benefits. The average time spent per week in trying to get benefits among our twenty interviewees was 6.5 hours, which included waiting on hold, call transfers to multiple representatives, travel to insurance company doctors, gathering medical records, and filling out paperwork.

The participants frequently encountered delays receiving medical records. In some cases, the claims process lasted years. One person reported seeing twenty-one different doctors during the course of the claim. All but two people interviewed filed appeals against the denial of benefits. We interviewed people who, for the most part, stood up for their rights, but millions of people withdraw early in the process due to fatigue and discouragement. Insurance companies know that delaying services will cause many people to give up, or perhaps die before they receive treatment. Companies also know that delaying and denying benefits results in greater profits as people become increasingly too weak to fight the system. Health and disability companies choose to maximize profits, retain earnings, and build reserves at the expense of the US consumer and taxpayer. They do so by systematically delaying, diminishing, and denying payments for promised services and benefits.

Deliberate Delay

Delays by the insurance industry were the most prevalent practice reported by our interviewees. All of the participants interviewed experienced numerous delays including long waits between correspondences, unreturned phone calls, and asked repeatedly to communicate all the details of their case to insurance company representatives.

When asked about delays during their dealings with health insurance companies, various interviewees reported:

“My insurance company would take weeks, sometimes longer to make contact with me.”

“It was very uncertain when they (insurance company) would contact me regarding my situation, if at all. Sometimes I would simply not hear back from them at all.”

“I ended up hiring a lawyer because I simply could not deal with the waiting and the aggravation I felt with my insurance company.”

“[The insurance disability process] took almost ten months. This was very hard to deal with because I had no money for awhile and was not able to work, so I was barely able to keep afloat.”

The practice of delaying authorization of payment for treatment or benefits, such as disability payments, seems to be a standard method used by the companies to wear a person down to the point where they give up on the claim. Interviewees reported that:

“[The disability company] wore me out accommodating the reassessment questions.”

“The real sense that I got was that they were just trying to wear me out, and they actually did. I was just at a point where I was just ready for a compromise, like anything would be better than nothing.”

Out-of-pocket expenses were enormous for interviewees asserting their rights to care and benefits. Delays in the authorization of payment for treatment and disability benefits consistently cost the interviewees in our study thousands of dollars, and in one case over a million dollars. People never recouped all of the legal and administrative costs of the claims process. For most people, out-of-pocket expenses are financially devastating.

The following statements are exact quotes from patients when asked about out-of-pocket expenses:

“I did eventually get payments but it took a long time and I ended up having to borrow money to cover myself, all the while trying to get better.”

“This cost me around \$4000 before I received benefits.”

“It was going to cost me about \$6000 to \$8000 in fees, just to retain the attorney and then there was no guarantee that we would win because its arbitration and he (lawyer) felt that the arbitrators would be biased. So at that point I gave up.”

“Due to re-injury and not getting adequate treatment, I just lost my whole career. I had a nest egg of \$40,000 and in the end it was all gone from seeking outside physical therapy, outside opinions, [and] traveling.”

“We spent about \$750,000 and then we spent another couple of hundred thousand dollars trying to take it to the Supreme Court.”

“I would have worked since 1991...and saved approximately \$300,000 in premiums had I known such unethical behavior was so commonplace in America. I spent my retirement and sold my home and business. I now no longer have any health care.”

“We spent probably close to \$150,000 of our own money for stuff that we had to have done.”

“Filing an appeal would have added another year to the process and I was rapidly becoming destitute.”

Another method of delayed treatment that many of our interviewees experienced was the request for excessive information. People who are disabled are also attending doctor's visits, taking medication, and trying to survive daily life. Companies demanded that claimants attend multiple doctors' visits and submit all copies of their medical records. Additionally, interviewees reported that companies requested financial and employment information and would speak to friends, colleagues, and employers; gathering information that was sometimes completely unrelated to

their claims. Interviewees stated that insurance companies requested copies of the same records multiple times.

Interviewee quotes:

“They questioned people that never should have been approached. The insurance company has actually made it less likely that I can return to work, which is against both of our desires. We purchase these policies for peace of mind and security if and when we should need them.”

“The way in which [disability company] failed to properly investigate my claim caused my employer to think that I was not being honest about it. So it has been an absolute nightmare.”

“I had to give them all of my personal information. They wanted to know everything about me inside and out.”

“The [disability company] closed my claim while I was going through surgery for lack of medical documentation. This delay has cost me dearly. The process of making contact with the [disability company] was a severe hardship during my chemotherapy and [continues] until this day.”

Interviewees reported that companies normally communicated within the timeframes required by law in any given state. However, the responses would be incomplete or demand additional information that resulted in long delays in receipt of health care services and disability benefits. Health and disability insurance companies have every reason to delay paying out benefits as long as possible because retaining money adds to their invested reserves.

Given that every interview participant experienced repeated delays of service, it is clear to us that health and disability claims processes have deliberate internal delay procedures built into the system. Managers and supervisors encourage claims representatives to promote the long-term retention of the companies' capital (patient premiums) by stringing out the claims process to delay payouts for as long as possible. Companies are aware that people have limited incomes and often cannot afford prolonged struggles for benefits. Frustrated, tired, and sick, people will often settle for smaller payouts or diminished services when the insurance companies extend the claims process for months and years. Many will give up altogether and simply suffer at home or die without the services they deserve.

“Because of delayed payments that [disability company] owed me my finances became a mess. My farm went into foreclosure but I got my Social Security in time to save the farm from having to be sold. But my credit was ruined and I had been forced to withdraw all the money from my 401K (\$290,000) resulting in substantial tax benefit losses. Prior to my illness I had \$150,000 a year income and my 401K. After three years I was down to eighty dollars in the bank. I absolutely believe that insurance companies deliberately delay claims.”

Patterns of Diminished Benefits

Diminished payment for benefits and treatment as well as ignoring the severity of a disability or illness was the second most common experience of our participants. Almost all of the participants

in the study either had a doctor tell them their injury or illness was non-existent or that it did not warrant expensive treatment.

A young man who was in an auto accident and taken to the emergency room at [HMO Hospital] reported:

“The treatment was very short and the doctor tended to bypass my problems which really made me upset. It felt like he was so busy at all times and that I simply was not a priority from his perspective.”

Other interviewees stated:

“My doctor at [HMO] did not set my arm or even cast the arm...my bones healed wrong and set in a way that would cause permanent damage or the inability to use my arm”.

“They give you these pills. You are supposed to take 250mg and they give pills that are 500mg and they say, ‘well just cut them in half.’” (Goldsmith 2003)

Pill-splitting is a way to cut co-pay costs for prescription medication. According to a researcher at the University of Michigan, “Veterans' hospitals and some health maintenance organizations (HMOs) have been requiring it of their patients for years as a way to lower health care provider costs”. (Gnagey 2006)

Acknowledgement of severity of injury or illness, and lack of pain management were some of the major issues interviewees reported.

“I’d get patted on the back and he’d (doctor) say, ‘I can give you counseling for this.’ When actually my shoulder blade was not holding against my back, but he didn’t bother to really assess it.”

“They [HMO] would say ‘Oh, your muscles are probably sore. Just take it easy for a few days. But that wasn’t the case, my shoulder blade was damaged. Nobody ever really looked closely.’”

“My insurance company had no idea about just how bad my situation was. They would often tell me to calm down and relax and that I just had a hurt arm and it would heal on its own. The idea that my insurance company was now my doctor was insane.”

“When [HMO] started their January 2004 policy of placing cancer patients at a lower priority to receive blood, in order to ensure [daughter] received blood and was able to continue her chemotherapy, I went off my chemo pills for four days to get it out of my system and lied about my medical condition in order to give blood. [HMO] nurses stated that it costs \$500 per unit of blood from the Red Cross.”

“I’d get more information when I took my car in for a check up than I ever did when I’d go to the doctor. [HMO] does not ask questions about anything, they just want to get on to the next patient.”

One woman's husband complained of chest pains and tightness on his left side. When the nurse took his blood pressure, it was extremely high. Despite these obvious warning signs, the nurse sent the man home with pain pills.

“She [doctor] sent him for a shoulder [only] x-ray and sent him home with a prescription for 100 morphine pills, another valium prescription, and a referral to orthopedics. He died the next morning while I was at work and my two boys, ages 10 and 15 at the time, were at school.”

Commenting on the care a person with chest pains receives at [HMO], one woman stated, “If you go in there with chest pains, if it's only been for a couple of hours, they're just going to tell you to take some aspirin and go home. It has to be a minimum of six hours before they even recommend you to go into do any testing.”

One woman told us that her [HMO] doctor told her that the lumps in her breast were benign. She demanded more tests that revealed breast cancer:

“My doctor [at HMO] did not like second opinions and results. My doctor did not want to do anything.”

“My doctor refused to give me any tests because he said this is expensive...you don't need this or that. I was afraid that if I complained then he would call other doctors and I would not get good treatment.”

“He [the doctor] never showed up [after surgery]. I had to complain at the head of the department because he didn't want to talk to me and my surgeon did not talk to anyone. They treated me as a joke.”

“[HMO] delayed chemotherapy three months in a row [because] the pharmacist stated she was too busy. At that time, I was sending letters to the medical Director and CEO of [HMO]. No one helped or cared.”

Given these testimonies and severity of the issues described by the participants, we asked if they escalated their complaints to departments in their state that oversee the industry. Most of our participants' complained that the State ignored their grievances or told them that the State could do nothing:

“I complained to the California Department of Insurance and said that [Disability provider] used my psychotherapy notes to justify to the California Department of Insurance about their denial of my claim and they totally ignored everything I said in my administrative appeal. I found out that the authorization violated California law and brought that to [Disability provider's] attention and they didn't care. Everyone who's in the California reassessment who has signed a [Disability provider] authorization has signed an authorization that violates that law (California Confidentiality of Medical Information Act).”

“The guy from the State Department of Managed Health Care (DMHC) basically told me that it would be a negative mark against them [HMO] but that he couldn't do anything more than that until he had gotten several negative marks from other people.”

“When I went through the state department (DMHC) and found out that even they couldn’t help me even though they thought I had a strong case, I became really depressed.”

“The California Department of Managed Healthcare is a corrupt organization that oversees [HMO]. The more you bother them, the more they don’t want to hear from you. I was told frankly, to never call their agency again.”

While the state regulatory agencies may not have the resources to assist all people with valid complaints, Americans believe they have a legal system through which to seek redress against an entities that breach a contract or perform illegal acts. However, many of our participants could not acquire adequate legal representation. Others spent a great deal of money on lawyers and still did not get everything to which they were entitled:

“Nobody would take [HMO] on. I mean you can’t sue [HMO].”

“He (the lawyer) said for him it is not good money. He said if it (the maximum claim award) is worth \$250,000 then it is not worth [it] to him.”

“If you don’t have attorneys you’re out of luck. I mean I’m an attorney and I needed an army.”

“I have a law degree and I can’t win, what chance do people with no education have? My next step is Federal court if I want anything. I’ll never be made whole from this situation.”

“I need an attorney to obtain the medical records I am required to release to others.”

The systematic act of offering diminished benefits seems to be a standard practice for health and disability insurance companies according to the people we interviewed. Every participant experienced various forms of diminishment of services and many felt the need to retain legal representation at their own expense. Companies built systems of diminishment by discouraging doctors from ordering expensive tests or using new treatments not yet authorized by the corporate offices. Additionally, doctors must attend to many patients each day. The pressures of the job translate to the patient as a lack of caring or proper attention.

We hold medical doctors in great esteem and recognize that millions of people benefit from good medical care every day in the US. Nonetheless, several of our interviewees faced serious illnesses that went undiagnosed for significant periods of time. In two of the cases, the patients died. When profits take precedence over care, some patients will inevitably suffer serious health and financial problems.

Case Studies in Denial of Benefits

Overt denial of promised benefits is more serious. Each of the twenty interviewees we talked to faced overt denial at sometime during their claim. Several of the interviewees have gone through more than one denial process. We recognize that the participants in our study are a select group of people who have experienced major trauma, anxiety, and abuse from health and disability insurance companies. In order to evaluate the issues, we researched two typical companies in the industry to determine if overt denial of claims was a deliberate practice.

Unum

Linda Nee, a former senior claims processor for Unum and a current independent disability claims consultant, discussed in an interview how her primary function at Unum was to deny claims.

“Each processor is ordered to deny a set dollar amount of claims each month and if the target was not achieved, they lost their jobs.” (personal communication, February 2007)

Unum, the largest disability insurance provider in the US, covers twenty-five million working people. (Unum, 2007) In the 1990s, Unum profits rose from a series of mergers with Provident and Paul Revere. As the profits rose, so did the number of denied legitimate claims. Many of these Unum clients came to realize that the insurance company that sold them “peace of mind” had a stronger commitment to profits than to fulfilling its promises to its customers.

In 2003, New York State Attorney General Elliott Spitzer began an investigation into the claims handling practices at Unum. Policyholders complained of long delays in receiving payments, independent doctor exams that provided results contrary to Unum records, and of reduced benefit payments. Spitzer, along with Insurance Commissioners from around the US uncovered a web of corruption that affected people in all 50 states.

In March 2003, Georgia Insurance Commissioner John W. Oxendine issued an order stemming from an examination of Unum’s disability insurance claims practices. He imposed a \$1 million fine, and ordered Unum to change its claims practices. (BestWire, March 19, 2003) In an *L.A. Times* article, Peter Gosselin states that in California, Unum committed “violations of state law in nearly one-third of a random sample of about 1,000 claims handled by UnumProvident.” (Gosselin 2003)

Delaying and denying claims proves profitable according to Linda Nee, “When claims are denied in a certain month, Unum receives profit realized in that month. Let’s say all claims denied in March contribute toward profit on March’s Profit and Loss Statement. The insured appeals the denial...nothing changes...the appeal takes six months...nothing changes, the profit is still realized...insured gets an attorney...nothing changes, motion filed...nothing changes and finally two years later a settlement for sixty-five percent of the claim reserve is made on the courthouse steps. Unum opens the claim and pays at the sixty-five percent rate and shows a thirty-five percent profit on the financial end in addition to the profit recorded in March when the claim was denied.” (Personal communication, June 2007)

According to Nee, Unum employees were encouraged to deny claims over a certain dollar amount, with monthly bonuses for adjusters with the lowest dollar amount of claims. Nee reported that, in her experience, Unum would pay the claim for a few years, then send notices that the company would end the payments because they did not have enough evidence to support the disability. In other cases, the company would force the claimant to apply for Social Security Disability Insurance (SSDI) and deem the claimant totally disabled in order to qualify for the federal benefits.

Ultimately, forty-eight states settled with Unum under the Multistate Settlement Agreement (MSA). Under the MSA, Unum it was touted that Unum would reassess approximately 215,000 claims it had previously denied and pay a negligible fine in relation to the financial benefits Unum reaped by its wrongful conduct. Unum was not required to admit any wrongdoing and states offered inadequate independent review of the claims that required reassessment. (Belth, 2004)

Former Insurance Commissioner of California, John Garamendi, referred to Unum as “an outlaw company...that for years has operated in an illegal fashion. Our settlement is designed to make it a poster child of a legal company.” (Gosselin 2003) However, the fine imposed by California was only eight million dollars. This was approximately the same amount Unum was forced to pay to a single California policyholder in one of the many thousands of lawsuits that had been filed against the company since the late 1990s. (Hangarter) It is an insignificant amount compared to Unum’s 2006 sales of \$10.5 billion dollars.

After the separate settlement with Unum in California, the state refused to require an admission of wrongdoing by Unum, but did issue detailed findings of wrongful conduct. The California Settlement Agreement (“CSA”) also contains additional conditions, beneficial to policyholders that could, if fully enforced, bring to an end much of Unum’s wrongful conduct. Pursuant to the CSA, the media reported that Unum was to reassess 26,000 claims dating back to 1997 by June 30, 2007. This settlement required the company to develop an internal system to reassess their claims. In the CSA, with only marginally greater oversight than in the MSA, the Insurance Commissioner essentially trusted Unum to reassess these claims by standards agreed upon by the state and the company.

As of June 30, 2007, CDoI reported that Unum made two thousand five hundred twenty-nine reassessment decisions, upheld one thousand three hundred fifty-three, reopened/paid/ closed five hundred seventy-nine, and reopened/paid/and opened four hundred eighty-five. These figures came with no information concerning the methodology of the reassessment numbers. The CDoI did not provide the number of claims that went to an independent reviewer. Nor did it address why Unum reassessed only nine percent of the 26,000 claims that they were required to examine. As of August 2007, the CDoI has not provided a final report.

Unum came under the review of fifty insurance commissioners and was found to have engaged in illegal business practices, yet continues to operate with little state oversight or regulation.

Kaiser Permanente

There are hundreds of “non-profit” health insurance hospitals and plans in the US. These hospitals operate under tax-exempt status. In return, the organizations must provide free and reduced services to low-income residents in the community in which they operate. A 2007 report by the Internal Revenue Service determined that forty-five percent of not-for-profit hospitals and health plans devoted three percent or less of their revenue to uncompensated care, and twenty-five percent of these institutions spent less than one percent of revenue on such care. (Francis 2007)) In 2002, the entire non-profit industry gained twelve billion dollars in tax breaks for providing limited care to low-income patients. (Flanagan 2007)

The Public Policy Institute of California conducted a study on the effect of hospital ownership in California and determined, “As the nonprofits behave more like the for-profits, nonprofit control of the market should be monitored with the same vigilance as for-profits.”(Public Policy Institute 1999) Non-profit hospitals were required to offer charitable contributions to the public in order to qualify for tax-exemptions, but since 1969 the federal government has been lax on its requirements, instead settling for health fairs and disease screenings. (Pear 2006) Catholic Healthcare West, a not-for-profit entity, settled a class action lawsuit in 2006, which accused them of overcharging the uninsured. They agreed to refunds for 750,000 people. (Hoover’s 2007)

Kaiser is one example of the problems associated with the for-profit model of US insurance and is not unique in its practices. In order to compete for members and profits, non-profit and for-profit HMOs, must employ similar business methods. While Kaiser Foundation Health Plan does not show profit in the same way as for-profit companies such as Wellpoint, it invests money into

marketing and advertising, raises rates, and institutes cost-cutting measures to increase its income and reserves.

The Foundation for Taxpayer and Consumer Rights (FTCR) claims that Kaiser's overhead has caused the consumer to pay increased rates. "Overhead costs—including advertising, administration, and CEO salaries—have become the fastest growing component of health care spending". (Flanagan 2007) Kaiser is able to declare non-profit status by placing their excess income in reserve accounts. The California Department of Managed Healthcare requires Kaiser to maintain a minimum level of reserves and, according to FTCR, Kaiser has \$9.3 billion in excess reserves. (Flanagan 2007)

The practice of declaring non-profit status while increasing cash reserves and denying care has roots in the Nixon administration. A recording of a conversation about Kaiser and the HMO industry reveals that President Nixon and Presidential Advisor John Erlichman viewed the profit-before-care model favorably:

Ehrlichman: Edgar Kaiser is running his Permanente deal for profit. And the reason that he can—the reason he can do it—I had Edgar Kaiser come in—talk to me about this and I went into it in some depth. All the incentives are toward less medical care, because—

President Nixon: [Unclear.]

Ehrlichman: —the less care they give them, the more money they make.

President Nixon: Fine. [Unclear.]

Ehrlichman: [Unclear] and the incentives run the right way.

President Nixon: Not bad. (Kaiser Papers from the Nixon Tapes, 1971)

Kaiser continues to increase revenues and membership despite numerous reports of abuse. In July of 2007, Kaiser was assessed a \$3 million fine for its "haphazard investigations of questionable care, physician performance and patient complaints" in California. (Weber, 2007) Additional charges and fines were level against a kidney transplant program that persuaded members to leave well-established transplant hospitals because Kaiser would no longer pay the expense outside its own facility. The program had numerous delays, which led to a dramatic decrease in patients receiving transplants. (San Francisco Chronicle June 24, 2006) In another case, Kaiser dumped disoriented, disabled, or otherwise ill patients on sidewalks outside homeless shelters. (Winton November 16, 2006)

In response to these situations of abuse, California inspectors at the Department of Managed Health Care investigated patient complaints of poor care. The inspection focused on determining how Kaiser handled the complaints, not on the nature of the complaints. (Weber July 25, 2007) These examples, among others, have resulted in fines of just a few million dollars.

Kaiser also benefits from a mandatory arbitration system that has little oversight from state or federal agencies. Arbitration forces a client to take a complaint to an arbitrator, for whom one must either pay or relinquish claims beyond a certain dollar amount, rather than taking it to court. Arbitration settlements generally provide less than the amount a plaintiff would win through the legal system.

Our interviewees covered by Kaiser claimed that arbitration was costly and biased.

"They make you sign an arbitration agreement form saying that if you have any problems with them (Kaiser) you agree to go to arbitration. They get to choose

the arbitrators, and the arbitrators you know, just by logic, are biased because obviously, if they want to work, they need to somewhat side in the favor of Kaiser or Kaiser isn't going to choose them".

"We had been [Kaiser] members for so long we hadn't signed the arbitration agreement and they came in with the paper while having a bypass surgery. He was so heavily medicated on morphine, he was so drugged out of his mind, in such immense pain, and they made him sign the paper, and that held up too in arbitration".

"So what they do is, if they settle the case nothing goes on that doctor's record [malpractice], because they settled it not admitting guilt, it's just settling. So there is nothing on the doctor's medical record. You are limited on what you can win at arbitration even for medical malpractice. It's \$250,000".

"The only question that the Kaiser attorney asked us when we were on the stand is 'so you drive a Mercedes, is that right?' because he wants the arbitrator to know these people don't need our money".

Kaiser's arbitration system came under scrutiny in 1997 when state investigations showed that Kaiser delayed arbitration on the death of a man because the settlement amount was less after death. (California Research Bureau, 1997)

Kaiser provides examples of practices that occur throughout the "non-profit" and for-profit health insurance industry.

Overt denials occur repeatedly in both profit and non-profit insurance organizations

"Over four days, sudden onset of terrible stiffness and pain in hips. Kaiser diagnosed me with *Polymyalgia Rheumatica* and refused to review diagnosis. I didn't believe arthritis came on so quickly. When I 'Googled' sudden onset arthritis, I kept getting shown sites for Lyme disease. I found a specialist outside of Kaiser and he tested me. [He] diagnosed *Ehrlichia* and Lyme disease. When the doctor's office sent the bill to Kaiser, it took them about eight weeks to send the first rejection. Kaiser said that this was not an emergency claim and would not be paid".

"I am told by my Lyme doctors that they're not going to pay for antibiotics past a one-month period, and one month of antibiotics for Lyme is not enough, unless you get diagnosed immediately".

The stories from our interviewees offer a glimpse into the circumstances experienced by many people in US seeking reliable, affordable, and safe health and disability care. The idea of insurance is to allow the people of a society to share a collective risk by pooling their resources to ease the loss of one member of the group so as not to cause a negative rippling effect throughout the community. If companies deny care, a person will likely continue a downward spiral in health, loss of income, and eventually become dependent on the state for care or simply die. Either way society inevitably suffers from the person's loss of productivity or the high cost of late term care for the dying.

Unum, a for-profit disability company and Kaiser, a non-profit HMO have large reserves and millions of members. They both use similar practices of delay, diminish, and denial of benefits.

Kaiser and Unum are not unique in the health and disability insurance industry in which profits and reserves supersede care, and in which a number of patients will experience serious negative consequences.

Privatization vs. Single Payer or Common Pool

In the US, private insurance companies sell health insurance to individuals and employers. Insurance companies do not provide any health care goods or services. They are the broker between the consumers and the providers of health care. Most people obtain health and disability insurance through employment related group plans. However, if one is not a member of a group plan; one must purchase an individual policy. If one cannot afford to purchase health or disability insurance. A person must be very low-income or elderly to qualify for state-subsidized care.

The debate over public single-payer health care versus private insurance company involvement is gaining momentum. The private insurance companies and HMOs have a desire to remain in the system and continue to make huge profits. In Massachusetts, private insurance companies pushed forward mandatory universal healthcare by requiring that everyone purchase health insurance. Other states are considering following suit.

President Bush, with the support of Congress, reformed Medicare in 2002, which increasingly privatized the system and boosted the profits of insurance companies. Bush also promised to veto a bill that expanded health care coverage to low-income children. In both cases, the President insists that the private sector is better at managing health care than the government. According to Bush, "Expansion of government in lieu of making the necessary changes to encourage a consumer-based system is not acceptable." (Lee 2007)

An example of the profiteering associated with mandatory privatized health insurance is a purchase made by a company owned by William Henry Trotter Bush, brother of H.W. Bush. Hoping to reap the profits of expanded private medical spending, WHT Bush, principal in Bush O'Donnell, acquired Community CarePlus, a Medicaid HMO in Missouri. According to the company's press release, Community Care Plus had the "highest percentage return on revenue of the Medicaid HMOs operating in metro St. Louis." (Deslodge 2004)

Private insurance companies are motivated to make as much money as possible and do so by systematically delaying, diminishing, and denying payment for promised services, and blaming individuals for their misfortunes. The state officiates in this process by maintaining health care for the poorest and protecting profits of the major providers with limited enforcement of regulation.

However, most of the industrialized countries in the world manage to provide all their citizens (and in some countries, immigrants) with relatively efficient, state-of-the-art health care that is paid for with taxes. While many proponents of private insurance argue that the citizens in these countries pay higher taxes, the individual cost to taxpayers is actually substantially less than the amount individuals and employers pay in health and disability care premiums and related expenses in the US. The total per capita health care costs in the US exceed health care costs of all other industrial countries, yet we leave huge gaps in service and systematically deny benefits to many of those in need. (WHO 2006)

Countries with common pool or single-payer health care systems provide similar levels of service to every person. In the US, insurance companies are not required to sell policies to people with pre-existing conditions, leaving many without care unless they qualify for Medicare, Medicaid, or other public programs. Private insurance companies are in fact motivated to delay, diminish, and deny care whenever they can. States assist them in this process by supporting limitations on

access to the courts and adequate redress, and by engaging in minimum or illusory regulatory enforcement.

Countries with common pool or single-payer systems do not tie health insurance to employment. In such countries, it is the responsibility of society as a whole to provide health care for each individual. In these societies it is understood that a person without access to proper health care is likely to become less productive and a bigger financial burden on society in the future.

The single-payer advocacy group, Physicians for a National Health Program reports that private insurance corporations spend an enormous amount of money on business-oriented expenses rather than health-related investments. Competition among private companies creates waste and duplication. According to a physician advocacy group, “When, for example, hospitals compete they often duplicate expensive equipment in order to corner more of the market. This drives up overall medical costs to pay for the equipment. They also waste money on advertising and marketing. The preferred scenario has hospitals coordinating services and cooperating to meet the needs of the public.” (Physicians for a National Health Program, 2007)

A 2003 study in the New England Journal of Medicine estimates that spending for the administrative costs associated with health care amount to over \$320 billion per year, or about thirty-one percent of overall health care costs in the US. This figure includes hospital administrative costs and time spent by doctors, nursing homes, and other home health providers on administering insurance claims. The study also takes into account the amount of money private insurers spend on costs not found in single payer systems, “Underwriting and marketing, account for about two-thirds of private insurers overhead.” The administrative costs in the Canadian national healthcare system amount to 16.7 percent, or about half of the administrative overhead of insurance costs in the US. (Woolhandler 2003)

The figure above does not consider the time and out-of-pocket expenses incurred by individuals and families related to personal administration of the policies and claims. A January 2007 article in the Bloomberg News reported, “A new study says that \$2.3 billion worth of time is spent in waiting rooms, doctors’ offices, hospitals and transportation in the first year after cancer is diagnosed. The study did not look at the value of time spent by members of a patient’s family”. (Bloomberg, January 3, 2007)

Inflated health care costs and limits on care in the US have very negative consequences for many families. A 2001 study conducted by professors from Harvard and Ohio University revealed that medical bills lead to one-half the bankruptcies filed in the US:

“In 2001 1.458 million American families filed for bankruptcy...About half cited medical causes, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced medical bankruptcy annually. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged \$11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage. Even middle-class insured families often fall prey to financial catastrophe when sick.” (Health Affairs, 2005)

State legislators, such as Shiela Kuehl of California, have introduced legislation for a single-payer system for their states.¹ Of the 2008 presidential candidates, only Dennis Kucinich advocates for a single-payer system.

People in the US have a choice. They can continue with the profit-driven private insurance health care system leaving many millions to languish without care, and many millions more to face the frustrations of systematic delays, diminishment, and denials of promised benefits. Alternatively, they can build a common pool health care system that provides necessary health care to everyone – for less than we are paying now.

CONCLUSION

Each person interviewed for this study had insurance at the onset of his or her malady. They paid monthly premiums through employer sponsored plans or had purchased individual/family policies directly from insurance companies. The people in this study believed they would receive the benefits they were promised in the event of an accident, disease, or illness. The management practices of the health or disability insurance company delayed, diminished, and denied payment for expected benefits.

Health and Disability Insurance companies are for-profit entities, despite some organizations operating under tax-exempt status. Customer care and quality of service falls to second place under this profit-driven model of health care. These practices are part of a growing structural arrangement between private business and government that is unlikely to be undone without extensive government re-regulation. As a health care regulator, the state is working for the benefit of capital expansion instead of health care for every person. In fact, the state is motivated to extensively regulate individual behavior and ignore corporate malfeasance.

At the beginning of this study, Barbara Ehrenreich, former State University of New York professor, journalist, and author of several books, states that she was unable to procure insurance because she had breast cancer. She goes on to state,

“This is not because health insurance executives are meaner than other people, although I do not rule that out. It's just that they're running a business, the purpose of which is not to make people healthy, but to make money, and they do very well at that. Once, many years ago, I complained to the left-wing economist Paul Sweezy that America had no real health system. ‘We have a system all right,’ he responded, ‘it's just a system for doing something else.’ A system, as he might have put it today, for extracting money from the vulnerable and putting it into the pockets of the rich.” (Ehrenreich 2007)

Private insurance has a structural motivation to delay, diminish, and deny payment for promised benefits, in order to maintain profit margins. They use these profits to propagandize the American public and influence voters through scare tactics of “socialized medicine” and long delays of service that supposedly occur in single-payer systems. Using corporate media and massive political donations to both parties, private health insurance companies have increased profits and maintained their influence in the system. The state complies with this arrangement and individuals within the systems use this compliance for revolving door career advancement.

¹ Shiela Kuehl's Single Payer legislation (S.B. 840) can be found at her website which includes studies, reports, fact sheets, and further reading <http://dist23.casen.govoffice.com/>

With its focus on profits, the industry has the power to deny life-saving procedures in the interest of profits. John A. Humbach, professor of law at Pace University, argues for criminal prosecution of HMO Denial:

“When people do things that they know are almost certain to have lethal consequences, and death results, criminal prosecution for homicide is normally called for. The existing criminal law provides no obvious reason why there should be an exception for actions by HMO functionaries who prevent their companies from performing their legal duties to authorize and pay for critical medical care.”

“Criminal sanctions in this country are not primarily aimed at people like HMO managers and administrative personnel, but are mostly intended for a very different segment of society.” (Humbach)

In times of crisis, the people in the US have joined social movements to demand justice and government action. The progressive movement in the early 20th century gained stronger regulations on medicines, medical education, and health care delivery systems. During the Depression, the Labor Movement won the Social Security Act and the expansion of disability and health care benefits for employees. The Civil Rights Movement and the War on Poverty led to Medicare and Medicaid.

The people in this study never anticipated the ways in which their lives would be changed by an inadequate and profit-driven system. They had health and disability insurance to protect them from insolvency and provide them with a minimum level of care and comfort. However, the companies with which the participants dealt managed to compound pain, trauma, and suffering instead of relieving it.

Adequate health care for everyone is a human right, acknowledged by the world in the 1948 United Nation’s Declaration of Human Rights. Most Americans pay higher combined taxes, health and disability insurance premiums, co-payments, and various health-related expenses than citizens in common pool, single-payer systems, yet, those countries allow all their citizens equal access to services. When the American people collectively decide that health care and basic social security is a right, which belongs to everyone, the health and disability system can be changed to provide necessary benefits for all.

“People don’t want to believe that it’s happening. They are so busy with their lives; they don’t care until it happens to them. Thing is that when it does happen to them, it’s too late. We could have cared less about health insurance until this happened to us.” Study Participant

Peter Phillips is a Professor of Sociology at Sonoma State University and Director of Project Censored. Bridget Thornton is a graduate student in the Interdisciplinary Studies Master program with specialties in Gender studies, History, and Sociology. The following Sonoma State University students in the Spring Investigative Sociology class assisted with this study: David Abbott, Brandon Beccio, Daniela Bravo, Laura Buck, Chris Castro, Andrew Kent, Chris Morello, Brian Murphy, Debra Sedeno, Kimberly Soho, Yuri Wittman.

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APPENDIX A

2006 Income and Growth of Major Health and Disability Insurance Providers (Source: 2007 Fortune 500 Companies)

<i>\$ in millions</i>	Profits	Revenue
AIG	14,048.0	113,194.0
Berkshire Hathaway	11,015.0	98,539.0
Prudential	32,488.0	3,428.0
Hartford	2,745.0	26,500.0
Cigna	16,547.0	1,155.0
Wellpoint	3,094.9	56,953.0
Aetna	1,701.7	25,568.6
Humana	487.4	21,416.5
Unum Group	10,718.8	411.0
TOTAL	\$92,845.8	\$347,165.1

APPENDIX B

Insurance Industry Corporate Board Members and Affiliations (Source: Business Week as of August 2007)

Key: G=Government Affiliation; M=Media Affiliation; F=Financial Affiliation

PRUDENTIAL

Gilbert Fran Casellas

Mintz Levin Cohn Ferris
Glovsky & Popeo, PC
Casellas & Associates LLC
Q-linx Inc. He
Swarthmore Group Inc.
McConnell Valdes LLP
(G) US Equal Employment
Opportunity Commission
(G) US Department of the Air
Force

James G. Cullen

Bell Atlantic Corp.
Agilent Technologies Inc.
Neustar Inc
Johnson & Johnson
Quantum Bridge
Communications Inc
(F) First Fidelity Bancorporation

James A. Unruh

(F) Alerion Capital Group, LLC.
Unisys Corporation
Fairchild Camera and Instrument
Corporation
Memorex Corporation
Tenet Healthcare Corporation
BioVigilant Systems, Inc.
LumenIQ, Inc.
Apex Microtechnology.

Frederic K. Becker

Wilentz Goldman & Spitzer P.A.

Jon F. Hanson

Healthsouth Corp.
National Football Foundation
CD&L Inc
Gemini Industries Inc
Yankee Entertainment
Sports Network LLC (YES
Network)
Pascack Community Bank
Wickes Inc.
New Jersey Sports and
Exposition Authority
Hackensack University Medical
Center

Constance Horner

Brookings Institution

US Commission on Civil Rights
Princeton University
Johns Hopkins University
(G) Associate Director for
Economics and Government of
the Office of Management and
Budget (Ronald Reagan)
(G) Office of Personnel
Management (Ronald Reagan)
(G) White House as Assistant to
President George H. W. Bush
(G) Director of Presidential
Personnel
(G) Deputy Secretary of US
Department of Health and
Human Services
Ingersoll-Rand Co. Ltd.
Bobcat Company
Pfizer Inc.
Foster Wheeler Ltd.
Annie E. Casey Foundation
(G) US Department of Defense
Advisory Committee on Women
in the Services
National Academy of Public
Administration.

William H. Gray III

Buchanan, Ingersoll & Rooney
PC
United Negro College Fund
(UNCF)
Bright Hope Baptist Church
Amani Group
(F) J.P. Morgan Chase & Co.
Dell Inc.
Pfizer Inc.
Visteon Corp.
Foster Wheeler Ltd.
MBIA Inc., Municipal Bond
Investors Assurance Corporation
Rockwell International
Corporation
Union Pacific Corporation
Ezgov.com
(F) The Chase Manhattan Bank,
N.A.
Warner-Lambert Co.
(M)Viacom Inc.
Electronic Data Systems
Corporation
CBS Corporation from

(G) United States House of
Representatives from 1979 to
1991
St. Peter's College
Rockwell Automation Inc.
Chairman of the House Budget
Committee
Appropriations Committee
Chairman of the House
Democratic Caucus and Majority
Whip
Jersey City State College
Rutgers University
Montclair State College
St. Peter's College
Temple University

Karl J. Krapek

Carrier Corp.
United Technologies Corp.
Otis Elevator Co.
General Motors
Lucent Technologies Inc.
Visteon Corp.
Delta Air Lines Inc.
The Connecticut Bank and Trust
Company
Connecticut State University
System
St. Francis Care Inc.

Gaston Caperton

College Board
National Commission on
Writing for America's Families,
Schools, and Colleges
Columbia University's Institute
on Education & Government at
Teachers College
Harvard University's John F.
Kennedy Institute of Politics
(G) Governor of West Virginia
Caperton Group
Owens Corning
(F) United Bankshares Inc.
Energy Corp. of America
West Virginia Media Holdings
Benedum Foundation
(G) Chair of the Democratic
Governors' Association

(G) National Governors' Association
(G) Intergovernmental Policy Advisory Committee on US Trade
Appalachian Regional Commission
Southern Regional Education Board
Southern Growth Policy Board
Gordon M. Bethune
GB-1 Partners

Continental Airlines Inc
Calair LLC
Expressjet Holdings Inc
Western Air Lines Inc.
Braniff Airlines
The British-American Business Council
Cendant Corp.
Travelport, Inc.
Aloha Airlines, Inc.
Aloha Airgroup Inc.
ExpressJet Holdings Inc
Willis Canada Inc

Honeywell International Inc
ANC Rental Corp.
Sprint Corp.
Sysco Corp.

Christine Poon
Bristol-Myers Squibb
Johnson & Johnson
Group of Johnson & Johnson
Fox Chase Cancer Center
Healthcare Businesswomen's Association

HUMANA

David A. Jones, Jr.
TeleCorp PCS Inc.
Tritel, Inc.
High Speed Access Corp.
(F) Mid-America Bancorp
(F) JG Funding
(F) Chrysalis Ventures, Inc.
Advanced Academics, Inc.
Health Enterprises Network
Intechra, LLC
(F) Chrysalis Ventures Fund III, L.P.
(F) Dragonvest Partners, LLC
Asterand Plc
Connecture, Inc.
HCCA International, Inc.
Greater Louisville Health Enterprises Network
Brookings Center on Health Policy
National Committee on US-China Relations
Yale President's Council on International Activities.
(G) **US Department of State's general counsel's office from 1988 to 1992**

Frank A. D'Amelio
Lucent Technologies Inc
(F) JPMorgan/Chase National Advisory Counsel

W. Roy Dunbar
(F) MasterCard International

Warren Buffett
MidAmerican Energy Holdings Co.
(M) Washington Post Co.
Coca-Cola
(F) Citigroup Global Markets Holdings Inc.

Eli Lilly & Co
Electronic Data Systems Corporation.

Kurt J. Hilzinger
AmeriSource Health Corporation

Michael B. McCallister
National City Corporation
America's Health Insurance Plans
Business Roundtable

W. Ann Reynolds
(M) Champaign-Urbana News Gazette
Lincoln Center Institute
Drew Foundation
Professor of Biology at The University of Alabama at Birmingham
President of the University of Alabama at Birmingham
Chancellor of the City University of New York
Chancellor of the California State University
Abbott Laboratories
Invitrogen Corporation
Maytag Corporation
Owens Corning.

James O. Robbins
(M) Cox Communications, Inc

BERKSHIRE HATHAWAY

Grinnell College
See's Candy Shops, Inc.
Gillette Co.

Bill Gates
ICOS Corp.

(M) Viacom Communications, Inc.
(M) Continental Cablevision of Ohio, Inc
(M) Montachusett Cable Television
(M) WBZ-TV News
(M) C-SPAN's
(F) STI Classic Funds of Sun Trust Bank
(F) Forstmann Little & Company
The Westminster Schools in Atlanta
(M) National Cable & Telecommunications Association (NCTA)
Juvenile Diabetes Research Foundation, International
Policy Holders Examining Committee of Northwestern Mutual Life Insurance Company
(M) Teleport Communications Group Inc.

James J. O'Brien
Ashland Inc
ATB Holdings Inc.
Valvoline
Fisher Graduate College of Business
American Chemistry Council
Midway College in Kentucky
Association of Governing Boards of Universities and College

Bill & Melinda Gates Foundation
Corbis Corporation
Microsoft

Donald R. Keough
Coca-Cola

Convera Corp.
IAC/InterActiveCorp
Allen & Company, Inc.
Electronic-Co., Inc.
Fizzion
Interactive Network, Inc.
(F) Questor Management
Company
HJ Heinz Co.
McDonald's Corp.
(M) Washington Post Co.

Walter Scott
Commonwealth Telephone
Enterprises Inc.
RCN Corp.
Peter Kiewit Sons, Inc.
(F) MidAmerican Energy
Holdings Co.
(F) Burlington Resources Inc.
Valmont Industries Inc.
Level 3 Communications Inc.
FirsTier Financial, Inc.
Kiewit Engineering Co.

Ronald A. Williams
(F) American Express Company
Lucent Technologies Inc.
Cardinal Health 414, Inc.
The Conference Board Inc.
WellPoint Health Networks Inc.
MIT Sloan School of
Management
Roosevelt University
(F) American Express Company

William C. Popik M.D.
Darwin Professional
Underwriters, Inc.
American Diabetes Association
The Disease Management
Association of America
University of California-San
Francisco
LifeMasters Supported SelfCare,
Inc.

Gerald Greenwald
Calpine Corp.
Sentigen Holding Corp.
Internet Brands, Inc
(M) Time Warner Inc., Prior to
its acquisition by America
Online
TechSpace, Inc.
(F) Evercore Partners Inc.
Authentix, Inc.
Aspen Institute
United Air Lines Inc.
(F) Greenbriar Equity Fund, L.P.

Charles Munger
(F) Wesco Financial Corp.
Costco Wholesale Corp.
(F) Citigroup Global Markets
Holdings Inc.
(M) Daily Journal Corp.
See's Candy Shops, Inc.
(F) Blue Chip Stamps

Howard G. Buffett
ConAgra Foods, Inc.
Lindsay Corporation
Coca-Cola
The National Foundation for
Teaching Entrepreneurship
Agro Tech Foods Ltd.

Ronald Olson
Western Asset Premier Bond
Fund
(M) Washington Post Co.
City National Corp.
Edison International

AETNA

Daimlerchrysler Corporation
Ford Motor Co.
(F) Dillon, Read & Co.
Princeton University
Woodrow Wilson School of
Public and International Affairs

Barbara Hackman Franklin
(F) Washington Mutual
Investors Fund Inc.
GenVec Inc.
Milacron Inc.
MedImmune Inc.
Dow Chemical Co.
AMP Incorporated
(F) Financial Accounting
Foundation Inc.
Lafarge SA
US-China Business Council
(F) Watson Wyatt Worldwide
Inc.
(F) NASDAQ Stock Market, Inc.

Betsy Z. Cohen
(F) The Bancorp Inc.
(F) Corporate Office Properties
Trust Inc.
(F) RAIT Financial Trust
(F) Jeffmortgage Inc
(F) JeffBanks, Inc.
Bryn Mawr College

Joseph P. Newhouse

Southern California Edison Co.
(G) Council on Foreign
Relations
California Institute of
Technology
The RAND Corporation
(M) Southern California Public
Radio
(F) Waf Western Asset High
Yield Portfolio

David Sanford Gottesman
Sequa Corp.
(F) Securities Industry and
Financial Markets Association

Thomas S. Murphy
(M) ABC, Inc.

Charlotte Guyman
No Known Affiliations

Susan L. Decker
No Known Affiliations

John D. MacArthur Professor of
Health Policy and Management
at Harvard University
John F. Kennedy School of
Government, Harvard
The RAND Corporation
RAND Graduate School from
1972 to 1988
(M) Editor of the *Journal of
Health Economics*
National Bureau of Economic
Research
Institute of Medicine of the
National Academy of Sciences
(M) *New England Journal of
Medicine* Editorial Board
American Academy of Arts and
Sciences
National Committee for Quality
Assurance

Edward J. Ludwig
Becton, Dickinson and Company
Johns Hopkins University
Advanced Medical Technology
Association
Hackensack University Medical
Center
College of the Holy Cross

Earl G. Graves
Earl G. Graves, Ltd
(M) *Black Enterprise* magazine
(F) Black Enterprise/Greenwich

Street Corporate Growth Partners, L.P.
AMR Corporation
American Airlines, Inc.
DaimlerChrysler AG
Howard University
National Office of the Boy Scouts of America

Ellen M. Hancock

Jazz Technologies, Inc.
(M) Exodus Communications, Inc.
Acuicor Technology Inc.
IBM
National Semiconductor
Apple Computer, Inc.
Colgate-Palmolive Company
Electronic Data Systems Corporation

Roger N. Farah

Polo Ralph Lauren Corporation
Venator Group, Inc. (now Foot Locker, Inc)

Larry C. Glasscock

Sprint Nextel Corp.
Anthem Insurance Companies Inc
(F) Zimmer Holdings Inc.
Rocky Mountain Hospital & Medical Service Inc

Angela Braly

Anthem Blue Cross and Blue Shield
Texas Tech University
Law School At Southern Methodist University

Jackie M. Ward

Flowers Foods Inc.
Sysco Corp.
Sanmina-SCI Corp.
Keebler Holding Corp.
(F) PRG-Schultz International Inc.
(F) Bank of America Corporation
Anthem Southeast, Inc.
SCI Systems, Inc.
Computer Generation, Inc.
Matria Healthcare Inc.
Premiere Global Services, Inc.

Warren Y. Jobe

(F) HomeBanc Corp.
Unisource Energy Corp.
Tucson Electric Power Co.

R.H. Macy & Co., Inc.
Federated Merchandising Services
Rich's/Goldsmith's Department

Barbara Hackman Franklin

(G) Former US Secretary of Commerce
Barbara Franklin Enterprises
American Institute of Certified Public Accountants
(G) US Consumer Product Safety Commission
(G) Staff Assistant to the President of the United States from 1971 to 1973
Dow Chemical Co.
GenVec, Inc
MedImmune, Inc
(F) Washington Mutual Investors Fund, Inc.
Economic Club of New York
US-China Business Council
National Association of Corporate Directors

WELLPOINT

William Henry Trotter Bush

Engineered Support Systems, Inc.
RightChoice Managed Care, Inc.
(F) Lord Abbett Bond-Debtenture Fund, Inc.
DT Industries
(F) Search Financial Services
(F) Mississippi Valley Bancshares, Inc.
Bush O'Donnell & Co., Inc.
(F) All Value Portfolio
(F) Americas Value Portfolio
Intrav, Inc.
Saint Louis University-St. Louis
(F) Boatmen's Bancshares, Inc
Yale University
Blue Cross and Blue Shield of Missouri
(F) Hartford National Bank and Trust Company
Maritz Inc
St. John's Mercy Health System
(G) Missouri Republican Party

William J. Ryan

(F) US Personal and Commercial Banking of Toronto-Dominion Bank
(F) Peoples Heritage Financial Group Inc.
(F) People's Heritage Savings Bank

Public Company Accounting Oversight Board Advisory Council

Molly J. Coye, M.D.

Health Technology Center
The Lewin Group
HealthDesk Corporation
Good Samaritan Health Hospital
(G) California Department of Health Services
Johns Hopkins School of Hygiene and Public Health
(G) New Jersey State Department of Health
(G) State of New Jersey Office of the Governor
National Institute for Occupational Safety and Health
Medical Investigative Officer
American Hospital Association
Institute of Medicine

(F) Bank of New England North
(F) Banknorth Group Inc.
University of New England
Trustee of Colby College.
Blue Cross and Blue Shield of Maine
(F) Federal Home Loan Bank of Boston
(F) Student Loan Association of New England
Anthem Blue Cross/Blue Shield
Maine Machine Products Company
Libra Foundation
Central Maine Power Company
(F) eFunds Corp. from
Pine Tree Council Boy Scouts of America
University of Maine Corporate Partners

Susan B. Bayh J.D.

College of Business
Administration at Butler University
Eli Lilly & Co
Barnes & Thornburg and
Gibson, Dunn & Crutcher LLP
(G) International Joint Commission of the Water Treaty Act between the United States and Canada
Esperion Therapeutics Inc.
Corvas International Inc.

Curis Inc.
(F) E-Bank
Golden State Foods Corp
Dendreon Corp
Dyax Corp.
Nastech Pharmaceutical Co. Inc.
Dendreon Inc
Cubist Pharmaceuticals Inc
Novavax Inc.

Victor Liss

Trans-Lux Corp.
Norwalk Hospital in Norwalk,
Connecticut
Honey Hill Care Center
Sacred Heart University
American Institute of Certified
Public Accountants
Connecticut and New York state
CPA societies.

William G. Mays

Mays Chemical Co. Inc
(F) First Indiana Corp.
Indiana Energy
United Way of Central Indiana
Indianapolis Art Museum
Indiana University Foundation
National Minority Supplier
Development Council

Donald W. Riegle Jr.
Eli Broad School of Business at
Michigan State University
(G) United States Senator from
Michigan from 1976 to 1994
(G) House of Representatives
from 1975 to 1977
APCO Worldwide Inc
Shandwick International
Stillwater Mining Company
TexCal Energy (GP) LLC
Cyberian Outpost Inc.
Harvard Graduate School of
Education

George A. Schaefer Jr.

Fifth Third Bank
Ashland Inc
Kenton County Airport
University of Cincinnati
Children's Hospital in Cincinnati

Robert B. Willumstad

(F) Citigroup Inc.
(F) Mastercard Incorporated
(F) Citifinancial Credit
Company
S. C. Johnson & Son, Inc.
(F) Commercial International
Bank Egypt SAE

Lenox D. Baker Jr., M.D.

Mid-Atlantic Cardiothoracic
Surgeons Ltd.
Johns Hopkins University.
Trigon Healthcare Inc.
Episcopal High School
Hermitage Foundation Museum.

Jane G. Pisano Ph.D

Natural History Museum of Los
Angeles County
University of Southern
California

Ramiro G. Peru

Saint Corporation
Swift Transportation Co. Inc.
Phelps Dodge Corp.
Southern Copper Corp
Eller Graduate School of
Management at the University of
Arizona

Julie A. Hill

Hiram-Hill Development Co.
Costain Homes Inc
Hillsdale Development Corp.
University of California at Irvine
Roundtable
Chapman University
Women's Leadership Board of
Kennedy School of Government
at Harvard University
Lend Lease Corp. Ltd.
(F) Lord Abbett Affiliated Fund
Inc
Holcim (US) Inc
Resources Connection Inc
Human Options
International Women's Forum

Sheila P. Burke

American Museums and
National Programs, Smithsonian
Institution
John F. Kennedy School of
Government, Harvard University
American Board of Internal
Medicine Foundation,
Marymount University

AIG

Habitat For Humanity
International Inc.
Adelphi University

Martin Sullivan

(F) International Lease Finance
Corp.

(G) Medicare Payment Advisory
Commission

(G) Chief of Staff to former
Senate Majority Leader Bob
Dole

(G) Secretary of the Senate in
1995

(G) Deputy Chief of Staff to the
Senate Majority Leader from
1985 to 1986

(G) Deputy Staff Director of the
Senate Committee on Finance
from 1982 to 1985

(G) Chief of Staff for the Office
of the Republican Leader of the
United States Senate

Chubb Corp.

Community Health Systems

Kaiser Family Foundation

Center for Health Care Strategies
Inc

Kaiser Commission on the

Future of Medicaid and

Uninsured and The National

Advisory Council at the Center

for State Health Policy

John E. Zuccotti

Real Estate Board of New York
Olympia & York

Weil, Gotshal & Manges LLP

WellChoice Inc

Partner of Brown & Wood

Tufo & Zuccotti

(G) First Deputy Mayor of the
City of New York from 1975 to
1977

Brookfield Financial Properties
Inc

(G) New York City Planning
Commission

(F) Dreyfus Funds

Empire Blue Cross and Blue
Shield

Columbia University

Doris Duke Foundation

Seven Worldwide, Inc.

(formerly, Applied Graphics
Technologies Inc.)

HealthChoice

WellChoice Inc

Starrett Corp.

Transatlantic Reinsurance
Company (United States)

C.V. Starr & Co., Inc.

United Guaranty Corporation

Ocean Choice International, Inc.

Edmund S.W. Tse

American International Assurance Co. Ltd. (China)

Rodney O. Martin, Jr.

American International Assurance Co. Ltd. (China)
(F) C.V. Starr & Co., Inc.
AGC Life Insurance Company

John T.W. Chu

Philippine American Life Insurance Co
(F) Development Bank of the Philippines.

Marshall A. Cohen

Cassels Brock & Blackwell LLP, Barristers and Solicitors
The Molson Companies Ltd.
(G) Government of Canada from 1970 to 1985
(G) Deputy Minister of Finance, energy, mines and resources, and industry, trade and commerce
(G) Officer of the Order of Canada in 1992
Golf Town Income Fund
(F) IBI Income Fund
Collins & Aikman Corp.
Premcor Inc.
(F) TD AmeriTrade Holding Corp.
Metaldyne Corp.
Barrick Gold Corp.
Lafarge North America Inc.
Trimas Corp.
SMK Speedy International Inc.
The Quorum Group
Speedy Muffler King Inc. Mr
(F) The Blackstone Group
Heartland
C.D. Howe Institute
Mount Sinai Hospital
(F) The Toronto-Dominion Bank
Haynes International Inc.

Stephen L. Hammerman

(F) Merrill Lynch & Co
(G) Legal Matters for the New York City Police Department

Morris W. Offit

(F) UJA-Federation of New York
(F) Offit Hall Capital Management LLC
(F) Julius Baer Securities
(F) Salomon Brothers.
Cantel Medical Corp.
(F) Wachovia Corp.
Johns Hopkins University
Financial Analysts Federation

George L. Miles Jr.

(M) WQED Pittsburgh Inc
(M) Thirteen/WNET
(M) KDKA, Pittsburgh
(M) WPCQ, Charlotte
(M) Westinghouse Television Group
(M) WBZ-TV
Urban League of Pittsburgh, Inc.
Foundation for Minority Interests in Media Inc.
Equitable Resources Inc
Harley Davidson Inc
Wesco International Inc
(F) Citizens Financial Group Inc.
Public Broadcasting Service
Applied Technology Systems Inc.
ATS-Chester Inc.
(F) Summit Bancorp.
(M) Westwood One Inc
Expeditionary Learning Outward Bound
University of Pittsburgh
Allegheny Conference on Community Development
Education Policy & Issues Center
Carnegie Museums of Pittsburgh
UPMC Health System
(M) Association for America's Public Television Stations
Mt. Ararat Community Activity Center

Michael H. Sutton

Allegheny Energy Inc.
(F) Securities and Exchange Commission (SEC) from 1995 to 1998
(F) Deloitte & Touche
Lizanne Thomas
Jones Day
Krispy Kreme Doughnuts Inc
(F) MainStay Funds
College of William & Mary

Richard C. Holbrooke

(F) Perseus, L.L.C.
Global Business Coalition on HIV/AIDS
(F) Lehman Brothers
(G) US Ambassador to the United Nations from 1999 to 2001
(G) Member of President Clinton's cabinet
(G) Assistant Secretary of State for Europe from 1994 to 1996
(G) Chief Architect of the 1995 Dayton peace agreement

(G) President Clinton's Special Envoy to Bosnia and Kosovo
(G) Special Envoy to Cyprus
(G) US Ambassador to Germany
(G) Assistant Secretary of State for East Asian and Pacific affairs 1977 to 1981
(G) Worked on Vietnam at the Johnson White House from 1966 to 1968
(G) Wrote one volume of the Pentagon Papers
(G) Member of the American delegation to the Vietnam peace talks in Paris from 1968 to 1969
Peace Corps Director in Morocco from 1970 to 1972
(M) Managing Editor of Foreign Policy from 1972 to 1977
American Academy in Berlin
Asia Society
(G) Council on Foreign Relations
National Endowment for Democracy
American Museum of Natural History
Telluride Foundation
International Advisory Board
Africa-America Institute
Citizens Committee for New York City
USA for UNHCR
Coca Cola
(M) AOL Time Warner
Credit Suisse First Boston
Human Genome Sciences Inc.
Quebecor World Inc.
Board of Refugees International
American Academy of Arts and Sciences

John J. Roberts

Petroleum & Resources Corp.
Adams Express Company

Martin S. Feldstein

National Bureau of Economic Research
Council of Economic Advisers
(G) President Ronald Reagan's Chief Economic Advisor
Eli Lilly & Co.
HCA Inc
Robeco Groep Nv
(F) J. P. Morgan & Co Inc
TRW Aeronautical
(G) Trilateral Commission
(G) Council on Foreign Relations
American Academy of Arts and Sciences

Corporation of Massachusetts
General Hospital
American Economic Association
American Philosophical Society
British Academy
Econometric Society
National Association for
Business Economics

Ellen V. Futter

American Museum of Natural
History
Barnard College
Consolidated Edison Inc.
(F) J.P. Morgan Chase & Co.
(M) Viacom Inc.
American Ditchley Foundation
Phi Beta Kappa Associates
Bristol-Myers Squibb
(M) CBS Inc
(G) Council on Foreign
Relations
National Institute for Social
Sciences
Academy of American Poets
American Academy of Arts and
Sciences
NYC & Co
Committee for Economic
Development
American Assembly
New York City Partnership Inc.
Yale School of Management

Frank G. Zarb

(F) Hellman & Friedman LLC

Ramani Ayer

BusinessLINC American
Insurance Association
The Business Roundtable
Insurance Information Institute
Financial Services Roundtable
(F) Listed Company Advisory
Committee to the New York
Stock Exchange
American Institute for
CPCU/IIA
Greater Hartford Chamber of
Commerce
Mark Twain House
Metro Hartford Regional
Economic Alliance
Hartford Hospital
Drexel University
Maharishi University of
Management

Thomas M. Marra

(F) The Travelers Inc.
(F) Smith Barney, Harris Upham
& Co. Incorporated
(F) National Association of
Securities Dealers, Inc.
(F) The Nasdaq Stock Market,
Inc.
(F) Lazard Frères & Co.
(F) Goodbody and Co.
Alexander & Alexander
Services, Inc.
(G) Executive Director of the
Energy Resources Council
(G) Administrator for the
Federal Energy Administration
from 1974 to 1977
(G) Assistant to the President of
the United States for Energy
Affairs from 1975 to 1977
(G) Associate Director of the
United States Office of
Management and Budget from
1973 to 1974
(G) United States Assistant
Secretary of Labor from 1971 to
1972
(F) Promontory Financial Group
(G) NIFA (Nassau County
Interim Finance Authority)
(F) Frank Zarb Associates, LLC
FPL Group Inc.
Hofstra University
Lower Manhattan Development
Corporation
The British-American Business
Council

HARTFORD

National Association of Variable
Annuities
Society of Actuaries
American Academy of Actuaries

Paul G. Kirk Jr.

Cedar Shopping Centers Inc.
Rayonier Inc.
Bradley Real Estate, Inc.
(G) Chairman of the Democratic
Party of the United States, and
from 1983 to 1985
Sullivan & Worcester
(G) Commission on Presidential
Debates
John F. Kennedy Library
Foundation
(G) Chairman of the National
Democratic Institute for
International Affairs
(G) Chairman of the Democratic
National Committee from 1985
to 1989

Fred H. Langhammer

Estee Lauder Companies Inc.
Dodwell Japan
RSL Communications, Ltd.
(F) Central Europe & Russia
Fund Inc.
Gillette Co.
The Walt Disney Co.
Nabisco Inc.
(F) Germany Fund Inc.
Inditex, S.A.
German-American Chamber of
Commerce, Inc
Japan Society
American Institute for
Contemporary German Studies
at Johns Hopkins University
Foreign Policy Association

Edward E. Matthews

(F) Morgan Stanley & Co.
(F) Princeton Investment
Company
Transatlantic Reinsurance
Company
(F) Putnam
(F) CV Starr & Co., Inc.
Starr International Company
(F) ILFC
Princeton University
Transatlantic Holdings Inc. from
Princeton Medical Center
Robert Wood Johnson
Foundation

Kirk and Associates Inc.
ITT Corporation
Sebastian's School
Stonehill College
Southern New England School
of Law.

Charles Strauss

Aegis Group plc
Unilever NV
Grocery Manufacturers
Association
Ganeden Biotech, Inc.
Marketing Corporation of
America
Gagliardi Brothers, affiliate of
H.J. Heinz and Company
Columbia Business School

Gail J. McGovern

Digitas Inc.
DTE Energy Co.
Conrail, Inc.

(F) Fidelity Investments
AT&T Corp.
Johns Hopkins University

Trevor Fetter

Santa Barbara Technology
Group.
Tenet Healthcare Corporation
Broadlane, Inc.
(F) Metro-Goldwyn-Mayer, Inc.
(MGM)
(F) Merrill Lynch Capital
Markets
Federation of American
Hospitals
US Chamber of Commerce
Committee on Economic
Development
Catalina Island Conservancy

Ramon de Oliveira

(F) Logan Pass Partners, LLC
(F) J.P. Morgan Chase &
Company.
SunGard Data Systems Inc
Graduate School of Business at
Columbia University
Stern School of Business at New
York University

Edward J. Kelly III

The Carlyle Group
(F) Mercantile Bankshares Corp.
(F) J.P. Morgan Chase
Davis Polk & Wardwell.
Constellation Energy Group Inc.
CSX Corp.
(F) Axis Capital Holdings Ltd.
(F) CIT Group Inc.
(F) Financial Services Group
Inc.
Johns Hopkins University
Petroleum & Resources Corp
Adams Express Company

H. Patrick Swygert

Howard University

H. Edward Hanway

America's Health Insurance
Plans
American Institute of Certified
Public Accountants
Council for Affordable Quality
Healthcare

Kristin Julason

No known affiliations

H. A. Wagner

University at Albany
State University of New York at
Albany from
Temple University
Historically Black Colleges and
Universities Capital Financing
Program Advisory Board
(G) US Department of Education
Washington, D.C. Area
Consortium of Colleges and
Universities
Community-Business
Partnership of the Greater
Washington Board of Trade
(F) Fannie Mae
United Technologies Corp.
The Victory Funds
Brown v. Board of Education US
Commemoration Commission
UNESCO
(G) Commission on Presidential
Debates
The Eisenhower Fellowships
(G) National Security Agency
Advisory Board

Robert W. Selander

(F) MasterCard Inc
(F) Citicorp

Michael G. Morris

American Electric Power
Company Inc.
Southwestern Electric Power Co
Ohio Power Co.
Public Service Company of
Oklahoma
AEP Texas Central Co
Kentucky Power Co.
Indiana Michigan Power Co.
AEP Generating Co
Appalachian Power Company
Ohio Valley Electric Corp
Indiana-Kentucky Electric
Corporation
Northeast Generation Co
Select Energy, Inc.

CIGNA

Agere Systems Inc.
Paccar Inc.
United Technologies Corp.
Air Products & Chemicals Inc.
Arsenal Digital Solutions
Worldwide, Inc.
A. P. Moller Inc
Business Roundtable
Lehigh University
Eisenhower Exchange
Fellowships Inc.

CMS Energy
Public Service Company of New
Hampshire
Consumers Power Company
Colorado Interstate Gas Co.
ANR Pipeline Co.
ANR Gathering Co
Western Massachusetts Electric
Co
Edison Electric Institute
The Connecticut Light and
Power Company
American Gas Association
Nuclear Electric Insurance
Limited
APCO
I&MC
SWEPCo
Connecticut Business & Industry
Association
St. Francis Care, Inc.
(F) Webster Financial Corp
Spinnaker Exploration Co
Institute of Nuclear Power
Operations
Nuclear Energy Institute
Association of Edison
Illuminating Companies
(G) US Department of Energy's
Electricity Advisory Board
(G) National Governors
Association's Task Force on
Electricity Infrastructure
(G) Connecticut Governor's
Council on Economic
Competitiveness & Technology
Business Roundtable
Columbus Downtown
Development Corporation
Detroit College of Law
Institute of Gas Technology
Eastern Michigan University
Foundation
Olivet College Leadership
Advisory Council
Library of the Michigan
Foundation

Carol Cox Wait

Boggs, Atkinson, Inc.
(G) Committee for a Responsible
Federal Budget

Robert H. Campbell

Pogo Producing Co.
Hershey Co.
Pew Charitable Trusts
Sunoco
Rocky Mountain Institute

Peter Larson
Brunswick Corp
Johnson & Johnson
(F) New York Stock Exchange
Inc

Jane E. Henney M.D
Health Affairs at University of
Cincinnati Medical Center
Association of Academic Health
Centers
(G) US Food & Drug
Administration
AmerisourceBergen Corp
AstraZeneca PLC.

William D. Zollars
YRC Worldwide Inc.
Ryder Integrated Logistics
Butler Manufacturing Co.
Cerner Corp.
ProLogis
Rogers Group, Inc.
National Association of
Manufacturers
Civic Council of Greater Kansas
City
Heart of America United Way
American Trucking Associations
University of Kansas Medical
Center
The Midwest Research Institute
The Carlson School of
Management

Donna F. Zarcone

Jon S. Fossel
NorthWestern Energy
(F) Oppenheimer Principal
Protected Main Street Fund II
(F) Baring Strategic Income
Fund
PR Pharmaceuticals, Inc.

Thomas R. Watjen
(F) Morgan Stanley & Co

Susan L. Ring
No known affiliations

Ronald E. Goldsberry
Case Corporation
OnStation Corporation
Ford Motor Company
(F) Deloitte Consulting
(F) UNC Ventures Inc

A. S. MacMillan Jr.

(F) Harley Davidson Credit
Corp.
(F) Chrysler Systems Leasing
Inc., a subsidiary of Chrysler
Financial Corp.

Roman Martinez IV
(F) Lehman Brothers
Investment Advisory Council at
Florida State Board of
Administration
Alliant Techsystems Inc
New York-Presbyterian Hospital
International Rescue Committee
(F) GreenPoint Financial Corp.

Isaiah Harris Jr.
Bellsouth President of
Advertising and Publishing Corp
BellSouth Enterprises
(F) KPMG Peat Marwick
Deluxe Corp.
YellowPages.com
United Way of Metropolitan
Atlanta
OFC Venture Challenge
International Multifoods Corp.
(F) Atlanta Life Financial Group
Henry W. Grady Foundation
Iowa State University
Foundation Board of Governors

James E. Rogers
Edison Electric Institute
(F) SCI Investors Inc
Specialty Coatings International,
Inc

Unum

Team Resources, Inc
The Maclellan Foundation
MetoKote Corporation

E. Michael Caulfield
(F) Mercer Human Resource
Consulting of Marsh &
Mclennan Companies Inc.
Prudential Insurance Company
of America
(F) Greenwich Associates
Mellon National Corp.

William J. Ryan
(F) US Personal and Commercial
Banking of Toronto-Dominion
Bank
(F) Peoples Heritage Financial
Group Inc.
(F) People's Heritage Savings
Bank
(F) Bank of New England North

James River Corporation
Caraustar Industries Inc.
Custom Papers Group, Inc
Owens & Minor Inc.
Wellman Inc. since
Cadmus Communications Corp.
Cincinnati Gas & Electric
Company (CG&E)
PSI Energy Inc. (PSI)
Cinergy Corp.
Interstate Pipelines for the Enron
Gas Pipeline Group
Akin, Gump, Strauss, Hauer &
Feld
(G) Federal Energy Regulatory
Commission (FERC)
(G) Law Clerk for the Supreme
Court of Kentucky
(G) Assistant Attorney General
for the Commonwealth of
Kentucky
(F) Fifth Third Bancorp
Duke Realty Corp
(F) Bankers Life Holding
Corporation
A O Irkutskenergo (F) INB
(Indiana National Bank)
(F) NBD Indiana Inc.
American Gas Association
US Chamber of Commerce
Business Roundtable
National Coal Council

Eric C. Wiseman
JanSport
V. F. Corp.
Global Intimate Apparel Coalitio

(F) Banknorth Group Inc.
University of New England
Trustee of Colby College.
Blue Cross and Blue Shield of
Maine
(F) Federal Home Loan Bank of
Boston
(F) Student Loan Association of
New England
Anthem Blue Cross/Blue Shield
Maine Machine Products
Company
Libra Foundation
Central Maine Power Company
(F) eFunds Corp.
Pine Tree Council Boy Scouts of
America
University of Maine Corporate
Partners

Michael J. Passarella

(F) PricewaterhouseCoopers
LLP

Archipelago Holdings LLC
Manhattan College board of
trustees

Hugh O. Maclellan Jr.

Maclellan Foundation, Inc
Covenant Transport Inc.
(F) SunTrust Bank, Chattanooga,
N.A.

C William Pollard

ServiceMaster Company
Miller Herman Inc. (now
Herman Miller Inc.)

Thomas A. Kinser

BlueCross BlueShield of
Tennessee
BlueCross BlueShield
Association in Chicago

Gloria C. Larson

(G) Secretary of Economic
Affairs for the Commonwealth
of Massachusetts
(G) Massachusetts Secretary of
Consumer Affairs and Business
Regulation
(G) Deputy Director of
Consumer Protection of the
Federal Trade
Foley, Hoag and Eliot LLP
Mass Inc.
Massachusetts Convention
Center Authority
Jobs for Massachusetts
Greater Boston Chamber of
Commerce
Keyspan Corp.
(F) RSA Security Inc.
Massachusetts Technology
Council
Massachusetts Women's Forum

Pamela H. Godwin

Change Partners, Inc
GMAC Insurance
Advanta Corporation
Academy Insurance Group
Colonial Penn Group, Inc

Edward J. Muhl

Navigant Consulting Inc
Peterson Worldwide Consulting
LLC
Reliance Insurance Group
(F) PriceWaterhouseCoopers
(G) Superintendent of Insurance
for the State of New York from
1995 to 1997

(G) National Association of
Insurance Commissioners
(G) Commissioner of Insurance
for the State of Maryland
(G) US Insurance Regulatory
Advisory Practice for
PricewaterhouseCoopers
Mid Atlantic Medical Services
Inc
MAMSI Life and Health
Insurance Company ("MLH")
Farm Family Holdings

APPENDIX C

Fortune 500 Affiliations with Boards of Directors of Top Insurance Companies

The following companies appear in the top 100 of the 2007 list of Fortune 500 companies (April 30, 2007) and reflect the affiliations of the board members of the companies in the preceding appendix. The amounts are in millions. (Insurance companies in bold).

COMPANY	REVENUES	COMPANY	REVENUES
Exxon	347,254.0	United Technologies	47,829.0
General Motors	207,349.0	Wachovia	46,810.0
Ford	160,126.0	Lehman Brothers	46,709.0
Citigroup	146,777.0	Time Warner	44,788.0
AIG	113,194.0	Microsoft	44,282.0
Bank of America	117,017.0	Sprint	43,531.0
JP Morgan	99,973.0	Sunoco	36,081.0
Berkshire Hathaway	98,539.0	Walt Disney	34,285.0
IBM	91,424.0	Prudential	32,488.0
Morgan Stanley	76,688.0	Honeywell	31,367.0
Merrill Lynch	70,591.0	Federated	28,711.0
Amerisource Bergen	61,203.1	American Express	27,145.0
Costco	60,151.2	Washington Mutual	26,561.0
Dell	57,095.0	Hartford	26,500.0
Johnson and Johnson	53,324.0	Aetna	25,568.6
Wellpoint	56,953.0	Travelers	25,090.0
Dow	49,124.0	Coca Cola	24,088.0
Pfizer	52,415.0	GRAND TOTAL	2,511,030.9