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MEDICARE ADVANTAGE: CHANGING NETWORKS AND EFFECTS ON CONSUMERS

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C O N T E N T S

Page

Opening Statement of Senator Richard Blumenthal, Member of the Committee 1
Opening Statement of Senator Sheldon Whitehouse, Member of the Committee 2

PANEL OF WITNESSES

Stephanie Kanwit, Principal, Kanwit Healthcare Consulting, and Former Special Counsel, America's Health Insurance Plans 4
Brian Biles, M.D., Professor, George Washington University School of Public Health and Health Services and Chair of the Department of Health Services Management and Policy 6
Judith Stein, Esq., Founder and Executive Director of the Center for Medicare Advocacy 9
Michael Saffir, M.D., Physiatrist and President, Connecticut State Medical Society 13
Raymond Welch, M.D., Dermatologist, Rhode Island Dermatology and Laser Medicine 15

APPENDIX

PREPARED WITNESS STATEMENTS

Stephanie Kanwit, Principal, Kanwit Healthcare Consulting, and Former Special Counsel, America's Health Insurance Plans 37
Brian Biles, M.D., Professor, George Washington University School of Public Health and Health Services and Chair of the Department of Health Services Management and Policy 51
Judith Stein, Esq., Executive Director, Center for Medicare Advocacy 58
Michael Saffir, M.D., Physiatrist and President, Connecticut State Medical Society 63
Raymond Welch, M.D., Dermatologist, Rhode Island Dermatology and Laser Medicine 67

STATEMENTS FOR THE RECORD

George C. Jepsen, Attorney General, State of Connecticut 73
Alan F. List, M.D., President and CEO, Frank and Carol Morsani Chair, Moffitt Cancer Center 75
Robert Buccieri, Medicare Beneficiary 77

MEDICARE ADVANTAGE: CHANGING NETWORKS AND EFFECTS ON CONSUMERS

WEDNESDAY, JANUARY 22, 2014

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:00 p.m., Room 2E, Legislative Office Building, 300 Capitol Avenue, Hartford, Connecticut, Hon. Richard Blumenthal, Member of the Committee, presiding.

Present: Senators Blumenthal and Whitehouse.

Also present: Senator Murphy.

OPENING STATEMENT OF SENATOR RICHARD BLUMENTHAL, MEMBER OF THE COMMITTEE

Senator BLUMENTHAL. Thank you everyone for being here.

For those who may not have been outside and for the record, I want to thank Chairman Nelson of the Special Committee on Aging. I serve on it, and he has given us permission to be here today and to have this field hearing on a topic that I know is very, very important to the State of Connecticut and to the State of Rhode Island.

I want to welcome my colleague, Senator Murphy and Senator Sheldon Whitehouse of Rhode Island.

We have a panel of five really outstanding witnesses today, and I want to welcome them all here, especially those who made it to Hartford from Washington and Rhode Island.

We think it is important to hold this hearing for a number of reasons. While we are seeing insurers decide to offer narrower networks, in an intent to reduce costs across the country, these decisions have a very dramatic impact here in Connecticut, where 2,250 providers were terminated with virtually no notice, and that termination affected about 61,000 patients under the Medicare Advantage program, about 43 percent of all the patients who have Medicare Advantage plans.

We are here today to hear from the folks who can shed some light on what these sudden terminations mean for patients, in the midst of deciding whether they stay with their Medicare Advantage plans, and what options are available to them and what can be done to prevent this kind of abusive and, very likely, illegal action from happening again.

Right now, the terminations have been enjoined. There will be an appellate argument next week.

I have joined in that argument as a friend of the court in a brief that I filed because I feel so strongly, as do my colleagues, about the importance of this issue to people in Connecticut and people throughout the country.

I do not know whether Senator Murphy or Senator Whitehouse have any additional statements that they would like to make.

Senator Whitehouse?

OPENING STATEMENT OF SENATOR SHELDON WHITEHOUSE, MEMBER OF THE COMMITTEE

Senator WHITEHOUSE. No. I just want to thank you both for your hospitality. It is good to be here in your state. Rhode Island, your eastern neighbor, has the same predicament with United.

I am pleased to serve on the Aging Committee with Senator Blumenthal and on the Health, Education, Labor and Pensions Committee with Senator Murphy, and since both of those committees have a keen interest in this issue, it is a delight to be here.

They are also terrific colleagues, and, on this issue, people talk about Washington and who is a showhorse and who is a workhorse. You have two workhorses in the Connecticut Senate on health care issues, so it is a great honor for me to be here with both of them.

Senator BLUMENTHAL. Thank you.

Senator Murphy?

Senator MURPHY. Thank you, Senator Blumenthal.

I just wanted to thank you for allowing me, as a non-Aging Committee member, to sit in on this hearing, but, as a member of the Health, Education, Labor and Pensions Committee, this is obviously an issue that we have jurisdiction over as well, so, really excited to be here.

This is a great panel, and I think what I hope that we will do here today is to examine both the immediate issue, which is of concern to thousands of Connecticut and Rhode Island residents, but also talk about the bigger picture because we do live in a world in which we are going to see the contraction and sometimes expansion, but certainly always change, in provider networks, and we have just got to sit together and figure out the best way to do that from a cost perspective, from a patient protection perspective and from a quality perspective.

Senator BLUMENTHAL. I should say that both Senator Murphy and Senator Whitehouse, along with myself, are members of a task force on health care delivery, which we have organized to look at these issues.

Sheldon Whitehouse has been an advocate on these issues from well before I was in the Senate, and I want to thank him particularly for his leadership.

Let me introduce the witnesses that we have here today, with the first panel before us.

Stephanie Kanwit is a Senior Health Care Consultant in Washington, DC, who currently serves as Special Counsel to America's Health Insurance Plans, AHIP, and the Pharmaceutical Care Management Association.

Prior to that, she served as General Counsel for AHIP and three stints as a partner in private law firms in DC and Chicago—Chadwell and Kayser, Lamet Kanwit and Davis in Chicago, Ep-

stein Becker and Green in Washington, and she also has served as Vice President of Health Litigation at Aetna here in Hartford.

Brian Biles comes to us from George Washington University School of Public Health and Health Service, where he is professor and Chair of the Department of Health Services Management and Policy.

Prior to his current position, he was Senior Vice President of the Commonwealth Fund and served for seven years as Staff Director of the Subcommittee on Health in the Committee on Ways and Means of the United States House of Representatives. He worked on the Health Subcommittees chaired by Representative Henry Waxman and Senator Edward Kennedy, two great heroes in health care advocacy, and he has authored numerous papers. I am not going to go through the entire list, but he has a master's degree in public health from Johns Hopkins University, and he received his doctor of medicine and bachelor of arts degrees with honors from the University of Kansas.

I am told—I hope, reliably—that your wife is from Connecticut.

Judith Stein, another hero, is the founder and Executive Director of the Center for Medicare Advocacy.

Anybody who has been in this building, anybody who has any experience in health care in Connecticut knows of her extensive experience in developing and administering Medicare advocacy projects. She has been a champion of Medicare beneficiaries, producing educational materials, teaching and consulting.

She has been the lead counsel or co-counsel in numerous Federal class action and individual cases, challenging improper Medicare policies and denials, and I have been privileged to join with her when I served as attorney general in some of those actions.

She also was a delegate to the 2005 White House Conference on Aging and received the Connecticut Commission on Aging Agewise Advocate Award in 2007.

She graduated cum laude from Williams College and received her law degree with honors from Catholic University School of Law.

Dr. Michael Saffir is a practicing psychiatrist, specializing in physical medicine, rehabilitation and pain management. He practices at the Orthopedic Specialty group in Fairfield, Connecticut and is the Division Chief of Medicine and Rehabilitation in the Department of Medicine at St. Vincent's Medical Center in Bridgeport. He is also President of the Connecticut State Medical Society.

Did I get your specialty wrong?

Dr. SAFFIR. Physiatrist. Physical medicine rehabilitation.

Senator BLUMENTHAL. Okay. Thank you.

I am going to ask Senator Whitehouse to introduce Dr. Welch, who is from Rhode Island.

Senator WHITEHOUSE. It is my great honor to have the opportunity to introduce Dr. Raymond Welch, who is a practicing physician in Rhode Island in the field of dermatology. He has been practicing in the Providence area for 28 years, focusing his work on the diagnosis and treatment of skin cancer. He is also an Assistant Clinical Professor at the Warren Alpert School of Medicine at Brown University.

He has a long record of recognitions. He was elected in 2007 to the Noah Worcester Dermatological Society. He is a member of the

New England Dermatology Society, the Rhode Island Dermatology Society and the American Society of Laser Medicine and Surgery.

He is a graduate of Albany Medical College in New York, served his residency at Albany Medical Center Hospital and completed his dermatology residence at Duke University Medical Center.

We are delighted that he took the trouble to come from Rhode Island to be here and to share his perspective.

Thank you very much.

Senator BLUMENTHAL. Thank you.

Why don't we——

Senator WHITEHOUSE. Should we get into the record now about United and whether their being here or not here, they were at least invited?

Senator BLUMENTHAL. Sheldon Whitehouse, Senator Whitehouse, makes the excellent point that I want to put on the record that UnitedHealthcare Group was invited. I did invite them to this hearing. They have declined to appear.

Why don't we begin going from my left to right?

We will begin with you, Ms. Kanwit.

STATEMENT OF STEPHANIE KANWIT, PRINCIPAL, KANWIT HEALTHCARE CONSULTING, AND FORMER SPECIAL COUNSEL, AMERICA'S HEALTH INSURANCE PLANS

Ms. KANWIT. Thank you. Good afternoon, Chairman Blumenthal and members of the Committee.

I am honored to be here in my home State of Connecticut. I am Stephanie Kanwit, and I am testifying today on behalf of America's Health Insurance Plans, known as AHIP.

I appreciate this opportunity to testify on issues surrounding provider networks in the Medicare Advantage Program and the strategies our members are employing in this area to hold down costs and, at the same time, improve value for their enrollees.

Health plans in the Medicare Advantage, MA, program have a strong track record of offering high-quality coverage options with innovative programs and services for both seniors and individuals with disabilities. As emphasized in our written testimony, one strategy that plans are pioneering involves the use of high-value provider networks along with programs that encourage enrollees to obtain care from providers who have demonstrated, based on performance, metrics, their ability to deliver high-quality and cost-effective care, and those are the keys.

Our written testimony focuses on three broad areas:

First, background on the MA program, including the value it delivers to beneficiaries.

Second, as the MA program faces a future of severe underfunding, we discuss the opportunity for these high-value provider networks I mentioned to preserve benefits and mitigate the cost impact on the MA beneficiaries.

Third, we focus on the leadership role that health plans are playing in advancing delivery system reforms, so, just some quick background. More than 14.5 million seniors in the United States and people with disabilities, about 28 percent of the Medicare population, currently are enrolled in MA plans.

Senator Whitehouse, that is higher in Rhode Island. It is about 35 percent.

Why? They value the care coordination and disease management activities, improved quality of care and innovative services and benefits that are available through these plans.

Now MA plans offer a different approach to health care delivery than beneficiaries experience under the regular Medicare fee-for-service, FFS, program. They have developed systems of coordinated care—key word, coordinated—for ensuring that beneficiaries receive health care services on a timely basis while also emphasizing prevention and providing access to disease management services for chronic conditions. These coordinated services and systems provide for the seamless delivery of health care across the continuum.

We are talking physician services, hospital care, prescription drugs and other health care services, all integrated and delivered through an organized system. The overriding purpose is to prevent illness, manage chronic conditions, improve health status and swiftly treat medical conditions as they occur rather than waiting until they have advanced to a more serious state.

The key question is this: Have they been successful?

The answer is yes.

First, we know that because survey findings show that MA enrollees are highly, highly satisfied with their health plans—90 percent, plus.

Secondly, we know that because research findings consistently demonstrate that MA plans have better health outcomes and beneficiaries receive higher-quality care than their counterparts in the Medicare FFS program.

The value that MA enrollees receive through their plans can also be seen in the additional services and benefits that are offered—services and benefits that are not offered in the Medicare fee-for-service program. Although these vary from plan to plan, these typically include case management, disease management, wellness and prevention programs, prescription drug management tools, nurse help hotlines, and vision, hearing and dental benefits.

MA plans also protect beneficiaries from high out-of-pocket costs, and this year, in 2014, all MA plans are going to offer an out-of-pocket maximum for beneficiary costs.

Another important feature of MA programs is enrollees have strong consumer protections, and this includes extensive network adequacy standards, which ensure that MA enrollees have access to all provider types, including primary care physician as well as specialists within a reasonable time and distance from their homes.

CMS works with MA plans when network changes are made to ensure that beneficiaries continue to have access to the benefits and services they need, but we are deeply concerned that the MA program is facing a future of severe underfunding that jeopardizes the stability of these plans.

The Affordable Care Act, the health reform law, ACA, imposes more than $200 billion in funding cuts on MA over a 10-year program. Through last month, December of 2013, only 10 percent of those cuts had gone into effect, but another 35 percent will be phased in between 2014 and 2016, so they are back-loaded.

On top of those cuts, MA enrollees are impacted by the new ACA health insurance tax that went into effect on January 1st, 2014.

Now facing such a challenging budgetary environment, MA plans are working hard to maintain access to high-value benefits and services for their enrollees, but we have serious concerns, as I mentioned, about the underfunding of the MA program as ACA cuts are phased in at an increasingly faster rate over the next several years.

The need is greater now than ever before for innovations that deliver increased values to beneficiaries with increasingly limited resources that are available to support the MA program.

In response to that challenge, MA plans are working hard to preserve benefits and improve quality for enrollees by developing what I mentioned previously—high-value provider networks.

What are high-value provider networks?

Health plans typically develop these networks using performance metrics, with a strong emphasis on quality criteria, to select high-performing, cost-effective providers, using widely recognized, evidence-based measures of provider performance such as those endorsed by the National Quality Forum. Health plans can create select or tiered networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality.

Now a central goal of these high-value provider networks, including those offered by MA plans, is to improve health care quality and efficiency through ongoing evaluation of provider performance, assessment of resource use, referrals to other high-performing providers and the exchange of health information with the plan and other providers caring for the same patients; so, that kind of coordination.

Critically, these high-value provider networks create strong incentives for providers to offer competitive prices in response to the increased number of patients they gain as a member of the network, and this, in turn, enables the health plans to deliver substantial savings to their enrollees in addition to connecting them to high-quality providers.

I want to thank you for considering our views on these important issues.

We look forward to working with Congress to strengthen and preserve the MA program, and, to achieve this goal, we urge you to help ensure that funding for the MA program is stabilized and that MA plans have the flexibility to advance high-value provider networks and other innovations that promote quality and efficiency for Medicare beneficiaries.

Thank you.

Senator BLUMENTHAL. Thank you very much.

Professor.

STATEMENT OF BRIAN BILES, M.D., PROFESSOR, GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES AND CHAIR OF THE DEPARTMENT OF HEALTH SERVICES MANAGEMENT AND POLICY

Dr. BILES. Thank you very much, Senator Blumenthal, Senator Whitehouse, Senator Murphy, for convening this hearing on what is really a new and very important issue.

I would note that my wife, in fact, did grow up in Easton, where her great grandparents moved from Slovakia in the 1880s to take over some of the farmland in that area.

Senator BLUMENTHAL. Not a lot of farmland left in Easton.

Dr. BILES. Not a lot. It is all—as you well know Easton.

The focus of this hearing—I think, it could be termed network narrowing of physicians by UnitedHealthcare's Medicare Advantage plans—is important now both in Connecticut and Rhode Island, and nationwide, and it is certainly to become more important in the years ahead, which I think is why this is such an important discussion. New Medicare policies to address the situation will be important, particularly to elderly and disabled beneficiaries.

The focus of today's hearing is United Healthcare's recent action, and a special concern regarding United's announcement is when it occurred and particularly occurred after the beginning of the Medicare beneficiary open enrollment period that began on October 15th and ran until December 7th.

I think if I were to focus on one area it is the lack of advance notice. I do not know whether it is too strong to say this is an example of bait and switch, but clearly, elderly, disabled beneficiaries went through an open enrollment period before all of this was clearly understood and they could take action in response.

The term, network narrowing, has been described as reduction in the number of physicians participating in managed care plans, and I will focus today in five areas.

First, the point is that Medicare beneficiaries always have the option to be covered by traditional Medicare, which has the broadest network, of course, of any health plan and any health insurance program the country.

Second, again, the managed care network narrowing that we see in Connecticut is neither new nor limited to Medicare.

Three, Medicare—and this is a particularly important issue—has been paying private plans more than it costs in traditional Medicare fee-for-service for beneficiaries enrolled in the plan. Our research found that extra payments—payments in addition to costs in Medicare, traditional Medicare—in 2009 averaged 14 percent, $1,100 per enrollee and a total of over $12 billion.

Fourth, as payments are reduced, the plans with policies have been mentioned in the ACA. To reduce these extra overpayments, it is clear that plans will accommodate and adopt more efficient and effective ways to provide care, including physician networks.

My fifth point then is policies that protect Medicare beneficiaries, as plans develop narrow networks, are important at this time.

To elaborate a bit, the most important point relative to changes is the underlying fact that beneficiaries must always choose to be covered by, and receive care from, plans rather than the traditional Medicare program.

We have studies from MedPAC, which indicate that Medicare beneficiaries in traditional Medicare have very broad access to physicians and are quite satisfied with that care. One study found that in spite of the general shortage of primary care physicians, less than two percent of Medicare beneficiaries in traditional Medicare reported a major problem finding a primary care physician.

There is—if you want to view it as—a fallback of a safety net, and that is where almost 75 percent of the Medicare beneficiaries are today.

The second point, of course, is that managed care plans with limited or narrow networks are neither new nor limited to Medicare.

If we go all the way back to the 1970s, President Nixon and Senator Kennedy developed the Medicare Assistance Act. That was all based on Kaiser Permanente, and the entire premise was that plans would have narrow networks. They could be efficient, they could manage for care, and as a result, could provide care both in a less expensive, but also more effective, manner.

We have seen over the years, particularly in the 1990s, on one hand, a national movement toward plans with narrower networks followed by a response, and then as the recession eased, the economy became more robust and employers moved to much broader networks.

If we then turn to the next point, which is that plans have been paid more in traditional Medicare over the past, since 2006. We find that Medicare Advantage, the Medicare Modernization Act, the prescription drug bill in 2003, implemented in 2006, paid all plans in the Nation more than costs in fee-for-service in the same county, and, again, the average was 14 percent, $1,100 in 2009.

The fourth point, of course, is in the ACA, as a general effort to reduce costs to Medicare and in health care, that included policies to reduce payments to hospitals and other providers, these extra additional payments to Medicare Advantage plans were gradually phased out through the year 2017, and our modeling indicates that by 2017 plans will be paid an average of 101 percent of costs in the same county.

History and current plan practices suggest that changes by Medicare Advantage plans to accommodate this gradual phase-down of these extra payments will likely include some network narrowing, so I think that is built into the system. I think it is expected.

I think the most important point of today's hearing is that since this is a new trend or event in Medicare, there is a need for new policies, particularly advance notice to beneficiaries.

Particularly, there is something called the advance notice of changes, which is due on September 30th, that right now only focuses on benefits and out-of-pocket costs and does not include any mention of changes in networks, so, if any changes in networks were included in that September 30th, notice with the open enrollment period running from October 15th to December 7th, I think that would give beneficiaries the notice they need and the time to decide a new plan—for example, in New Haven, the Aetna plan—or perhaps to shift back to traditional Medicare.

We might also note if you pick that December 30th date, then plans would be negotiating with physicians, and I do think there is both not only the beneficiary point of view but the physician point of view, but that plans need to engage in that discussion and negotiation then much earlier in the year in order to provide the adequate notice to beneficiaries.

I think in conclusion that there is a broad background to the issue that suggests that network narrowing is reasonable—it has certainly been historically understood and accepted—but that as

we move from these, again, $1,100 a year extra payments to plans to something closer to costs in traditional Medicare, that new policies dealing mostly and foremost with beneficiaries, but also with physicians, are needed at this time.

Thank you very much.

Senator BLUMENTHAL. Thank you very much.

Judith Stein.

STATEMENT OF JUDITH STEIN, ESQ.,
FOUNDER AND EXECUTIVE DIRECTOR OF
THE CENTER FOR MEDICARE ADVOCACY

Ms. STEIN. Thank you very much for holding this hearing, Senator Blumenthal, and for coming back home, and the same to Senator Murphy.

I mentioned to Senator Whitehouse that in addition to having longstanding alliances with Senators Murphy and Blumenthal, I have a family of my daughter, son-in-law and children in Providence, Rhode Island, both of who went to Brown, so it is really wonderful to have you here today.

Senator WHITEHOUSE. Which we take terribly seriously, so thank you for mentioning that.

Ms. STEIN. As you know, I am the founder and Executive Director of the Center for Medicare Advocacy, which I founded in 1986, after having done elder and health care law at Connecticut Legal Services for 10 years.

The center is a private, nonprofit organization. I think it is the only organization in the country that can boast it is based on the quiet corner of Connecticut and has a satellite office in Washington, D.C. We are in Mansfield, Connecticut, and we serve the entire state and also hear from people, and try and advocate as best we can, from those all over the country.

The center provides education and legal assistance to advance fair access to Medicare and quality health care for Medicare beneficiaries throughout the country and Connecticut. We represent Medicare beneficiaries, respond to over 7,000 calls and e-mails annually, host web sites, webinars, publish a weekly electronic and quarterly print newsletter, and provide materials, education and expert support for Connecticut's CHOICES program.

I am also proudly a member of the executive committee of the Connecticut Elder Action Network formed and hosted by the Connecticut Commission on Aging.

We are an unusual organization in the country in that there are not too many of us who represent Medicare beneficiaries, and, as a consequence, we also formed and host the National Medicare Advocates Alliance, where some few dozen of us meet regularly, and the center provides issue briefs to keep people abreast of Medicare issues and how to help low and middle-income, chronically ill, elder and disabled people.

As you know and as the reason for our hearing today, in 2013, UnitedHealthcare jettisoned approximately 2,250 providers and health care facilities from its Connecticut Medicare Advantage network—2,250. That is a huge number, particularly in this small state—about one physician or hospital or nursing home or other health care provider lost for every 27 people in the United network

in the state and for every 260 Medicare Connecticut beneficiaries. Neither physicians nor Medicare patients were given adequate notice of this extraordinary decision.

As the 2013 Medicare enrollment period and year came to a close, many older and disabled people enrolled in a UnitedHealthcare Medicare Advantage plan learned that their doctors or local hospital would not be available to them in United's reduced Medicare Advantage network in 2014.

We began to receive calls at the center from people who had heard this news and were frightened, from our friends at the Connecticut Medical Society, from our friends in all the offices of our very fine congressional delegation.

On December 7th, I presented at a meeting held by Rosa DeLauro, Congresswoman from the Greater New Haven area in Wallingford. When we had a Q&A, about 25 percent, maybe 30, of the questions asked by the 150 people on Medicare in the audience were about their UnitedHealthcare problems.

Many others did not learn until after the new year.

Others will not learn—and this is very important—until they seek medical care in 2014. Only then will they find that their doctor or other health care provider is no longer in their Medicare plan.

In fact, we have been asked why CMS is not hearing about this problem, and I think the answer is two-fold.

How would people know to contact CMS? Who is and what is CMS from the point of view of the older and disabled people who rely on Medicare, and their families? How do they know where to call? I can tell you 1–800–MEDICARE is not the place.

Secondly, as I indicated and as others have noted, many, many people will not know about this until they seek medical assistance into the year. That is when we know, historically, we find people calling us about Medicare Advantage and Medicare regularly.

Many people think that Medicare Advantage means that they have an advantage to their regular Medicare, that it is something on top of their Medicare.

Under ordinary circumstances, we often get calls after February or March from people who cannot get health care from their traditional doctor.

One client of ours and his family learned about the United network cut only when health care was urgently needed. Susan W. called the Center for Medicare Advocacy on behalf of her parents who are both in their 80s.

He had a stroke in 2013, with bleeding in his brain. He was helicoptered from his local hospital to Yale—New Haven Hospital due to the complexity of his condition. Now he is finding in the middle of his care that his medical and rehabilitation needs are severely limited and further complicated by the United Medicare Advantage network cuts.

His longtime primary care doctor is no longer in-network, and I echo the comments of the good doctors—that that is the relationship that matters to people.

His local hospital is no longer in United's Medicare Advantage network. He must travel farther to another unknown hospital, far-

ther from his elderly wife, and find a new doctor in the midst of getting care for a stroke.

Most importantly, he cannot obtain the nursing care or rehabilitation he needs at the nursing home closest to his wife and community since it, too, has been cut from United's Medicare Advantage plan.

As with many Medicare beneficiaries, Mr. W has long been in traditional Medicare with supplemental Medigap coverage, but he switched to United's Medicare Advantage plan in 2011, like my uncle, because it was less expensive. This worked until he became ill and United exercised its business prerogative to severely reduce providers from its Medicare Advantage network.

We know we will hear at the center from many other people like Mr. W and his daughter as the year proceeds and they need health care, but their providers, their doctor, their hospital, their nursing home, in some instances, their home care agency are found to no longer be in the Medicare Advantage network.

United's health care actions would be bold in the private health insurance market. They should not be tolerated in the public Medicare arena. All Medicare Advantage plans, including United, as Professor Biles just testified, are paid more—more—by taxpayers than it would cost to provide the same coverage in traditional Medicare.

While I respect my colleague from AHIP, I have yet, over my 30-plus decades of doing this work, to find one of these plans regularly providing coordinated care. In fact, not only has my 92-year-old uncle just had terrible problems with his Medicare Advantage plan, with no coordination of care, but we often find that, despite the public funding being more than that which would be necessary for people getting the same care in traditional Medicare, Medicare Advantage plans often provide less when people are truly ill.

United owes its Medicare enrollees and providers at least timely notice and a fair remedy when significant network reductions like these are planned. It owes its Medicare enrollees and taxpayers a truly adequate array of providers when it is receiving public funds—robust payments. It should not be able to enroll Medicare beneficiaries one year only to decimate its network the next.

What protections can be put in place?

First, for current United enrollees like Mr. W, who have been hurt by provider cuts, they should receive help. Further Congress should act so that such severe network reductions do not happen in the future. Accordingly, the Center for Medicare Advocacy recommends the following:

•First, to protect current UnitedHealthcare Medicare Advantage enrollees—and we know this is happening in other states; New York, Rhode Island, Florida—require UnitedHealthcare, because it is receiving robust public funding, to pay the in-network rate on behalf of individuals such as our client, Mr. W., who cannot find the quality care they anticipated in-network.

•Second, provide a special enrollment period for UnitedHealthcare Medicare Advantage enrollees so that they can either change to another Medicare Advantage plan or reenter traditional Medicare and receive the care from all of the networks available to them.

•Third, require UnitedHealthcare to provide quality transition services to enrollees such as Mr. W., who are in the middle of treatment, so that they are—and also, the gentleman who testified—spoke to the press this morning—so that they can limit the disruption of their health care. That gentleman and Mr. W should be able to continue their care with the providers they know and who have been treating their very desperate medical situations.

Secondly, how can we protect future Medicare Advantage enrollees from what we are hearing are expected future network cuts because the plans will no longer be getting 14 percent more? That is what ACA did. It started to scale back paying 14 percent more to private plans to be in the system.

Now they can be in the system, but, why should taxpayers and all Medicare enrollees be paying what was about $150 billion over 10 years additional Medicare Advantage plans than would be necessary in traditional Medicare?

Require Medicare Advantage plans to provide notice, at least, I said, 60 days, but the notice that Professor Biles suggested in the ANOC, the notice that goes out, of change, on September 30th would also do, when more than a certain percentage of providers are to be cut from a Medicare Advantage plan—significant advance notice prior to the beginning of the enrollment period on October 15th.

Review the definition of an adequate Medicare Advantage network, to ensure all necessary services are available within a truly reasonable geographic area. Norwalk, as we know her in Connecticut, is not truly a reasonable geographic area for a gentleman with end-stage renal disease to get to the care he needs when he lives in Bridgeport.

Limit the percentage of each kind of provider a Medicare Advantage plan may cut from its network.

Require Medicare Advantage plans to pay as if an enrollee's provider was in-network if the plan is determined by CMS to have unreasonably reduced its Medicare Advantage providers.

Provide a special enrollment period for Medicare Advantage enrollees to change Medicare Advantage plans or reenter traditional Medicare if their plan is determined to have unreasonably reduced its provider network.

Importantly, level the playing field between the two Medicare models. For example, include a prescription drug benefit in traditional Medicare and identify other incentives in the Medicare Advantage program that entice beneficiaries to migrate from traditional Medicare to Medicare Advantage, and these were really put in place in the law that was passed in 2003.

Retain reasonably priced first-dollar Medigap coverage. I know this will be before you, Senators, in budget cuts that you will be looking at, and there is this notion that people should buy Medigap coverage but pay out of pocket before it comes into effect. This will further push people to Medicare Advantage.

As is the case in Connecticut and some other states, make it a Federal requirement that Medigap insurance offer enrollment. Wider access to Medigap will give Medicare Advantage enrollees more flexibility to return to traditional Medicare if their Advantage plan no longer meets their healthcare needs.

In conclusion, Connecticut's older and disabled community, and our Nation's older and disabled community, deserve better treatment than they have received from UnitedHealthcare's Medicare Advantage plan. This kind of behavior should not happen again, and Medicare beneficiaries caught in this year's dramatic network cuts should be helped.

Thank you for holding this hearing and for giving me the opportunity to testify.

Please let me know if the Center for Medicare Advocacy can do anything further to help.

Senator BLUMENTHAL. Thank you very, very much.

I want to assure, by the way, all the witnesses that your full statements will be in the record. We are going to make them a part of the record, without objection.

Let me turn now to Dr. Saffir.

STATEMENT OF MICHAEL SAFFIR, M.D., PHYSIATRIST AND PRESIDENT, CONNECTICUT STATE MEDICAL SOCIETY

Dr. SAFFIR. Thank you, Senator Blumenthal and Senator Whitehouse.

I would like to commend you, sir, on the recommendations that you have put together. They are very pointed and successful.

Good morning. I am Dr. Saffir. I am board-certified physiatrist in pain and sports medicine with the Orthopedic Specialty Group in Fairfield. I am the President for the Connecticut State Medical Society, representing more than 6,000 practicing physicians and physicians-in-training in the State.

I received my medical degree from the State University at Downstate Medical Center and completed my residency, training and fellowship in neuromuscular diseases and electrodiagnostics at the Rusk Institute, NY University.

In addition to my practice, I serve on the Connecticut State Worker's Compensation Commission and Medical Advisory Committee, where I helped to develop the current attorney-physician guidelines, insurance payer-physician guidelines, treatment guidelines and an RVU-based fee schedule.

I am also a member of the Connecticut Prescription Monitoring Program.

United's abrupt, significant cuts to its Medicare Advantage program in Connecticut are deeply concerning for both patients and physicians. United's actions will have significant negative effects on the physician-patient relationship, the patient access to care and continuity of care for Medicare beneficiaries—a vulnerable population with complex medical needs, including many with chronic conditions and disabilities that limit mobility.

When UnitedHealthcare decided to drop the physicians in Connecticut from its Medicare Advantage plan, they did it in a way that seemed to maximize confusion for patients and doctors.

I would like to let you know that we did ask directly to United. We actually had some of their senior medical directors fly into Connecticut to talk to us, and we were told that there was no cause; it was just a contract; it was not based on quality.

In fact, the United Medicare Advantage plan has an advisory panel with physicians. Most of them were unaware that this proc-

ess is going forward, and you would think that if you were making a medically based decision that your advisory panel would be involved, so many of them stepped down.

The physician terminations letters were sent by bulk mail in early October. Some received multiple letters indicating termination. Other doctors had no letter at all but found out by going to the web site and finding that the names had been removed from the provider directory.

Physicians who actually received a letter were given no reason for termination, which made it difficult to appeal.

Phone contact with United staff was challenging, as well as looking in the online directory.

Both patients and physicians had problems determining network participation. Terminated physicians were listed as remaining in-network. Physicians who had not received a letter were listed as dropped, and many physicians received some verbal assurance, but no written confirmation was provided, adding to the confusion.

United made those physician cuts just before the 2013 open enrollment period began on October 15th, and, as was highlighted here earlier, patients are required to choose a plan during that period, and once selected they are locked into that plan without other options. United failed to notify many patients of the network changes until mid-November, halfway through the open enrollment period.

From a physician care perspective, United's actions have been extremely disruptive. As physicians, we counsel our patients about health based on the most accurate and up-to-date clinical information. It is difficult to provide similar counseling when patients ask questions about whether or not we would be able to continue treatment and what the continuity of care would be. There was a lack of accuracy and timeliness of United's information for them to make decisions.

Many Connecticut State Medical Society, CSMS, members have shared their stories of patients who were confused and upset by the changes, because United gave patients no reason for the network changes, some patients were worried that the doctors may have done something wrong.

Most recently, United patients have received letters saying that they can switch to another doctor for their care, but when the patients call this doctor's office they are told they cannot be seen or will have to wait weeks or months for an appointment.

Why? United never bothered to ask those listed doctors if there was any room left in the patient panels or if they were able to accept Medicare patients.

Throughout this process, the Center for Medicare and Medicaid Services, CMS—their lack of oversight and enforcement has been disappointing. Simply regurgitating that United played by the rules is not enough.

A common-sense review of travel time and distances requirements for the elderly and medically vulnerable patients clearly showed that existing guidelines are unrealistic, even dangerous.

Following a 90-day notice guideline does not help patients or physicians when that notice was provided in a disorganized and incomplete manner. Even more critical, CMS did not seem to con-

sider the 90-day notice ran through the open enrollment period. Physicians had to make choices for their 2014 health care without knowing whether their doctors would be able to take care of them.

Even more, for complicated patients with multiple medical conditions, they would have to see different physicians for these conditions and decide which physicians they would go with and which plan.

To calculate these decisions were challenging and difficult. No patient should have to make that choice.

Many of our members have had patients ask whether they could pay a little extra and stay with the doctor they know and trust. Patients were horrified to learn that their doctor—it was not a matter of a few dollars, but since there were no out-of-network benefits in the Medicare Advantage plans, they would have to pay the full cost. No patient should have to make that choice.

This is truly a watershed moment. United's actions have clearly shown that they place a higher priority on maximizing profit than maximizing their members' health.

Congress needs to recognize what is occurring here in Connecticut and across the country, in neighboring states like Rhode Island, and have patients have better choices when they are going into the open enrollment period.

I would advocate for that beneficiary notice that Professor Biles talked about as being an intelligent option.

The solution is simple. Patients' access to care needs to be protected and maintained for this most vulnerable population.

United needs to be held accountable for its lack of clarity and transparency in this process and should demonstrate that its actions do not jeopardize access to care and actual provision of care to patients.

CMS should provide a common-sense oversight of United and not simply accept the insurer's word that the networks are adequate.

What we would like to see happen is that improvements in oversight and policing occur and that changes in the law or regulations that CMS applies to these Medicare Advantage plans are implemented, and we look forward to working with you on it.

Senator BLUMENTHAL. Thank you.

Dr. Welch.

STATEMENT OF RAYMOND WELCH, M.D., DERMATOLOGIST, RHODE ISLAND DERMATOLOGY AND LASER MEDICINE

Dr. WELCH. Senator Whitehouse, Senator Blumenthal and Senator Murphy—did he leave?

Senator BLUMENTHAL. Senator Murphy had another commitment that he had to attend.

Dr. WELCH. I see.

Ladies and gentlemen, good afternoon. When I was asked to speak, I worried that perhaps I would be inadequate to address the policy issues. Thankfully, I do not have to do that. I could not possibly have said anything that addresses my concerns on a nationwide and Federal Medicare scale than what has been said.

What I can do as a practicing physician is address the personal side of this. I may add two additional things.

I want to take issue with the idea that the doctors that were terminated were terminated because of any inadequacy in their art or science.

Also, I would like to address the idea that UnitedHealthcare takes care of patients or any insurance company takes care of patients. I believe it is the physicians the nurses that do that, and I have never, when I had a concern about my patients, said, gee, I wonder what an insurance representative would say?

I challenge any doctor here—have you ever had help from an insurance company, stopping bleeding, setting a fracture, treating a cancer, an infection or an inflammatory disease?

Those of you who are not doctors or patients, have you ever been sick and said, gee, I hope there is an insurance agent who can help me with this fever?

Senator WHITEHOUSE. For the record, I have never seen an ambulance in Rhode Island go to an insurance office.

Dr. WELCH. Thank you.

In October 2013, we received a letter from UnitedHealth plan informing me that we had been terminated, effective February 2014 from the UnitedHealth plan Medicare Advantage program. We were informed this was by virtue of a contract that permitted termination without cause with 90 days' notice.

We requested information regarding the metrics that had been used to decide who was terminated. This request was denied on the basis that the information was proprietary.

Our appeal was held by a phone conversation with two UnitedHealth plan medical directors—UnitedHealth plan medical directors—on December 5th, 2013. Only one question was raised for discussion—did we feel that we were properly and legally notified?

We said, no, on the basis of many mistakes that had been in correspondence that was mailed to us regarding confusing us with other practices, et cetera.

In any case, our appeal was denied.

UnitedHealth plan has publically stated that their intention in contracting their Medicare Advantage network, by eliminating approximately one-third of Rhode Island doctors, is to improve quality while lowering costs. No data has been released describing how eliminating some of the finest doctors in Rhode Island will improve quality. I can only speculate how contracting the network will lower UnitedHealth's costs by increasing their profits.

I would like to share with you who my patients are that are affected by this termination. These are the same generation as our parents or, as some of us get older, our siblings. They are the veterans of three wars.

Ninety-four percent of my affected patients are skin cancer or pre-cancer patients, most of whom have had multiple skin cancers. One is a heart transplant who has had 164 separate skin cancers. Another saw four of her doctors, including myself and a cardiologist, terminated.

One patient, 88 years old and a survivor of 8 skin cancers in the last 13 years, kept asking, what do I do now, as I excised yet another squamous cell carcinoma from his chest. What do I do now?

Some of my patients are simply too old to understand what is happening to them. I dare say my mother, who is forgetful but not demented, would struggle with this.

Some clearly did not understand that there was a time deadline to change their insurance.

Some have told us they assumed that since there was no rational reason given for my termination that our appeal would be successful.

Since the termination, the State of Rhode Island and UnitedHealth plan cut a separate deal for the retirees. Patients will be allowed to see their terminated doctors as long as those doctors agree to accept the out-of-network fee schedule.

UnitedHealth is already our lowest payer and actually, for their MA plan, discount their payments to doctors. We expect the out-of-network fee schedule to be even further reduced. Nonetheless, we will accept the out-of-network fee.

This accounts for about one-half of our UnitedHealth Medicare Advantage patients.

About one-half of the remaining patients have switched their insurance to other carriers rather than lose their doctors, including the patient who stood to lose all four of her doctors and the heart transplant patient. This passes the burden of their obviously expensive skin cancer care to the new insurer and relieves UnitedHealth plan of this cost.

These people have to be taken care of. The cost is the same no matter who delivers it unless they get inadequate care or simply fail to find another doctor.

One of our patients switched back to traditional Medicare A/B with UnitedHealth, Medigap or supplemental insurance. Due to her skin cancer history, she saw her monthly costs double.

The remaining patients have stayed with UHP. Some are too old to understand what has happened to them. Some are in employer-provided retiree plans with no choice and cannot change.

A review of the dermatology providers UHP lists as available includes a doctor who is dead, doctors who have retired, doctors who have left the state, a doctor who is an internist and has no credentials in dermatology, doctors who are part-time or not seeing new patients. One of the doctors is me under an old EIN number and at an address I left 10 years ago in Providence.

Apparently, the doctor that——

Senator WHITEHOUSE. If you move back, do you think you would get coverage?

Dr. WELCH. I do not know because I think in order to qualify I have to continue to not see patients.

Most of the private practice dermatologists in Rhode Island have been terminated, including several of our finest dermatologists. I will back this statement up if anybody wants to talk to me later. I will give you names and credentials.

We have been told that UnitedHealth plan is telling Medicare Advantage patients with no out-of-network coverage, that if they try three times and cannot find another dermatologist, then UnitedHealth plan may issue a letter that allows the patient to continue with us for a given period of time. This suggests that

UnitedHealth plan realizes they do not have enough dermatologists to cover the loss of terminated dermatologists.

In summary, UHP has not improved quality by terminating about one-third of the dermatologists in Rhode Island—and, by the way, this goes for other specialties as well—particularly since the availability of qualified replacements in adequate numbers is questionable.

In fact, being forced to switch from providers such as myself, who were intimately familiar with their cases, to new providers may delay care. In the case of my patients, this means delayed diagnosis and treatment of skin cancer with increased morbidity, suffering and death for elderly patients.

It would appear that UnitedHealth may lower their own costs by passing on the costs of care for their more expensive patients to other insurance carriers or by paying terminated providers less to care for state retirees or by charging patients who switch to their supplemental Medicare plan an increased premium.

On my oath, I have sworn to serve the highest interests of my patients through the practice of my science and my art and that I will be an advocate for patients in need and strive for justice in the care of the sick. This is why I am here today, and I hope you will join me in defending our elderly patients' right to the best quality health care.

Thank you for allowing me to speak before this Committee, and I will try to answer any questions.

Senator BLUMENTHAL. Thank you, Dr. Welch.

I am going to turn first to Senator Whitehouse for his questions.

Senator WHITEHOUSE. Thank you very much, Chairman Blumenthal.

Let me thank all of the witnesses for their testimony. I thought it was a particularly helpful and instructive hearing.

What I extract from it is the conclusion that there are really three problems going on all at once in the middle of this.

One is a consumer protection problem, and that is that people are being subjected to a lot of potentially unfair treatment, a lot of confusion, a lot of anxiety, problems of due notice and, of course, the nuisance of having to accommodate by finding a new provider who may not be the one you are comfortable with. All of that creates, I think, a significant consumer protection issue.

Unfortunately, it is a consumer protection problem that falls most heavily on those who are sickest because it is for them that the anxiety and that the change will be the greatest. If you are healthy through all this and you never see a doctor, it is kind of an abstract problem that you have to face, but, when you are in the throes of a real illness, this is where it hurts you.

It is not only a consumer protection problem. It is a consumer protection problem that has a particular burden for those who are the most ill and the most vulnerable, so I think that is a very real concern.

The second problem is the problem of Medicare gamesmanship. As Ms. Stein mentioned, Medicare Advantage was supposed to compete head to head with Medicare and that she promised that it would be less expensive than Medicare when they fought for the right to compete head to head with Medicare, and by the time we

passed the Affordable Care Act in Congress, they were 14 percent above Medicare. They were being paid a premium when they said they could do it at a discount.

The Affordable Care Act gets rid of that premium, and that may enhance the incentive that private carriers have to cherry-pick the Medicare population, to try to make sure that the seniors who are golfing every weekend are the ones that they get and the ones who are in the hospital all the time are the ones that Medicare gets.

That would be consistent with a recurring problem that we are seeing in the American corporate world, which is an effort to privatize profits and socialize costs and use their power in government to take advantage of the general public for their own purposes, so you see it in a whole array of different areas, but it is certainly an acute problem here.

When you see the way this is done, there is at least a flag of suspicion up that they are doing this in order to dump expensive patients and to cherry-pick their patient mix and move expensive patients to Medicare and be able to make more money off of the population that they reserve.

Until that concern has been rebutted, I think it stands plainly as a logical concern.

The third is—and Senator Blumenthal, Senator Murphy and I are all keenly working on this—you know, we have got one of the most expensive health care systems in the world. Actually, we have the most expensive health care system in the world by a margin of about 50 percent above the second most expensive health care system in the world, which I think right now is Switzerland.

Doing something about that cost problem is vital. One of the tools to do something about that cost problem is a well-managed network, a good network, a high-value network, to use Ms. Kanwit's phrase.

High-value networks can lower cost. High-value networks are measured by good outcomes produced by the doctors in the network, good electronic health record information technology in the network, good—what would you call it—coordination of care and handling of patients between doctors and specialists in the network and providing the very best care and not unnecessary care and eliminating errors and all that kind of stuff. All of that is very much worth doing.

There is a final problem here, which is that when an insurance company chooses to use its network for a bad purpose, for the purpose of cherry-picking, for the purpose of shoving expensive patients over to Medicare and keeping the less expensive ones for itself—which remains, as I said, an unrebutted proposition here in this hearing because United would not show up—there is an opportunity cost.

You cannot have a network that is at once designed to dump your more expensive patients and at the same time is designed to be the high-value network that should be the goal of our system. You make a choice. You cannot choose both. It is one or the other.

When you choose the path that United appears to have chosen, you are foregoing the path of a responsible high-value network, and that should be of concern to all of us.

I really do not have any questions so much as to get your feedback on whether you think I have properly extracted the three harms that are at issue here, and, in my view, there has been no testimony to rebut at this point the, I guess, default proposition that United is behaving in exactly those ways.

Ms. KANWIT. Senator, if I may, I cannot speak to United where AHIP was not directly involved in that, clearly, but I would like to talk about two of the issues you raised.

I appreciate your nod to high-value networks because we, too, at AHIP think that is the way—we think it is the way to go in the future to get our costs under control and our quality up.

On the consumer protection problem, our testimony covers, but there is more information.

CMS has extensive, extensive rules, actually consistent with some of Ms. Stein's suggestions, which allow for both adequacy of care and continuity of care—adequacy being that the network, the MA network, must have providers both in a geographical sense and in a quantity sense, enough specialists, enough PCPs, primary care providers, to make access easy for that particular beneficiary.

There is that adequacy thing and then coupled with the continuity of care provision, which is also enshrined in our code of Federal regulations, which CMS administers, talking about what happens when a beneficiary either cannot get adequate care within a network. That beneficiary can get out-of-network care at the in-network price if he or she needs, for example, a specialized oncologist somewhere, so those issues are there on the continuity.

If there are network changes, which there will inevitably be—and CMS, as a matter of fact, wisely, Senator, wants to keep flexibility so that health plans in the MA space can do innovations. That is one of the points of MA, but that flexibility——

Senator WHITEHOUSE. I will concede to you that there are CMS rules that help protect against some of the worst possible consumer protections, but I hope you will concede that the testimony we have heard today shows that for a lot of consumers this choice by United has been a very anxious-making, discouraging, inconveniencing and, in some cases, potentially even care-threatening or compromising occasion.

Ms. KANWIT. I do not have the facts to opine on that, to be honest with you. I have not followed it, and I just know what is in the public wheel and the conversation here this morning.

Senator WHITEHOUSE. Okay.

Ms. KANWIT. I do think that there are consumer choices out there, if I could point out quickly.

For example, there are 12 MA plans, as Professor Biles has talked about the other consumer choices. There are about 12 other MA plans in the State of Connecticut, and those plans, in turn, have different benefit designs that a consumer could choose.

In Rhode Island, there are five MA plans that a consumer could also go to.

Senator WHITEHOUSE. But you agree that the number of plans that is available does not cure a problem of short notice or notice that somebody does not really, you know, experience the problem until they have signed up and then the problem detonates and they

go to their doctor for the first time six months later and he says, by the way, I am not in the network any longer.

I think those are consumer protection problems that are not solved by the existence of other networks because the person's choice was not either informed or prepared enough for them in order to be able to take advantage of the other networks.

Ms. STEIN. Senator, I would comment that the issue with network analysis—unfortunately, there had been a medical review process where there had been some oversight on the CMS side in the past, but that was streamlined so that it was simply a calculation of numbers and a list of names.

As my colleague to my right here pointed out, some of those names were people who were dead or who moved out of the state or did not practice correctly.

An insightful analysis is clearly required. Simply just saying, oh, yes, you know, there are 50 names, and this should take care of it, and they can handle everything you need; we have not checked with them; we do not know if they are alive, is not adequate.

Senator WHITEHOUSE. You would think very much that a high-value network determination would pick up the deadness of a doctor.

Ms. KANWIT. Absolutely.

Ms. STEIN. Further, it is my understanding that—I think quite audaciously, if I am correct—the Connecticut congressional delegation requested a list of the names of the doctors who were in that work still and those who were not and was unable to get that information.

Whatever protections there are were clearly inadequate, and also, I think that this demonstrates perhaps an outlier activity; that is, it is unusual.

United is—I think, you know, you have got Medicare, Medicaid and United. United, like, owns healthcare in this country.

Senator WHITEHOUSE. It is big.

Ms. STEIN. It is very dangerous, and it is branded by AARP, so people go to United.

I had people say to me, well, I am not affected, right, because I am still with AARP, so, while there are protections, they clearly have been inadequate.

The definition of an adequate network needs to be reviewed to make sure it really meets the needs of, first the beneficiaries and then the physicians.

I can tell you as a breast cancer survivor, if you are in the midst of getting care, you do not have a fungible oncologist, a radiation oncologist, an infusion center. These things are not just going to one Wal-Mart or the other.

I would urge a review of what protections did not work and what needs to be done to make them work.

Certainly, this cannot be proprietary information. My office could not get the information, but, how can the United Connecticut delegation not get this information, and how can CMS and this Administration, which I know and love, have been so, I think, repeating—regurgitating, I think the doctor said—the statements that it meets the rules?

Maybe it did, but it obviously shocks equity and good conscience, what has happened, which means the rules are inadequate.

Senator WHITEHOUSE. Well, thank you.

Ms. STEIN. We need to level the playing field with traditional Medicare.

Senator WHITEHOUSE. I am going to very shortly return to Rhode Island, which, in our neck of the woods, we think is a long drive from here. We think a drive from Providence to Newport is a long drive in Rhode Island; so, from Hartford, back.

Let me take this opportunity to thank Chairman Blumenthal for holding this hearing. I really, truly do think it has been instructive.

In addition to the individual cases, I really think that as we are looking forward at how we fix the health care system and solve the huge 50 percent extra cost burden that Americans forced to bear because of the inefficiencies in the cost system, we are really playing with fire, and our insurance companies are really playing with fire when they are messing around with networks.

We had bad network behavior in the bad old HMO days, as you will remember and as a lot of Rhode Islanders still remember, when what got you into the network was cutting a special deal with the insurance company; it had nothing to do with the patient.

Those were bad old days, and the HMO situation got so bad that Hollywood made movies about people who were, you know, the victims of that HMO mentality. Now we have to fight against that now that we have patient-centered and high-value networks that need to be done.

If the whole process of pulling physician networks together gets made disreputable by behavior like this, it is going to be very hard to take the steps we really need to have to build the high-value networks that Ms. Kanwit spoke so eloquently about.

There is a real carry-on cost to the health care system, and I think to all of us, if we do not get this right and if we do not take the kind of action that Senator Blumenthal is leading on.

Again, my pleasure to be here, and I will excuse myself and thank my Connecticut colleagues for their hospitality today.

Senator BLUMENTHAL. Thank you, Senator Whitehouse. We wish you well on your long drive back to Rhode Island, and thank you so much for your leadership in this area.

I might just say since we had on this panel two former attorneys general, as well as two former United States attorneys, part of this problem strikes me as enforcement. You know, what Senator Whitehouse referred to as the flag of suspicion—I think it is more like a cannon burst so far as possible illegality here is concerned.

After all, a court has found that United Healthcare Group very probably broke the law and, therefore, has enjoined its abusive action.

I guess I want to pick up on what Judith Stein emphasized and others have alluded to—why isn't there better Federal enforcement in this area?

Most people, as you remarked, do not know what CMS means, what those initials stand for and what its role or responsibility is.

There are really two elephants in this room. One is United Healthcare, and the other is CMS and why it has not taken more effective action.

I just to confirm what Ms. Stein said. In fact, the Connecticut delegation sought this information from United Healthcare, and they were unwilling to provide it.

Let me open that question to all of you, having observed for a long time Federal enforcement efforts in this area, and let's turn the light on CMS and other agencies that have a responsibility.

Dr. BILES. Senator, I think my response would be you are exactly right, and part of that, of course, is both the number and the expertise of the individuals in CMS responsible for managing what is now a $120-plus billion a year program.

I think CMS has, of course, many responsibilities—hospitals, physicians—across the board. I think in terms of the numbers and maybe particularly the focus in this area, I would say, has been lacking.

I know in our case we are interested in data, being researchers. If we look at the Federal center that provides data, they have over 100 databases with physicians, hospitals, prescription drugs. There is not a single database that has been released on the Medicare Advantage program.

Beyond that, again, just issue by issue—and I think Judy could comment—they have just been very reluctant to view this as a kind of Federal program with the sort of transparency that one would expect in a Federal program.

Ms. KANWIT. Let me also say that, to come to the defense of CMS, they have had these regulations in place, our plans work hard to comply with them, Senator, and that the regulations—that CMS wants the plans to have the flexibility in Medicare Advantage to make innovations that are not possible in the Medicare fee-for-service system.

As Senator Whitehouse so eloquently said, we need to move away from the rigidified—the disjointed—Medicare fee-for-service system to a much more collaborative and communicative thing with doctors and hospitals and health plans all working together to get health care costs down.

Medicare Advantage was supposed to be innovative. It was supposed to provide benefits. Hence, it is a little more costly although not always.

Medicare Advantage—actually, Medicare Advantage beneficiaries in many cases are two percent lower in local markets—the premiums—than fee-for-service. Two percent lower.

It is not always—and it is not comparing apples to comparing if you compare fee-for-service, with all due respect to Ms. Stein, to Medicare Advantage because the Medicare Advantage has so many more benefits tacked on than the Medicare fee-for-service.

Senator BLUMENTHAL. I understand your point in the abstract, and you are right that Senator Whitehouse was very powerful and eloquent in describing the dynamic of what is supposed to be occurring.

What we have here is 61,000 patients whose health care was severely jeopardized. They were put through the emotional wringer, not to mention the possible detrimental effect to their health care of, at the very least, opaque and abrupt treatment by United Healthcare, not only in Connecticut but in Rhode Island, in Ohio,

in Florida, across the country. It was not an aberrant occurrence here.

In Connecticut, the medical society went to court, and I joined them, not because I have any legal standing—in fact, I do not—but I was representing the interests of those patients. They were representing the doctors.

I think the question can be legitimately asked—where was CMS?

If CMS felt it did not have the resources or the authority, don't we need to do something about that enforcement gap?

Obviously, I appreciate your coming to their defense, but I do not mean that you are personally responsible to answer the question.

Ms. KANWIT. No, I am speaking generally for the Medicare Advantage program, Senator, and the advantages it brings to beneficiaries who are very, very happy generally. Over 90 percent, I mentioned, happiness rates and satisfied rates with the Medicare Advantage program.

CMS also has come out with statements in this particular case, the United case—again, I do not speak for United——

Senator BLUMENTHAL. Thank you.

Ms. KANWIT. [continuing]. Talking about the open enrollment periods, et cetera, one of which we are in the middle of right now, until February 14th.

Senator BLUMENTHAL. Let me turn to the other witnesses who may have some response to the question I have raised.

Dr. SAFFIR. Well, we were going to comment that in terms of communication, obviously, this is an example where communication was not well done, so that enhanced value of communication did not clearly not occur in this situation.

We did try to reach out to United to get answers. I know that you sent letters. The delegation sent letters.

The attorney general sent letters, and did not get answers.

We did send requests out to CMS and got answers that were less than satisfactory, and those examples are available, and I am sure have been submitted as part of the paperwork and information for this hearing, so that was not satisfactory.

I think that the network analysis needs to have better review. Like I said, United had a medical advisory panel that was unaware of this process. They should have been engaged. When you make a medical adequacy decision, it makes sense to have doctors involved.

In terms of deciding how to best manage costs, I mean, your brother published an article in the New England Journal that talked about these costs and ways to look at it. It cannot be done working with just bureaucrats since it involves the health care of patients. You have to have doctors involved.

Ms. STEIN. Senator, when Medicare Advantage came into effect in 2003, there was, in fact, the movement to privatize Medicare happened. It did not happen with Social Security, but it happened with Medicare and, to me, shockingly, to the extent of taxpayers and all Medicare beneficiaries paying a huge amount more in order to do that.

It is true that the law, I think, needs to be reviewed because there was a sense that this was not always state action—and I know you know what I mean by that—but these were private enti-

ties and that, yes, the government was not intertwined in the way it is with the traditional Medicare program.

These private entities receive huge amounts, as you know, of public dollars in a way that is actually partly responsible for the alleged bankrupting of the Medicare program. United is not entitled to be a Medicare Advantage plan, and somehow the American people have misunderstood, have not been heard enough, of what we are paying, what it is costing us, to have private insurance plans be part of Medicare.

I suspect that AHIP—I do not know—is as sorry as any of us that United did what it did because it is creating a huge problem for the good guys in the system, but they are the biggest guy, or one of the biggest guys.

We have to make sure that the laws that were put into effect, largely as a consequence of the law that was passed in 2003 and the regs that followed, which were at the time very much intended to move people to Medicare Advantage—and that happened.

It used to be you could move back from traditional Medicare to Medicare Advantage at this time. This Administration switched that. The philosophy switched. The implementation and the regs have not caught up.

If from this hearing we actually could believe that we would look at the regs to see if they meet this kind of circumstance, when in fact the clever notion to deal with the doctors and that removes the sick patients—clever, I say in a negative way—shows us how much can happen under the current regs.

We need to make sure that the burden is on the plan to show that what it has done is to lead to innovation, good flexibility, true coordination of care and more services, not $75 toward eyeglasses, not a health club membership, but all those things that the MA plans and their industry always want to tell us. The burden should be on the plan to show that value is really happening.

I can tell you I am one of the few attorneys who represents Medicare beneficiaries as my career. It has yet to be shown to me. We were told that in Medicare+Choice, and we have been told that in Medicare Advantage.

This whole country is paying dearly for what is not good flexibility. This kind of flexibility is terrible. Medicare could not get away with it.

What is innovation?

What is coordinated care?

What real more services are being offered?

I think those regs and the burden of showing that needs to be really reviewed.

Ms. KANWIT. Senator, may I just quickly respond?

Yes, two quick points to Ms. Stein's questions.

On the quality issue, the data out there—and these are not AHIP's data; they are in respected publications, like Health Affairs, and we cite them in page three of our testimony—show the huge quality differences: 17 percent, 20 percent for breast cancer, diabetes, cardiovascular disease, et cetera, in Medicare Advantage plans, so there are demonstrable quality differences.

I also cannot let go unanswered Ms. Stein's impassioned plea on the alleged motives for the network changes that United, or anyone

else, ever makes in the Medicare Advantage plan. There is really no incentive for an MA carrier to plan to cherry-pick, as Senator Whitehouse talked about.

All of it is risk-adjusted. The premiums that the plan gets are risk-adjusted by CMS, so it does not—the plan can take on a person with six chronic illnesses versus a person who is playing golf every day and not be hurt financially.

There is also guaranteed issue in Medicare Advantage. Anyone can sign up—whether you are healthy as a horse or have 20 chronic diseases.

The point is there is no particular incentive for plans to do that, so I just want to correct the record on that.

Dr. WELCH. May I speak?

Senator BLUMENTHAL. Of course, Dr. Welch.

Dr. WELCH. Thank you.

Blue Cross-Blue Shield of Rhode Island has taken on—is it 8,500—8,500 more patients as a result of this, patients who would not leave their doctors.

As I pointed out, my patients are skin cancer patients. They need a lot of procedures that are expensive, so those patients are no longer part of United Health's risk pool.

In addition, they discount the fees that they pay to us below what Medicare pays.

Now, just so everybody understands, the way that the Medicare fees are arrived at—there is a panel of doctors called the RUC panel which makes recommendations across specialties. These are considered by the government—CMS, I believe—and then relative values, procedures and services are assigned that are felt to be fair and equitable.

United Health, to get these efficiencies, discounts those. They then charge the patient a $40 co-pay, so, for a $45 service, that means the patient pays $40, United Health pays $5, and the doctor discounts his services.

I think that there is financial incentive here.

Another point that troubles me—you mentioned earlier that these—there is a phrase I need to have documented. I think the first word is value. Does anybody remember what that phrase is?

Value? The panels have value?

Ms. KANWIT. High-value provider networks.

Dr. WELCH. High-value provider networks, right.

Oh, by the way, thank you for commenting. I admire your courage.

One of the ways that you said that those high-value would be determined was through published metrics by a which a doctor could be determined to be providing good quality care, something like that. Maybe I am paraphrasing you.

Ms. KANWIT. No, that is accurate.

Dr. WELCH. Okay. Well, let's suppose those are there.

I will, to you, lay out my credentials, my 33 years of experience, my record in taking care of patients, my honors and awards. I will lay that out.

United Health will not tell us the metrics upon which we were judged nor will they share their data.

The importance of the data is there are mistakes in here—bad providers.

By the way, that dead dermatologist was excellent five or six years.

They make mistakes, but we are not allowed to evaluate the data.

I am confident that my quality and my skills would equal any dermatologist practicing in New England. I challenge you to show otherwise, publically, in any court you want—basketball, tennis, court of law. Prove it. Okay?

Put your money up. Prove it.

Otherwise, what you have done is you have taken a doctor who is devoted his career to caring for his patients and managing skin cancer away from those patients and said, go find another doctor.

We are not widgets. We are not interchangeable parts. Some of us specialize in one thing. Some of us are interested in another. There are reasons that the doctors in Yale dermatology, by the way—who, I believe, were all terminated—are ranked among the highest in the world.

Forgive me. I told my wife I would not get passionate.

Senator BLUMENTHAL. Thank you, Dr. Welch.

Dr. WELCH. You are welcome, sir.

Senator BLUMENTHAL. Just for the record, because Ms. Stein mentioned it, I want to say United Health Group is, in fact, the largest Medicare Advantage provider, at least in Connecticut, with 43 percent, as I mentioned earlier—61,000. The next largest is Emblem Health, which has 32 percent and 45,000. The next largest are Aetna with 16 percent; WellCare Health Plans, five percent; WellPoint, four percent.

United Health Group is not just a small outlier. It is the major provider in Connecticut, and my guess is a major provider in those other states where similar kinds of opaque and abrupt actions have been taken.

Dr. Saffir, did you have something?

Dr. SAFFIR. You mentioned Emblem Health, and so I had the opportunity to get together with some of my colleagues in New York, and I am sure Senator Schumer was also paying attention to this, but Emblem Health had also considered doing some network changes, but, given the reaction and the, I guess, sloppy nature that United incurred, they decided to back off.

It, again, leads me to believe that it was profit-based because if it was for the good of the patients and they backed off, then that is a sad mistake, but I think that they realized this opportunity to make their networks more profitable was not the time to be taken now.

I think the example that United, as the large payer that it is, needs to be the example that we look at how we do this better. I think that is a clear example.

I also say the regular Medicare program, for the amount of services it delivers, has been shown to be one of the most efficient in terms of the net medical loss ratio costs. What it provides versus its overhead expenses—what the CEOs, what the administrators, what everybody else gets—are not exorbitant in the regular Medi-

care system compared to what the salaries might be for some of the for-profit health plans.

Ms. STEIN. Yes, I think that is one of the things I would like to have. I keep being frustrated that people are not being told, at least in Connecticut, you can get back to traditional Medicare and see your physicians—speaking to your constituent.

It is extraordinarily important for them to know that.

Unfortunately, the way this system is stacked towards MA now, towards private Medicare, it means they have to pick up a Medigap plan, and in many states they cannot do that. In Connecticut, happily, we have extra protections, but it is expensive.

That is part of the reason that we need to look at how can we level the playing field and then let the private market in if it can play according to the same rules, but do let people know that they can go back to traditional Medicare, and in Connecticut they can get, if they need, a Medigap plan.

Senator BLUMENTHAL. I will just tell you that my office has been dealing with tens, if not hundreds, of inquiries, trying to direct them in ways that can reassure them and restore the health care that they feel they need and deserve, and the kind of practical work that you are doing with your clients, I think, has been enormously valuable as well.

Professor?

Dr. BILES. Senator, I was just going to comment. Generally, as we have said, this is a national issue, and it is one that is likely to increase.

I think a point that has just been made is that the five major plans—United, Kaiser, Humana, Blue Cross, WellPoint and Aetna—have more than 60 percent of the enrollees nationwide, so here we see a giant, out-of-state insurer, but that is not unique. That is the pattern primarily across the country.

The lessons from here are not just for Connecticut but for the Nation.

I think then back to the three points that Senator Whitehouse made; I think the advance notice by September 30th would make a big difference and particularly if the plans then interacted with their physicians earlier than that.

They will complain they do not get their rates until September, but to use that an excuse not to make this sort of information available to beneficiaries during the self-enrollment period, I think, is wrong.

Secondly, CMS has never done very much in this physician network adequacy area, and, again, to some extent, when they are overpaid by——

Senator BLUMENTHAL. CMS—just for the record and for the understanding of everybody who is listening today, CMS actually has a legal responsibility in that area, does it not?

Dr. BILES. Yes, but this is not an area, I think it is fair to say, particularly since these very substantial extra overpayments beginning in 2006 that really focused in this area.

Again, as the payments ratchet down, this does become an area in which the individuals at CMS would need to create a whole new team and people to manage that.

Then I think the third area is this whole risk adjustment and gaming, and I do think, on one hand, Medicare Advantage has the best risk adjustment system in the country. On the other hand, it requires plans to submit data, and you would guess that plans have resisted submitting more and more data, so I think that is a third area in which your kind of comments about CMS's diligence is probably appropriate.

Ms. KANWIT. You know, MA plans, to the professor's comments, really want to make their beneficiaries happy. They want to do a good job. They want to follow CMS regulations. I do not know why they would resist producing data to CMS.

We, at AHIP, just for example, Senator, have a really good working relationship with CMS. We talk to them all the time about issues related to this.

They provide incredibly detailed oversight. They just proposed, actually just last week, additional rules in the Part C Medicare Advantage space, so they are looking at this with a fine-tooth comb.

I think the regulation is particularly adequate and what we are discussing here today is how to move the American health care system, Senator Whitehouse said, into the 21st Century and couple cost efficiency and get the quality.

One final point to the professor's comments—the real issue here is how many choices have, and it does not make any difference how big a particular plan or how small a particular plan is in the Medicare Advantage space, say, in Connecticut.

What really counts is consumer choices. There are 12 different MA carriers, MA plans, in Connecticut, and, as I mentioned, each of those plans have different permutations of those plans. You can have an HMO plan, a PPO plan, within MA, so consumers have a lot of different MA choices.

Senator BLUMENTHAL. Well, consumer choice is an extraordinarily valuable feature until there is bait and switch, and then consumers may choose but may find that their choices put them in a position they had not expected.

I think there has been some of that here. Bait and switch is a fair way to characterize what the effect has been.

In addition to egregiously deficient notice, I think there has been fairly common agreement—I do not want to speak for everyone—that the notice here left a lot to be desired.

Remember, after patients were notified, they were also told that their physicians could appeal, and so they might remain in the network anyway, and they had a deadline to make decisions.

Nobody can forgive them for being more than a little bit confused and anxious about the choices that they had under this system because they had no idea what the consequences of choices would be in addition to the complexity of the system.

All of the permutations, you know, are a little bit like—I do not want to impugn another industry, but we all know the fine print that can often make choices more confusing or misleading or even deceptive.

I think that this hearing has been enormously valuable, as Senator Whitehouse said, and your testimony will be a part of the record.

I am going to close this part of the hearing at this point.

You have been very, very helpful and cooperative.

As long a journey as the Senators may think they had, some of you have come from much longer distances, and we truly appreciate it, including Rhode Island, Dr. Welch, and thank you very much for being here today.

If you want to add anything to your statement, we are going to keep the record open for a week so that you can feel free to submit anything else in writing that you would like to do, and we will make that part of the record also, without any objection.

Thank you very much.

Ms. KANWIT. Thank you very much.

Ms. STEIN. Thank you, Senator.

Senator BLUMENTHAL. We will hear now from Mr. Buccieri if he is agreeable to doing so.

By the way, while you are switching, I want to give a particular thanks to the staff of the Committee on Aging, who has been so helpful and cooperative.

I also want to thank my staff for their excellent work. Rich and Laurel are here today. I think many of you have spoken to them and others on my staff who have been so helpful.

Mr. Buccieri, I want to again thank you for being here today. Both your bravery and your eloquence are very much appreciated not only by myself but the Committee as a whole, and I want to really thank you for, again, sharing your story as you have with my staff and the public and just allow you to briefly summarize your experience with the Medicare Advantage plan in which you were enrolled.

Mr. BUCCIERI. Thank you for the opportunity.

My name is Robert Buccieri, B-u-c-c-i-e-r-i. I have been on United Healthcare Medicare Advantage plan for almost two years, and I think that they have done—thus far, it has been a great policy up until the fall when I started receiving one letter after another letter after another letter of cancellations—my nephrologist, the doctors at Yale Transplant, one by one, the medical group they belong to, as well as the dialysis center in Norwalk.

It has been an emotional roller coaster, dealing with this, and I thank you and your staff for helping me along the way. We are not done, but I think we are making progress.

I just wish that United Healthcare, even with their responses, was more definite instead of vague. In one letter I just got yesterday, it said I could see my doctor for 25 minutes from like a 4-month period. I do not even understand what that means, and it is things like that.

With the dialysis, even it is so many visits, but it is just difficult because even if I see my doctor and they give you a 90-day window, if it is not resolved in another 90 days, I have to do it all over again, and who knows what is going to happen at that point.

Senator BLUMENTHAL. I gather there was some emergency condition that required you to seek treatment immediately.

Mr. BUCCIERI. Yes. Well, my doctors have been very good at stabilizing, but progression is very slow, and right now I am in stage five kidney disease, which I guess is called end-stage renal disease, and I am on the transplant list that, you know, they have in the hospital, and even just maybe a week ago I received a phone call

from United Healthcare saying that maybe I could go to Boston or maybe I could go to New York. Who wants to go to New York or Boston when you have one of the best hospitals in the State of Connecticut?

It is just things like that.

Senator BLUMENTHAL. These network changes have real-life practical consequences for your treatment—where it is done, by whom and so forth.

Mr. BUCCIERI. Absolutely.

Senator BLUMENTHAL. Has Yale been helpful and cooperative—Yale-New Haven?

Mr. BUCCIERI. They have, and you know, people have been very good about helping, even the reps I have at my health care, but obviously, they are very limited to what they can do or what they can say, and I have asked for them to get things in writing, but even with that, it has not come through.

Senator BLUMENTHAL. Have you sought to contact United Healthcare?

Mr. BUCCIERI. On many occasions. As I said, I guess my nurse liaison or nurse case manager for my health care is very good, and she has been calling the dialysis center because at one point she said that they signed a national contract, but my problem was—or my question was my nephrologist is the medical director of the dialysis unit. I said, how is that going to affect, or is that going to affect, the situation?

She was unsure, and she called back and said that some are changing the doctors and using a different nephrologist.

I have been with this doctor for, I guess, two years, and I have a very good rapport with him, and I want to continue that. I do not really want to start a new doctor.

When they asked me that maybe I could go to New York or Boston, I said that is a possibility, but then you begin again at the bottom of the list, and here we go, you know, waiting another couple of years or who knows how long.

Senator BLUMENTHAL. You begin at the bottom of the list in terms of eligibility for the transplant.

Mr. BUCCIERI. Yes.

Senator BLUMENTHAL. You begin with a new doctor whom you do not know, and you have to go to a place that is distant from where you live.

Mr. BUCCIERI. Yes.

Senator BLUMENTHAL. All of those factors make it very, very difficult and different to receive health care under those terms.

Mr. BUCCIERI. That is true.

Senator BLUMENTHAL. Is there anything else that you would like to add?

I know that my staff has been very much engaged in seeking to help you, and we appreciate your cooperation in that effort, too.

Mr. BUCCIERI. I appreciate the help, and your staff has been very helpful—Grady, in particular.

I think the main thing—obviously, I would like to get the whole thing solved and get my doctor back, but if in fact they cannot, I would like to get some sort of notification in writing saying what I can do because even if they say I can see my doctor, how do I

go to the doctor and tell them that I want to see someone out of network, but do not worry; they are going to get paid for it?

You know, I think it is going to be very difficult.

Senator BLUMENTHAL. Well, thank you again for being here.

Grady Keefe of my office and I are going to continue working with you and fighting for you.

Again, we are very, very grateful—the whole Committee is—for your attendance today and your participation. Thank you so much.

Mr. BUCCIERI. Thank you for this opportunity and the help you have provided.

Senator BLUMENTHAL. Thank you.

I am going to close the hearing.

As I mentioned earlier, the record will stay open for one week in case any Committee members have questions for the witnesses or if the witnesses have additional submissions.

With that, this hearing is adjourned. Thank you.

[Whereupon, at 3:47 p.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

Provider Networks in the Medicare Advantage Program

by

Stephanie Kanwit, J.D.
Principal, Kanwit Healthcare Consulting

on behalf of
America's Health Insurance Plans

for the
Senate Special Committee on Aging

January 22, 2014

I. Introduction

Chairman Blumenthal and members of the committee, I am Stephanie Kanwit, principal at Kanwit Healthcare Consulting, and I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. I previously served as Special Counsel to AHIP from 2004 until 2010, and prior to that was a partner in a Washington, D.C. firm specializing in health care law and head of Aetna's litigation

department, based in Hartford. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate this opportunity to testify on issues surrounding provider networks in the Medicare Advantage (MA) program, and strategies our members are employing in this area to hold down costs and improve value for their enrollees. In the MA program, health plans have a strong track record of offering high quality coverage options, with innovative programs and services to serve seniors and individuals with disabilities. One strategy that plans are pioneering involves the use of high-value provider networks. In recent years, health plans – initially in the commercial marketplace and more recently in MA – have implemented programs that encourage enrollees to obtain care from high-value providers that have demonstrated, based on performance metrics, their ability to deliver high-quality, cost-effective care. We appreciate the committee's interest in learning more about these innovative programs and other opportunities for improving patient care for MA enrollees.

Our testimony focuses on the following:

- Background information about the MA program, including its role as a safety net for over 14.5 million seniors and individuals with disabilities, the value MA plans deliver to beneficiaries, and the deep funding cuts that have been imposed on the MA program through recent legislative and regulatory changes that may negatively impact beneficiaries.

- The opportunity for high-value provider networks to preserve benefits and mitigate the cost impact on beneficiaries as the MA program faces a future of severe underfunding.

- The leadership role health plans are playing in advancing delivery system reforms.

II. Background on the Medicare Advantage Program

More than 14.5 million seniors and people with disabilities currently are enrolled in MA plans because they value the care coordination and disease management activities, improved quality of

care, and innovative services and benefits that are available through these plans. These MA enrollees account for approximately 28 percent of the Medicare population.

MA Plans Provide Value to Beneficiaries

MA plans offer a different approach to health care delivery than beneficiaries experience under the Medicare fee-for-service (FFS) program. MA plans have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. MA plans also help to reduce emergency room visits for routine care, ensure prompt access to primary care physicians and specialists when care is needed, and promote communication among treating physicians about the various treatments and medications a patient needs.

The success of these strategies is evidenced by survey findings which show that MA enrollees are highly satisfied with the care they receive through their health plans. A February 2013 North Star Opinion Research survey found that 90 percent of beneficiaries are satisfied with their MA plans, 94 percent are satisfied with the quality of care they receive, and 90 percent are satisfied with the benefits they receive.[1]

Furthermore, a broad range of research findings consistently demonstrate that the innovative strategies adopted by MA plans translate into better health outcomes for enrollees:

[1] North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

- A 2013 study published in *Health Affairs* found that MA plans' performance measures for breast cancer screening, diabetes care, and cholesterol testing were consistently better when compared to FFS Medicare. For example, in 2009 mammography screening rates were over 13 percent higher, eye tests for individuals with diabetes were 17 percent higher, and

cholesterol screening rates for individuals with diabetes and cardiovascular disease were 7-9 percent higher in MA plans compared to FFS.[1]

- Data published in February 2012 in the *American Journal of Managed Care* indicated that the hospital readmission rate for MA enrollees was about 13 percent to 20 percent lower than for Medicare FFS enrollees.[2]

- A study published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a MA special needs plan (SNP) had "seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare."[3]

- Research published in November 2010 in the *American Journal of Managed Care*, coauthored by researchers affiliated with The Brookings Institution and Harvard University Department of Economics, concluded that MA plans outperformed the Medicare FFS program in 9 out of 11 clinical quality measures.[4]

The value that MA enrollees receive through their plans also can be seen in the additional services and benefits that are offered by MA plans – but are not available in the Medicare FFS program. While these extra features vary from plan to plan, the following are specific examples of the additional services and benefits that many MA plans offer to improve enrollees' coverage and manage their overall health and well-being on an ongoing basis:

- Case management services;

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[1] Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. "Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare." *Health Affairs* 32. no. 1228-1235. July 2013.

[2] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104. This study was preceded by a series of working papers and reports published by AHIP's Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in Medicare Advantage than in Medicare FFS among patients with at least one admission.

[3] Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients." *Health Affairs*. January 2012. Vol. 31, no. 1, p. 110-119.

[4] Brennan, Niall MPP & Shepard, Mark BA. "Comparing Quality of Care in the Medicare Program." *American Journal of Managed Care*, November 2010.Vol. 16 No. 11, p. 841-848.

- Disease management programs;
- Wellness and prevention programs;
- Coordinated care programs;
- Prescription drug management tools integrated with medical benefits;
- Tools and data collection to address disparities in care for minorities;
- Nurse help hotlines;
- Enhanced coverage of home infusion, personal care and durable medical equipment;
- Personal health records to offer beneficiaries greater control over their health information and to coordinate information better; and
- Vision, hearing, and dental benefits coordinated with medical services.

MA plans also protect beneficiaries from high out-of-pocket costs. In 2014, all MA plans offer an out-of-pocket maximum for beneficiary costs, and almost 60 percent of enrollees are in plans that have annual out-of-pocket maximums of $5,000 or less. These out-of-pocket maximums – which are not offered by the Medicare FFS program – help protect Medicare beneficiaries from catastrophic health care expenses that otherwise might pose a serious threat to their financial security. MA plans also help reduce out-of-pocket costs for enrollees by reducing premiums for Part B and Part D, and by limiting cost-sharing for Medicare-covered services, including primary care physician visits and inpatient hospital stays.

MA Has Strong Consumer Protections, Including Network Adequacy Standards

Another important feature of the MA program is that enrollees have strong consumer protections. This includes extensive network adequacy standards, established by the Centers for Medicare & Medicaid Services (CMS), which ensure that enrollees in MA plans have access to all provider types, including primary care physicians and specialists, within a reasonable time and distance. The agency works with MA plans when network changes are made to ensure that beneficiaries continue to have access to the benefits and services they need.

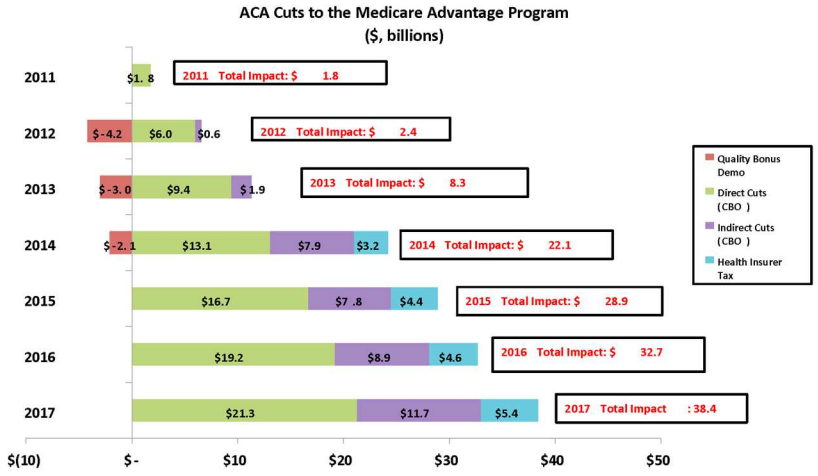
Additionally, coverage is "guaranteed issue" and MA plans offer coverage to all beneficiaries regardless of their age or health status, although Special Needs Plans (SNPs) enroll only vulnerable beneficiaries who meet certain criteria. All beneficiaries who choose an MA plan pay the same premium as all other plan enrollees. CMS performs annual reviews of MA plan benefit packages to ensure that they are appropriate to beneficiaries with all health conditions. In addition, nearly 90 percent of all MA enrollees are enrolled in MA plans that offer Part D prescription drug benefits, which allows beneficiaries to receive medical and prescription drug coverage from the same health plan – similar to how people receive coverage in the commercial market. MA plans typically re-design and reduce the cost sharing that applies under the Medicare FFS program. They may offer lower cost sharing as an additional benefit and typically eliminate deductibles and establish copayments rather than coinsurance.

Additional consumer protections provide that an MA enrollee who is not satisfied with a plan's decision about providing or paying for covered services may exercise appeal rights through an internal plan appeals process, as well as automatic external review if the plan's decision is not wholly in the beneficiary's favor. MA plans also comply with detailed requirements associated with CMS oversight activities that include operational and financial audits, evaluation of quality improvement projects, validation and evaluation of data on a broad spectrum of operational activities (e.g., customer service, resolution of appeals, and provider network adequacy), review and approval of plan marketing materials, and strong standards for the conduct of marketing activities.

The MA Program Faces a Future of Severe Underfunding for Enrollees' Benefits

While it is very clear that the MA program is highly valued by beneficiaries, we are deeply concerned that the program is facing a future of severe underfunding that jeopardizes the stability of these plans for the beneficiaries they serve.

The Affordable Care Act (ACA) imposes more than $200 billion in funding cuts on the Medicare Advantage program over a ten-year period. Through December 2013, only 10 percent of these cuts had gone into effect. Another 35 percent of the ACA funding cuts will be phased in between 2014 and 2016. MA enrollees are further impacted by the new ACA health insurance tax that went into effect on January 1, 2014. An actuarial study[5] by Oliver Wyman found that this will require MA plans to allocate an estimated $16 to $20 per enrollee per month in 2014 and $32 to $42 per enrollee per month by 2023 for the ACA health insurance tax, which is imposed on top of the ACA's significant funding cuts. The average expected increase in the cost of MA coverage as a result of the health insurance tax is estimated to be $3,590 per enrollee over ten years. This number represents a direct reduction in the resources that will be available to support the health care benefits of more than 14.5 million Medicare beneficiaries who value the improved quality of care, additional benefits, and innovative services their MA plans provide.



To further illustrate what these cuts mean for beneficiaries, the table below provides data estimating the combined impact of the ACA's funding cuts and the new health insurance tax on MA enrollees in Connecticut in 2015. These data show, for example, that the combined impact will be an estimated $50 per member per month – or $600 for the entire year – for MA enrollees

[5] Oliver Wyman, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans*, October 31, 2011.

in five counties (Fairfield, Hartford, New Haven, New London, Windham). In Litchfield and Middlesex Counties, the combined impact is estimated to be $60 per member per month or $720 for the entire year. In Tolland County, the combined impact is estimated to be $70 per member per month or $840 for the entire year.

2015 Medicare Advantage: ACA's Estimated Impact Per Member Per Month

Methodology Notes:
• Enrollment data is based on analysis of December 2013 CMS enrollment data posted at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/MCRAdvPartDEnrolData/01_Overview.asp.
• Payment cut estimates are based on AHIP modeling. Assumes no changes in MA enrollment patterns and enrollment in 4-star and above plans increases to 55% nationwide by 2017. Incorporates growth rate assumptions based off the 2014 May CBO Baseline with growth rates of -.8% in 2015, +2.2% in 2016 and + 2.9% in 2017. Does not account for Regional PPOs. Estimates are rounded to the nearest 10th.
•Health Insurer Tax estimates are based upon findings in Oliver Wyman study, "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans" (October 31, 2011).

State	County	MA Enrollment	MA Penetration	Estimated 2015 PMPM Impact: ACA Payment Cuts	Estimated 2015 PMPM Impact: Health Insurer Tax Cuts	Estimated 2015 Total PMPM Impact (Payment Cuts + Health Insurer Tax Cuts)	Estimated Annual Impact (Payment Cuts + Health Insurer Tax Cuts)
Connecticut	Fairfield	30,901	22%	$20.00	$30.00	$50.00	$17 million
Connecticut	Hartford	41,742	26%	$20.00	$30.00	$50.00	$25 million
Connecticut	Litchfield	6,655	18%	$30.00	$30.00	$60.00	$4 million
Connecticut	Middlesex	7,059	22%	$30.00	$30.00	$60.00	$5 million
Connecticut	New Haven	40,415	27%	$20.00	$30.00	$50.00	$23 million
Connecticut	New London	8,005	16%	$20.00	$30.00	$50.00	$5 million
Connecticut	Tolland	5,616	24%	$40.00	$30.00	$70.00	$5 million
Connecticut	Windham	4,282	21%	$20.00	$30.00	$50.00	$3 million
State Total		144,675	24%				$87 million

In the face of these funding cuts, MA plans are working hard to maintain access to high-value benefits and services for their enrollees. However, in 2014, beneficiaries across the nation are beginning to experience the impact of these cuts in the form of higher out-of-pocket costs, fewer choices, and reduced benefits. Beneficiaries in over 2,000 counties across the country in which more than 60 percent of all MA enrollees live have fewer plan options today compared to 2013, and many enrollees are experiencing higher premiums and out-of-pocket costs.

Looking forward, we have serious concerns about the underfunding of the MA program and how this will harm beneficiaries – particularly vulnerable enrollees with complex needs and low incomes – as the ACA's cuts are phased in at an increasingly faster rate over the next several years. These concerns underscore the importance of maintaining the future viability of the MA program and avoiding any additional funding cuts through either the legislative or regulatory process. We urge the committee and the entire Congress to focus instead on providing relief,

before even deeper cuts begin to take effect in 2015, to avoid further disruptions in the choices and benefits of MA enrollees.

III. The Role of High-Value Provider Networks

As a direct result of the serious funding challenges facing the MA program, the need is greater today than ever before for innovations that deliver increased value to beneficiaries with the increasingly limited resources that are available to support the MA program. In response to this challenge, MA plans are working to preserve benefits and improve quality for enrollees by developing high-value provider networks at a time when the nation is transitioning toward a 21st century health care system and away from FFS payment systems. We urge the committee to view these efforts through this prism as you focus on these innovations.

Improving Quality and Efficiency Through High-Value Provider Networks

In the effort to advance delivery system reforms, one of the many areas in which health plans, including sponsors of MA plans, are making great strides is in the development of high-value provider networks. Health plans typically develop these networks using performance metrics – with a strong emphasis on quality criteria – to select high-performing, cost-effective providers. Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans can create select or tiered networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality.

A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value network and tiering programs most often focus on cardiovascular conditions, diabetes, preventive services, and patient safety. This study[6], authored by AHIP researchers and published by *Health Affairs* in August 2013, focused on data from 23 health plans and identified 546 distinct performance measures that plans are using in various payment and delivery models. Process, outcome, and utilization measures accounted for 80 percent of these performance measures. The study concluded that policymakers and stakeholders who seek less variability in the use of performance measures to

[6] A. Higgins, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs* 32, no. 8 (2013).

increase consistency should balance this goal with the need for flexibility to meet the needs of specific populations and promote innovation.

A central goal of high-value provider networks – including those offered by MA plans – is to improve both health care quality and efficiency through ongoing evaluation of provider performance, assessment of resource use, referrals to other high-performing providers, and the exchange of health information with the plan and other providers caring for the same patient. Private sector high-value networks also discourage enrollees from using poor quality providers and services that have been shown by evidence to be ineffective. Additionally, these strategies to move towards greater reliance on high-value networks may also be used by health plans to offer technical assistance to providers in organizing care, and provide physicians with other decision support tools and ongoing feedback on performance compared to peer groups.

Another key advantage of high-value provider networks is that they create strong incentives for providers to offer competitive prices, in response to the increased number of patients they gain as a member of the network. This, in turn, enables health plans to deliver substantial savings to their enrollees, in addition to connecting them to high-quality providers.

Research Findings on the Benefits of High-Value Provider Networks

A number of studies and research findings indicate that high-value provider networks are successful in encouraging consumers to take advantage of better-performing providers and facilities while helping to reduce spending. For example:

- One plan's program assesses providers across 21 specialties based on quality of care and cost efficiency, with the best-performing providers receiving a "Premium Two-Star" designation. This program yields an estimated average savings of 14 percent, with savings ranging from 7 percent to 19 percent depending on physician specialty.[7]

- Another plan's tiered provider network uses clinical performance and cost efficiency criteria to assess providers in 12 specialties and enables employers to set the level of incentives to

[7] UnitedHealthcare Insurance Company, UnitedHealth Premium Designation Program: FAQ for Employers (2011).

reward employee behavior. The plan reports that its high-value providers are 1 percent to 8 percent more cost-efficient relative to other providers within the network.[8]

- Recognizing in-network hospitals and selected specialties (general surgery, ob-gyn, cardiology, orthopedics, and gastroenterology) on quality, cost efficiency, and accessibility performance generated savings for one plan of up to 10 percent.[9]

- A study of a high-value network in California found that the use of provider tiers resulted in 20 percent lower health care costs and 20 percent higher quality.[10]

- In California, some of the largest employers – including the state employee program (CALPERS) – have offered a high-value plans option with premium savings of up to 25 percent over traditional broader network plans.[11]

- Health plans are also incorporating high-value and tiered networks as part of new innovations in care delivery and payment – including adoption of patient-centered medical homes and value-based insurance design. By combining multiple payment and benefit design strategies, these innovations are assuring greater value and efficiency in care delivery while promoting affordable coverage.[12]

IV. Other Health Plan Innovations in Delivery System Reform

In addition to advancing high-value provider networks, health plans – in both the commercial market and in public programs – have demonstrated leadership in implementing a broad range of delivery system reforms and new payment models.

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[8] Institute of Medicine, *U.S. Roundtable on Evidence-Based Medicine* (Washington: National Academies Press, 2010).

[9] BlueCross BlueShield of North Carolina, *New BCBSNC Products Offer Cost Savings for Individuals and Employers* (Chapel Hill, NC: BlueCross BlueShield of North Carolina, December 12, 2012).

[10] R. Steinbrook, "The Cost of Admission – Tiered Copayments for Hospital Use," *New England Journal of Medicine* 350, no.25 (2004): 2,539-2,542.

[11] Duke Helfand. "A shift toward smaller health networks." *Los Angeles Times*; April 3, 2011.

[12] Joseph Burns. "Narrow Networks Found to Yield Substantial Savings." *Managed Care*; February 2012.

Partnering With Providers to Address Both Quality and Efficiency

Health plans are redesigning payment mechanisms to move away from the practice of rewarding volume through FFS payments and toward encouraging better outcomes and improved efficiency through accountable care organizations (ACOs), patient-centered medical homes, and bundled payments. In moving away from retroactive payment to a prospective design, these new models are built on accountability, shared risk, and population-based care.

AHIP has convened three invitational summits over the past two years bringing together health plans and their provider partners to discuss how they have restructured their payment contracts, key features of their programs, and the results they are seeing. While these initiatives are at various stages of development and implementation, we have observed two distinct features that are fundamental to the new models being launched across the country: (1) collaboration between health plans and their provider partners; and (2) both quality performance and cost reduction goals are being negotiated. This approach allows health plans to engage in meaningful population-based measurement and gives providers confidence that performance metrics are transparent and fair.

Another major development is that health plans are redesigning benefit structures at the same time they are changing payment mechanisms. These changes are designed to work synergistically to reward providers for achieving results, while also rewarding patients for making choices to use higher-performing hospitals and physicians and regularly obtaining services that are crucial for chronic care management. Strategies advancing either payment restructuring or benefit design cannot work optimally if they are working alone. To maximize results, they need to be aligned and coordinated, and health plans are in a unique position to make that happen.

In building new payment models, health plans are offering their provider partners more data, as well as decision-support tools. These data help physicians recognize gaps in care, such as which patients need comprehensive case management, which patients are most at risk of developing serious conditions, and which are in need of immunizations and preventive care.

From our research, we have noted several characteristics that are present in today's plan-provider collaborative models that are yielding promising results. Buy-in for these new arrangements must

start with leadership. Clinical integration, a culture of initiating change, a robust health information technology infrastructure, and acceptance of new payment arrangements are all key criteria.[13] In addition, a relationship of three or more years is critical to achieving efficiencies among all partners.

Preliminary data suggest that new private sector ACO models are off to a strong start, with initial quality improvements of approximately 10 percent, a 15 percent decrease in hospital readmissions and total inpatient days, and an initial annual savings of $336 per patient.[14]

Plans also are moving to budget-based methodologies in their provider contracts.[15,16] This approach combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments tied to nationally accepted measures of quality, effectiveness, and patient experience. Other developments in the market today involve the creation and implementation of non-financial infrastructure and support systems. Plans have introduced an array of programs designed to support physicians with patient-centered medical homes, providing access to skilled care coordinators, improved data sharing, and reporting among participating practices.[17,18]

Patient engagement and consumer transparency tools are important complements to enhanced provider partnerships. Health plans are working closely with patients on an array of programs that help increase medication compliance, promote rewards for seeking health appraisals and meeting personal goals, and provide low-cost or no-cost coverage for certain preventive and other high-value benefits. Health plans also are making information about premiums, costsharing, and deductibles available in readily understood, web-based formats.

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[13] Ellis P, Sandy LG, Larson AJ, Stevens SL. Wide variation in episode costs within a commercially insured population highlights potential to improve the efficiency of care. *Health Affairs* (Millwood). 2012;31(9): 2084-2093.
[14] Higgins A, Stewart K, Dawson K, Bocchino C. Early lessons from accountable care models in the private sector: partnerships between health plans and providers. *Health Affairs* (Millwood). 2011;30(9):1718-1727.
[15] Song Z, Safran DG, Landon BE, et al. The 'Alternative Quality Contract,' based on a global budget, lowered medical spending and improved quality. *Health Affairs* (Millwood). 2012;31(8):1885-1894.
[16] Markovich P. A global budget pilot project among provider partners and Blue Shield of California led to savings in first two years. *Health Affairs* (Millwood). 2012;31(9):1969-1976.
[17] Patel UB, Rathjen C, Rubin E. Horizon's patient-centered medical home program shows practices need much more than payment changes to transform. *Health Affairs* (Millwood). 2012;31(9):2018-2027.
[18] Raskas RS, Latts LM, Hummel JR, Wenners D, Levine H, Nussbaum SR. Early results show WellPoint's patientcentered medical home pilots have met some goals for costs, utilization, and quality. *Health Affairs* (Millwood). 2012;31(9):2002-2009.

Innovations in value-based insurance design (VBID) have been developed to help improve health – encouraging individuals who are healthy to stay healthy, and encouraging individuals with certain risk factors, and/or those with chronic conditions, to seek treatment. A key component of these strategies is a health-risk assessment (HRA) tool, along with administrative data to help plans identify individuals at risk and provide customized action plans. Indeed, data from a number of sources show that these programs are helping to increase drug therapy compliance among chronically ill patients[19] and producing non-medical benefits, including increased productivity among the working-age population, and reduced absenteeism.[20] Another important step has been the development of culturally competent care plans that bring together the patient, the patient's family and/or caregivers, and a team of providers and experts to coordinate medical care and necessary home and community-based services.[22,21]

V. Conclusion

Thank you for considering our views on these critically important issues. We look forward to continuing to work with committee members to strengthen and preserve high quality, affordable health plan choices through the MA program, while ensuring – as essential steps toward achieving this goal – that funding for the MA program is stabilized and that MA plans have the flexibility to advance high-value provider networks and other innovations that promote quality and efficiency for Medicare beneficiaries.

Additionally, our members are fully committed to continuing to play a leadership role in advancing delivery system reforms that improve health care quality and efficiency for Medicare beneficiaries and the broader U.S. population.

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[20] Fendrick AM. Value-based Insurance Design Landscape Digest. National Pharmaceutical Council. July 2009. [22] Gazmararian J, Carreón R, Olson N, Lardy B. Exploring health plan perspectives in collecting and using data on race, ethnicity, and language. *American Journal of Managed Care*. 2012;18(7):e254-e261.

[21] Claffey TF, Agostini JV, Collet EN, Reisman L, Krakauer R. Payer provider collaboration in accountable care reduced use and improved quality in Maine Medicare Advantage plan. *Health Affairs* (Millwood). 2012;31(9):20742083.

MEDICARE ADVANTAGE: CHANGING NETWORKS and EFFECTS ON CONSUMERS

Committee on Aging
United States Senate
Hartford, Connecticut
January 22, 2014

Brian Biles, MD, MPH
Professor, Department of Health Policy
School of Public Health and Health Services
George Washington University

Senator Blumenthal and Senator Whitehouse, thank you very much for convening this hearing today on this new and important Medicare issue.

The focus of this hearing -- the "network narrowing" of physicians by United HealthCare's Medicare Advantage plans -- is an important issue now in Connecticut and is certain to become even more important all across the nation in the years ahead. New Medicare policies to address the situation discussed here today will be very important to elderly and disabled Medicare beneficiaries both in Connecticut and nationwide.

I am Dr. Brian Biles. I am a physician and a professor in the Department of Health Policy at George Washington University. My research at GWU, supported by the Commonwealth Fund, has focused on Medicare and managed care plans, with an emphasis on the costs and quality of care for beneficiaries for more than 10 years. At GWU, my team has analyzed Medicare Advantage (MA) plan costs per Medicare beneficiary relative to average costs in traditional Medicare fee-for-service (Traditional Medicare) since 2006. Most recently we have modeled the impact of the MA plan policies in the Affordable Care Act, when fully implemented in 2017, on MA plans and Medicare beneficiaries. Copies of these studies are included for the record.

The focus of today's hearing is United HeathCare's recent action to reduce the number of physicians participating in the United HeathCare's Medicare Advantage network in Connecticut for 2014.

The United HealthCare MA plans will not include over 2,000 providers in CY 2014 that were previously included in the United provider network in Connecticut. Most notably, United HealthCare did not extend participation in its MA plan network of physicians by the Yale Medical Group.

This issue especially focuses on the effect of this timing of the announcement of this reduction which was _____, after the beginning of the Medicare beneficiary open enrollment period that ran from October 15 to December 7 in 2013.

The term "network narrowing" has been used to describe the reduction of the number of physicians participating in a managed care plan's physician and provider network. Today I will focus my comments on five areas regarding MA plan "network narrowing" as a national issue of importance to the elderly and disabled that now requires new Medicare policies.

The first and most important point is that Medicare beneficiaries always have the option to be covered by traditional Medicare and receive their care from the large majority of the physicians in the nation who participate in traditional Medicare fee-for-service. Since its inception in 1982, Medicare managed care plans have always been a voluntary option to, and not a replacement for, the basic traditional Medicare program.

Second, the managed care plan "network narrowing" that we now see in Connecticut is neither new nor limited to Medicare. The fundamental concept of HMOs and managed care began with the Nixon proposal in 1971. HMOs subsequently expanded significantly in the 1990s and became a national issue at that time.

Now, the Kaiser Family Foundation, which tracks private employer health insurance coverage, reports that employed based health insurance has seen the number of employers whose largest plan is based on a more narrow or "high-performance" provider network increased from 15% percent in 2007 to 23% in 2013.

Third, Medicare has paid private plans more than the costs in traditional Medicare fee-for-service – or "extra payments" – for beneficiaries enrolled in the plans beginning with plans in rural counties in the Balanced Budget Act of 1997. Extra payments to MA plans were extended to virtually all Medicare private plans nationwide by the Medicare Modernization Act of 2003, the legislation that established the Medicare prescription drug benefit.

Our research at GWU found that extra payments to MA plans in 2009 averaged 13% and $1,100 per enrollee for total of $___ b in annual extra payments.

Fourth, as Medicare extra payments to MA private plans are gradually reduced over many years, from an average of 113% of costs in traditional Medicare in 2009 to an average of 101% in 2017, by policies included in the Affordable Care Act, MA private plans across the nation will need to become more efficient – including by selecting physicians and other providers that practice a more efficient, effective model of care.

Fifth, new policies that protect Medicare beneficiaries but that also allow MA plans to develop narrow networks are important. These policies would include clear advance notification to beneficiaries of changes in physician networks before the beginning of the MA plan open enrollment period on October 15 and special enrollment periods. They would also include an special enrollment period for enrollees in a MA plan that reduced its provider and physician network in the middle of a plan enrollment calendar year.

I will now discuss these five points in somewhat more detail.

The first, and most important, point relative to changes in Medicare Advantage plan physician networks is the underlying fact that Medicare beneficiaries may always choose to be covered by, and receive their care from, physicians in the traditional Medicare fee-for-service program.

Traditional Medicare is the nation's largest health insurance program and has the largest physician network of any insurer. MedPAC reports that a 2011 survey of Medicare patients in traditional Medicare, and for comparison 50- 64 year olds in private health insurance, found that overall access to physician care by Medicare beneficiaries is good. The survey found that "while most Medicare beneficiaries have multiple doctor appointments in a given year, most beneficiaries continue to report timely appointments" and that "Medicare beneficiaries were more satisfied with the timeliness of their routine appointments" than the privately insured under 65 population.

It is especially notable that, in spite of the national pattern that trains a many fewer new US physicians in primary care that other nations, only 1.3% of Medicare beneficiaries reported a major problem finding a primary care physician.

The second point is that managed care plans with limited or "narrow" networks are neither new nor limited to Medicare. This is not surprising given the national attention to increasing health care costs – first in the early 1970s as Medicare and employer health care costs increased, next twenty years ago in the early 1990s by employers and insurers, and now again by employers in recent years.

The first proposal to address increasing health care costs by establishing private managed care plans was made by President Nixon in 1971, in the era of increasing health care costs following the implementation of Medicare in 1966. The initial Federal health maintenance organization, HMO, development program was adapted from the Kaiser-Permanente group practice model system. It anticipated that the all of the new HMO plans would include limited numbers of selected physicians and providers. These plans would manage the costs of care for by limiting each of the price, volume and intensity of medical care.

The early approach to restraining health care cost increases based on HMOs with limited provider networks was expanded nationwide in the early 1990s during a recession as employers sought to limit employee health insurance costs. This focus on limiting heath care costs with

narrow provider networks was subsequently lost in the late 1990s with a robust economy and a vigorous backlash to the strictures of managed care by both physicians and employees.

More recently, there has been a renewed interest by employers in health insurance plans with limited networks. The Kaiser Family Foundation tracks private employer health insurance coverage with an annual survey. Kaiser reported in September 2013 that among large firms with employer based health insurance, the firms with a largest plan that included a more limited "high-performance" provider network increased from 15% in 2007 to 23% in 2012.

The third point, and the one that explains the most about why Medicare plans have had very extensive provider networks, is that Medicare from 2006 through 2010 explicitly paid private plans in virtually every county in the nation more that the costs for the same beneficiary in traditional Medicare fee-for-service.

Beginning with the enactment of prospective payment to HMO plans by Medicare in 1982, private plans were paid 95% of average cost in traditional Medicare in the county. Studies by CBO and others later found that, to inadequate risk adjustment of payments, Medicare in this era actually paid the HMO plans more than average costs in traditional Medicare.

In 1997, the Balanced Budget Act of 1997 for the first time explicitly paid Medicare plans – those in rural areas – more than average costs in traditional Medicare in the same county. These extra payments to MA plans in rural areas were extended to plans in counties with low costs in urban areas in 2000, and then to Medicare private plans in all areas of the nation by the Medicare Modernization Act of 2003.

Our research at GWU found that with the MMA payment policies, extra payments to MA plans nationwide averaged 13% and $1,100 per enrollee in 2009. The costs of extra Medicare payments to MA plans in excess of costs in traditional Medicare fee-for-service were projected by CBO at just more than $150 b over 10 years in 2009.

The fourth point is that the ACA included a number of new policies to reduce future Medicare payments and make Medicare more efficient. These policies, in addition to reducing future Medicare payments to hospitals and other providers, phased down the extra payments to MA plans over seven years to a national average of 101% of the costs of traditional Medicare in 2017.

As Medicare extra payments to MA private plans are gradually reduced over the seven years through 2017, MA plans will need to change their internal organization and operation. These changes will logically include new provider organization and payment policies since payments to providers average 85% of plan operating costs. History and current plan practices in the employer market suggest that changes by MA plans to accommodate the phase out of extra payments will likely include some "network narrowing".

The fifth point is that new policies Medicare that would both protect beneficiaries while allowing MA plans to pursue "network narrowing" in future years are very important at this time.

The most important of these new beneficiary protection policies would include clear advance notification to beneficiaries of changes in physician networks before the beginning of the MA plan open enrollment period on October 15. Plan physician and provider changes would thus become part of the Annual Notice of Change (ANOC), that plans now report, which now include changes in MA plan benefits covered and cost sharing but not do include the clearly more important elimination of network physicians and providers.

The new October 1 ANOC change announcement would include the names and locations of all providers leaving the plan provider network. This pre-open enrollment notification would give every beneficiary enrolled in a MA plan adequate time to understand the personal meaning of any specific "network narrowing" for the following year that begins on January 1.

The new policy should also include a new Special Enrollment Period for MA plan enrollees if a MA plan acts to discontinue plan physicians or other providers during a plan calendar year.

Finally, the Medicare plan finder now includes no information on in-network physician and other providers.

In conclusion, Medicare beneficiaries are all elderly over the age of 65 or are permanently and total disabled. It goes without saying that many individuals in these two groups need and use large amounts of health care. Many of them depend on their primary care physician, and often on specific specialty physicians to keep them healthy and accommodating their medical conditional as much as possible.

In the future year, it will clearly be reasonable for MA plans to reduce their physician and other provider networks. These plan network changes should not be prohibited, but new and

important protections for elderly and disabled Medicare beneficiaries who depend on their physicians and other providers should be adopted now – in time for the new policies to be in effect by the fall of 2014 when the next round of MA plan "network narrowing" is likely to occur.

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
113TH CONGRESS, 2ND SESSION
HEARING REGARDING UNITED HEALTHCARE AND MEDICARE ADVANTAGE

January 22, 2014

Senator Blumenthal and members of the Committee, thank you for holding this hearing and inviting me to testify. I am Judith Stein, founder and executive director of the Center for Medicare Advocacy (the Center). The Center is a private, non-profit organization based in Mansfield, Connecticut with offices in Washington, DC and throughout the country.

The Center provides education and legal assistance to advance fair access to Medicare and quality healthcare for Medicare beneficiaries throughout Connecticut and the United States. We represent Medicare beneficiaries throughout the state, respond to over 7,000 calls and emails annually, host websites, webinars, and publish a weekly electronic and a quarterly print newsletter. The Center also provides materials, education, and expert support for Connecticut's CHOICES program. I serve on the Executive Committee of the Connecticut Elder Action Network (CEAN).

IMPACT OF RECENT UNITED HEALTHCARE ACTIONS

As you know, in late 2013 United Healthcare jettisoned approximately 2,250 providers and healthcare facilities from its Connecticut Medicare Advantage network. Two thousand two

hundred and fifty. That's a very large number, particularly in this small state - about one physician or hospital or nursing home, or other healthcare provider lost, for every 260 Medicare Connecticut beneficiaries. Neither physicians nor Medicare patients were given adequate notice of this extraordinary decision by United. As the 2013 Medicare emollment period and year came to a close, many older and disabled people enrolled in the United Healthcare Medicare Advantage plan learned that their doctors or local hospital would not be available to them in United's reduced Medicare Advantage network in 2014. Many others did not learn until after the new year, others will not learn until they seek medical care in 2014, only to find their doctor or other healthcare provider is no longer in their Medicare plan.

Our clients are one example of a family that learned about the United network cut only when health care was urgently needed. Susan W. called the Center for Medicare Advocacy on behalf of her parents, who are both in their 80s. Mr. W. had a stroke in 2013 with bleeding in his brain. He was helicoptered from his local hospital to Yale New Haven due to the complexity of his condition. Now he is finding his medical and rehabilitation needs severely limited and further complicated by United's Medicare Advantage network cuts. His long-time primary care doctor and his local hospital are no longer in United's Medicare Advantage network. He must travel farther to another, unknown hospital and find a new doctor.

Most importantly, he cannot obtain the nursing care or rehabilitation he needs at the nursing home closest to his wife and community since it too has been cut from United's Medicare Advantage plan. As with many Medicare beneficiaries, Mr. W. had long been in traditional Medicare with supplemental Medigap coverage, but switched to the United Medicare Advantage

plan in 2011 because it was less expensive. This worked until he became ill and United exercised its business prerogative to severely reduce providers from its Medicare Advantage network. We know we will hear from many other people like Mr. W. as the year proceeds and they need health care but find their providers are no longer in the United Medicare Advantage network.

United Healthcare's actions would be bold in the private health insurance market. They should not be tolerated in the public Medicare arena. All Medicare Advantage plans, including United, are paid more by taxpayers than it would cost to provide the same coverage in traditional Medicare. In return for such public funding, particularly such robust funding, United owes its Medicare enrollees and providers timely notice and a fair remedy when significant network reductions are planned. It owes its Medicare enrollees a truly adequate array of providers. It should not be able to enroll Medicare beneficiaries one year, only to decimate its network the next.

PROTECTIONS SHOUD BE INSTITUTED FOR MEDICARE ADVANTAGE ENROLLEES

Individuals such as Mr. W., who have been hurt by provider cuts in United Healthcare's Medicare Advantage plan, should receive help. Further, Congress should act so such severe network reductions do not happen in the future. Accordingly, the Center for Medicare Advocacy recommends the following:

1. Protect Current United Healthcare Medicare Advantage Enrollees

- Require United Healthcare to pay the in-network rate on behalf of individuals such as Mr. W. who cannot find the quality care they anticipated in network.
- Provide a Special Enrollment Period for United Healthcare Medicare Advantage enrollees to change Medicare Advantage plans or re-enter traditional Medicare.

- Require United Healthcare to provide quality transition services to enrollees such as Mr. W., who are in the middle of treatment, to limit disruption of their healthcare.

2. Protect Future Medicare Advantage Enrollees

- Require Medicare Advantage plans to provide notice at least 60 days before the Annual Enrollment Period when more than a certain percentage of their provider network is to be cut. And, regardless of the overall percentage, provide notice to each enrollee whose physicians or closest hospitals and nursing homes will no longer be in the network.
- Review the definition of an adequate Medicare Advantage network to ensure all necessary services are available within a reasonable geographic area.
- Limit the percentage of each kind of provider a Medicare Advantage plan can cut from its network.
- Require Medicare Advantage plans to pay as if an enrollee's provider was in network if the plan is determined to have unreasonably reduced its Medicare Advantage providers.
- Provide a Special Enrollment Period for Medicare Advantage enrollees to change Medicare Advantage plans or re-enter traditional Medicare if their plan is determined to have unreasonably reduced its provider network.
- Level the playing field between the two Medicare models. For example, include prescription drug coverage in traditional Medicare and identify other incentives in the Medicare Advantage program that entice beneficiaries to migrate from traditional Medicare to Medicare Advantage.
- Retain reasonably prized, first-dollar Medigap[1] coverage.

[1] AKA Medicare Supplement Insurance.

- As is the case in Connecticut and some other states, make it a federal requirement that Medigap insurance offer open enrollment. Wider access to Medigap will give Medicare Advantage enrollees more flexibility to return to traditional Medicare if their Advantage plan no longer meets their healthcare needs.

CONCLUSION

Connecticut's older and disabled community deserves better than the treatment they have received from United Healthcare's Medicare Advantage plan. This kind of behavior should not happen again, and Medicare beneficiaries caught in this year's dramatic network cuts should be helped.

Thank you for holding this hearing and for the opportunity to testify regarding this important matter. Please let me know if the Center for Medicare Advocacy can help in any way.

Res:

Judith A. Stein, Esq.
Executive Director

Testimony of Michael F. Saffir, MD

Senate Special Committee on Aging

Medicare Advantage: Changing Networks and Effects on Consumers

January 22, 2014

Good morning. I am Dr. Michael F. Saffir, a board-certified physiatrist in pain and sports medicine with the Orthopaedic Specialty Group in Fairfield, Connecticut. I am President of the Connecticut State Medical Society, CSMS, representing more than 6,000 practicing physicians and physicians in training. I received my medical degree from the State University of New York Downstate Medical Center, and completed both my residency training and a fellowship in Neuromuscular Diseases and Electrodiagnostics at the Rusk Institute at New York University Medical Center. In addition to my practice, I serve on the State of Connecticut Workers Compensation Commission Medical Advisory Committee, where I helped to develop current attorney-physician guidelines, insurance-payer-physician guidelines, treatment guidelines, and an RVU-based fee schedule. I am also a member of the Connecticut Prescription Monitoring Program Advisory Panel.

UnitedHealthcare's abrupt, significant cuts to its Medicare Advantage network in Connecticut are deeply concerning for both patients and physicians. United's actions will have significant negative effects on the patient-physician relationship, patient access to care, and continuity of care for Medicare beneficiaries, a vulnerable population with complex medical needs, including many with chronic conditions and disabilities that limit mobility.

Testimony of Michael F. Saffir, MD – Senate Committee on Aging

When UnitedHealthcare decided to drop thousands of Connecticut physicians from its Medicare Advantage network, they did it in a way that seemed to maximize confusion for patients and doctors.

The physician termination letters were first sent via bulk mail in early October. Some physicians received multiple letters indicating termination, while some received no letter at all but found out by going to the United website that their names had been removed from the provider directory. Physicians who actually received a letter were given no reason for termination, which has made it very difficult, if not impossible, to appeal United's termination. Phone contact with United staff, as well as the United online directory, provided often-contradictory information about physician network status: both patients and physicians had problems ascertaining network participation. Terminated physicians were listed as remaining in-network; physicians who had not received a letter were listed as dropped. Over the past few months, physicians have received verbal assurance that they are in the network, but no written confirmation has been provided.

United made those physician cuts just before the 2013 Medicare Open Enrollment period began on October 15. As you know, Medicare patients are required to choose a health plan during this period for the following year. Once they select a plan, they are locked in until the following year. United failed to notify patients of the network changes until November 14-15 – nearly halfway through the Open Enrollment period.

From a physician care perspective, United's actions have been extremely disruptive. As physicians, we counsel our patients about their health based on the most accurate and up-to-date clinical information. It is difficult to provide similar counseling when patients ask questions about the United network, since the accuracy and timeliness of United's information has been lacking throughout this entire process.

Many CSMS members have shared their stories of patients who were confused and upset by the changes. Because United gave patients no reason for the network changes, some patients were worried that the doctor had done something wrong. More recently, United patients have received letters saying that they can switch to another doctor for their care, but when patients call this doctor's office, they are told that they can't be seen, or that they will have to wait weeks or even months for an appointment. Why? Because United never bothered to ask these listed doctors if there was any room left in their patient panels, or even if they were able to accept Medicare patients.

Throughout this process, the Centers for Medicare and Medicaid Services' (CMS) lack of oversight and enforcement has been disappointing. Simply stating that United played by the rules is not enough. A common-sense review of the travel time and distance requirements for elderly, medically vulnerable patients clearly shows that the existing guidelines are unrealistic, even dangerous. Following a 90-day notice guideline doesn't help patients or physicians when the notice was provided in a disorganized, contradictory and incomplete manner. Even more critically, CMS didn't seem to consider that the 90-day notice ran directly through the entire Open Enrollment period. Patients had to make choices for their 2014 health care without knowing whether their doctors would be able to care for them. It is even more complicated for patients with multiple medical conditions who see many different physicians for their care – a cardiologist, an orthopedist, an endocrinologist for their diabetes, a pulmonologist for their COPD – and have to calculate which is the most important to keep. No patient should have to make that choice.

Many of our members have had patients ask whether they could pay a little extra and stay with the doctor they know and trust. Patients were horrified to learn that staying with their doctor wasn't a matter of a few dollars a month in out of network fees – because Medicare Advantage plans offer little

or no out of network benefit, the patient would be responsible for paying most (or all) of the cost. This is an unsustainable expense for someone on a fixed income. No patient should have to make that choice.

This is truly a watershed moment. United's actions have clearly shown that they place a higher priority on maximizing profit than on maximizing their members' health. Congress needs to recognize what is occurring here in Connecticut and across the country with these terminations. Patients, during Open Enrollment, are given little notice and no clear understanding of network changes and then physicians and patients are left to figure things out.

The solution is simple: patient access to care needs to be protected and maintained for this most vulnerable of populations. United needs to be held accountable for its lack of clarity and transparency in this process, and should demonstrate that its actions do not jeopardize access to care and the actual provision of patient care. CMS should provide common sense oversight of United, and not simply accept the insurer's word that existing networks are adequate.

Testimony of Raymond H. Welch, MD
Senate Special Committee on Aging
Medicare Advantage: Changing Networks and Effects on Consumers
January 22, 2014

Good Morning. I'm Dr. Ray Welch of RI Dermatology and Laser Medicine, a small practice consisting of myself and my Physician Assistant, Erich Karasko. I graduated Alpha Omega Alpha from Albany Medical College, trained for 2 years in internal medicine, then received my dermatology training at Duke University. I am a Board Certified Dermatologist and a Fellow of the American Academy of Dermatology. I am also an Assistant Clinical Professor of Dermatology at Brown University. My practice has been serving the RI area for over 25 years and has become known for the diagnosis and treatment of skin cancer.

In mid-October of 2013, we received a letter from UnitedHealthcare (UHC) informing us that our contract with their Medicare Advantage products was being terminated as of February 1, 2014. We would continue to be UHC providers for ALL other United products. We were given the opportunity to request an appeal of this action which we immediately did.

Our first thought was "How could they do this and why?" We have provided the highest quality care for these patients for years. Our second question was "Who will this affect?" The answer was some of our patients with the highest incidence of skin cancer including melanoma and some of our most elderly patients. One patient who would be affected has been diagnosed with 142 skin cancer lesions and therefore, is seen every 3 months with multiple biopsies at each visit. In fact, of our 120 affected patients, over 90% have had skin cancers or pre-cancers. 36% have had more than 6 skin cancer lesions. Almost 10% of our patients with UnitedHealthcare's Medicare Advantage plan are 89 years old or older. These are patients that need our continuity of care. But, of course, skin cancer care incurs higher costs.

We requested information from UHC on the metrics they used to determine who would be removed from their Medicare Advantage network so that we could prepare an appeal of their decision. We were told that this information was considered "proprietary information" belonging to UnitedHealthcare alone. In fact, in talking with other dermatologists in Florida and RI, we learned that the appeal hearing was limited to answering the question, "Were you informed of your termination in accordance with the provisions of your contract?" No other discussions, information or statistics were allowed to be considered.

There is a secondary and chilling consequence to this lack of transparency for the metrics for termination. UnitedHealthcare has established that they will terminate doctors not only without cause, but without providing the reason for termination. In areas where UnitedHealthcare covers a large segment of the market, such as in my own Rhode Island, doctors will be left to worry how best to please UnitedHealthcare, rather than how best to

advocate and care for their patients. It is this perversion of the doctor-patient relationship that I fear the most. It is said you cannot serve two masters. The master that physicians serve must be their patients, not UnitedHealthcare.

Our "appeal" was held on December 5, 2013 via telephone conference call with a UHC moderator and 2 UnitedHealthcare medical directors. Indeed, the only question under discussion was the termination procedure, not the quality of care. United has publicly stated that the contraction of the network was to "create a more focused network to allow UHC to work more closely with providers to improve outcomes and, ultimately, lower costs" but no doctor or provider has been allowed to refute the implied statement that they are not providing high quality, cost effective care for their patient population.

What is the effect of these terminations? Some of our patients are retirees of the State of Rhode Island. The State was able to negotiate an out-of-network benefit for these retirees to allow them to see the terminated providers, if the providers are willing to accept the out-of network fee schedule. We are not sure exactly what the fee schedule will be but we have decided to accept a possibly lower fee in order to assure continuity of care for these patients. This course of action by UHC lowers their cost for these patients.

About half of the remaining patients have switched their insurance to other carriers rather than lose their doctors. One of our patients indicated to me that she would lose all 4 of her doctors if she remained with United. Our patient with almost 150 lesions has switched to another carrier. The transfer of these patients to other carriers lowers the cost of providing Medicare plans for UHC.

Other patients have switched back to traditional Medicare A/B with a Medigap or supplemental insurance. One of our patients did so and elected to stay with UnitedHealthcare for her supplemental insurance but saw her monthly cost double. She was told that, due to her skin cancer history, she would have to purchase the more expensive plan. In this case, United has improved its bottom line by forcing the patients to pay more upfront.

Most of the patients still covered by UHC Medicare Advantage plans are either on employer-provided retiree plans and can't change to another carrier or have not switched. One very elderly patient told me she was just too old to deal with it. During this final month of our contract, I have patients ask me daily, "What do I do? Where can I find another doctor?" I can't give them a good answer. Some of our patients were told by UHC that I was on the current provider list. However, United was using an EIN which was used before we incorporated 10 years ago. Our current practice is listed as terminated. I looked over the listings of doctors remaining in the network and have found other egregious errors. Several dermatologists on the list have retired. Many on the list are working only part-time. Some on the list have not been practicing in RI. One doctor on the list passed away. Most on the list are not accepting new patients. Almost all of the private practice dermatologists in RI were terminated. Most dermatologists left in the network are accepting few, if any, new patients. The hospital affiliated residency training programs were not terminated. However, University Dermatology has indicated to us that

they are not accepting new patients at this time. I have almost no dermatologists to suggest to these patients.

What does this mean? For patients who need to find new doctors, there is a significant loss in continuity of care. I know these patients and their cancer history. Doctors are not interchangeable widgets. I have achieved considerable expertise in skin cancer care through years of training, studying and caring for these patients. Furthermore, there may be a delay in their care. Some may not find a new dermatologist. For skin cancer patients who are seen 2-4 times every year and may have multiple biopsies and cancers each year, the transfer of care may delay care and lead to an increase in untreated skin cancer and the resulting morbidities, possibly death. Some of advanced years may give up trying to find another doctor. This is truly unacceptable. I cannot believe that the government ever thought that giving Medicare Advantage plan contracts to publicly held corporations would result in a limitation of access to care.

What can Congress and CMS do to assure our seniors of access to high quality care? We would offer these suggestions:

1) Network contraction does not lower costs except by limiting access. Therefore, we would suggest that any doctor who is credentialed by Medicare and by an insurance carrier for any of its products must be included in the Medicare Advantage products offered by that carrier. If the carrier can prove to an independent appeals board that a provider is charging for medically unnecessary visits, then let that form the basis of termination.
2) CMS should require that all metrics used in terminating a provider be transparent and subject to appeal.
3) CMS should require all carriers to verify the adequacy of their network and the accuracy of their provider lists.
4) Congress should review all Medicare Advantage plans to assure that they save the Medicare system money. Currently, Medicare administrative costs run about 3%-6% while private insurance companies costs run generally greater than 10% and even as much as 20%. Carriers are paid above the Medicare fee schedule but often reimburse physicians below the Medicare amount. In addition, patients often face high copays as much as $40- $50 for office visits. The insurance company pays only a few dollars to the provider. The patient has paid the majority of the bill. CMS should assure that Medicare funding is used solely for patient care and not for profit margins.
5) Network contraction can be a means for forcing providers to accept lower fees to retain their patients. Ultimately, this will lead to a decline in access to care for seniors. Physician practices must generate revenue to pay for employees, benefits, taxes, etc. Therefore, we strongly suggest that CMS require all Medicare Advantage plans to pay at Medicare fee schedules and not below.

I have dedicated my life to serving and caring for my patients in accordance with the Oath I professed 33 years ago. In that oath, I vowed;

"That above all else I will serve the highest interests of my patients through the practice of my science and my art;
That I will be an advocate for patients in need and strive for justice in the care of the sick."

This is why I am here today and I hope that you will join me in protecting and advocating for these Medicare patients.

Statements for the Record

GEORGE C. JEPSEN
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of The Attorney General
State of Connecticut

TESTIMONY OF CONNECTICUT ATTORNEY GENERAL GEORGE JEPSEN BEFORE THE UNITED STATES SENATE SELECT COMMITTEE ON AGING JANUARY 22, 2014

Thank you for the opportunity to provide written testimony to the committee concerning the impact of recent significant changes to United Healthcare's ("United's") Medicare Advantage Plan ("MAP") on Connecticut seniors.

As you may know, my Office received numerous complaints from Connecticut senior citizens enrolled in United's MAP. As a result, we explored several issues pertaining to United's decision to terminate approximately 20% of its MAP provider network. We initially contacted United for basic information regarding the impact the terminations might have on patients. These efforts ultimately proved unfruitful. United failed to be specific in its responses to our questions, including the actual number of doctors being terminated and the number of patients who would be impacted by the terminations. It became clear to us that United had not thoroughly evaluated its remaining provider network to ensure it would be sufficiently robust to provide all covered services to its enrollees.

Having not been provided from United even the most basic information about the size and scope of its network reduction, I wrote to the Centers for Medicare and Medicaid Services (CMS) to highlight United's lack of consideration of these critical factors and to request specifically that CMS, as the regulator of Medicare Advantage Plans, look into the question of whether the remaining United network would be adequate to provide necessary covered services to its members. In addition, I requested that CMS extend open enrollment to affected members, as it was clear that members were not given timely notice sufficient to allow members to make informed decisions during the open enrollment period. CMS responded by stating that it would work with United to ensure that its remaining network met Medicare standards, with the caveat that United had broad discretion to determine the constituency of its network. It seemed clear at this point that CMS had not thoroughly evaluated whether United's post-termination network would be adequate before United sent out termination notices to providers and that CMS did not exercise any prior approval authority over whether a termination of the unprecedented size and scope planned by United would be appropriate for its Medicare membership.

It also was evident that the regional CMS office in Boston was not in charge of conducting a local analysis of the impact of the terminations in Connecticut. Rather, my Office was informed that the regulatory oversight over the termination was charged to CMS's regional office in San Francisco. Given the size and scope of United's multi-state termination efforts, I was surprised to learn that regulators in San Francisco were charged with evaluating the

adequacy of United's Connecticut MAP network. I remain skeptical about whether CMS can adequately scrutinize the local impact of these terminations without mobilizing the appropriate regional offices to evaluate network adequacy impacts within their own jurisdictions.

Based on this experience and other smaller network adjustments by Medicare Advantage Plans in the past, I strongly believe that CMS oversight of MAP network reductions requires significant reforms. Among other things, I recommend the following reforms:

1. That Medicare Advantage Plans be required to obtain prior authorization and approval for terminations to providers that exceed a minimum threshold.

2. That the system of notification for changing networks be reformed to require that changes to networks be fully noticed in writing to members in advance of the annual open enrollment periods, thus allowing such members enough time to make choices about their coverage in the subsequent calendar year.

3. That each regional office be responsible for fully assessing the network adequacy of any Medicare Advantage Plan that seeks to implement terminations of providers above the minimum threshold in its jurisdiction. Each network adequacy review should assess not only whether remaining primary care and specialty providers exist that can provide the covered services for all members under the plan, but that those remaining providers actually have capacity to absorb any migration of patients that results from a large scale termination.

4. That CMS require Medicare Advantage Plans to seek approval for all correspondence issued to providers and consumers pertaining to a pre-approved termination plan.

5. That CMS review contractual termination requirements for providers under Medicare Advantage Plans and determine whether those termination provisions are both Medicare compliant and followed as a condition for prior approval of a termination that exceeds the minimum threshold.

While I fully understand that Medicare Advantage Plans need flexibility to make adjustments to their provider networks in order to enable them to provide coverage for plan services in a financially responsible way, I believe that the United's recent terminations clearly demonstrate the need for more oversight and reforms geared towards ensuring that consumers can continue to receive the high-quality covered healthcare that Medicare promises, and for consumers to be apprised of changes with sufficient notice to enable them to make fair and individualized choices regarding the healthcare plans that are available to them.

I believe that United's mass termination of providers reflects a trend to strive for cost savings through network reductions. United's recent announcement that Yale Medical Group and the Yale New Haven Hospital System will be leaving its network is further evidence of this trend. It is therefore more important than ever that these reductions be scrutinized by regulators to protect vulnerable patients and be transparent to consumers in order to ensure real choice in the marketplace.

I appreciate the Committee's consideration of my comments and recommendations on this important issue.

ALAN F. LIST, M.D.
PRESIDENT & CEO
FRANK AND CAROL MORSANI CHAIR

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January 24, 2014

Chairman Bill Nelson
Senate Special Committee on Aging
Dirksen G31
Washington, DC 20510

Ranking Member Susan Collins
Senate Special Committee on Aging
Dirksen G31
Washington, DC 20510

Dear Chairman Nelson and Ranking Member Collins:

Moffitt Cancer Center appreciates that the Committee on Aging has convened a hearing to learn more about the impact of decisions by insurance companies to eliminate providers from their Medicare Advantage networks.

Moffitt Cancer Center, the only National Cancer Institute-designated Comprehensive Cancer Center based in Florida, offers high-quality, cost-effective cancer care while conducting a wide array of cancer research. Moffitt is one of the busiest cancer hospitals in the U.S., treating in excess of 50,000 cancer patients per year.

Patients treated at Moffitt Cancer Center have significantly better survival rates than the national average for many types of cancers, according to data from the National Cancer Data Base and Moffitt's Cancer Registry.

Late last year, we were disappointed to learn that UnitedHealthcare chose to exclude Moffitt Cancer Center and Moffitt physicians from its network of providers for its Medicare Advantage members, effective Jan. 1, 2014. This includes Medicare HMO/PPO products sold under the names Secure Horizons, Evercare and AARP Medicare Complete.

This decision affected up to 2,000 current patients of Moffitt Cancer Center who were enrolled in these plans last year. Patients who remained with these plans are still eligible to come to Moffitt, but they will pay high out-of-pocket costs for care. Many NCI centers throughout the U.S. were similarly impacted.

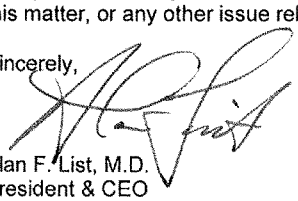
Jack Larsen, CEO of UnitedHealthcare, explained that the insurer is dropping thousands of physicians from its AARP MedicareComplete networks because of "systematic underfunding." UnitedHealthcare's decision may make sense on paper: Cut out premium providers and therefore cut costs. But Mr. Larsen isn't considering what this decision will cost patients and the health care system overall. When facing a disease as serious and complex as cancer, patients need access to the highest level of care and latest treatments.

This decision is short-sighted. UnitedHealthcare's AARP plans may still cover cancer care this year, but it won't be at the top-rated facility in Florida with the best outcomes. As a result, these patients will receive fragmented care, leading to more misdiagnoses, ineffective and costly treatments, as well as disappointing results -- at a cost borne jointly by their insurance company and the Medicare program.

The situation with UnitedHealthcare and Moffitt is unfortunate, but it is not unique. It is indicative of the changing health care landscape and the financial pressures insurers and providers face. More than ever, patients need to research their options and make the best health care decisions for them.

Thank you for taking the time to consider our concerns on behalf of Medicare recipients facing a cancer diagnosis. Please do not hesitate to contact me for more information on this matter, or any other issue related to cancer treatment and research.

Sincerely,



Alan F. List, M.D.
President & CEO

Robert Buccieri
17 Adamson Ave
Norwalk, CT 06854

January 24, 2014

RE: Changes in United Healthcare

Senator Blumenthal
Legislative Office Building
300 Capitol Ave
Hartford, CT.

Dear Senator Blumenthal,
My name is Robert Buccieri and a lifelong resident of Connecticut. Born and raised in Norwalk. I am 55years old and have stage five kidney disease or commonly known as End Stage Renal Disease (ESRD).

I was given the privilege to receive Social Security Disability in 2010 and researched United Healthcare Medicare Solutions initially because of its reputation. I studied their website and found my doctor, and my local hospitals were providers. The coverage, co-pays, and public opinion were all good, and so I chose United Healthcare. I've been very happy with my choice until this fall.

When diagnosed with ESRD my primary care physician Dr. Tao-Nan Chi referred me to Dr. Paul Wiener, a nephrologist. Together they saved my life. I have a great relationship with both of these doctors. With their help I am "on the list" for a kidney transplant at Yale –New Haven Hospital, one of the finest hospitals in this country. We are fortunate to have such a resource in our state. I am on the verge of going on dialysis and have visited The DaVita Center in Norwalk.

The kidneys not only filter blood, they keep your body's chemistry in check. I am on about a dozen different medications to maintain this balance. Several of these medications I take two and three times daily. Along the way I've gone thru many procedures, tests, and monthly blood-work at Yale for tissue typing. I had everything in order and patiently waiting for a kidney.

In the fall of 2013, United Healthcare turned my world upside down. I received a letter stating my nephrologist was not going to be a provider as of February 2014. Then a Yale transplant surgeon was removed. Then a second Yale transplant surgeon, and finally the Yale Medical Group in which they both belong were eliminated as well. I also found out my local dialysis unit was no longer going to participate.

I frantically called Carolyn Short, my nurse case manager at United Healthcare. She went out of her way to find solutions to my concerns. She called the dialysis unit on my behalf and found out I can use the center by switching to another local nephrologist – Dr. Kumar. Not perfect, but a solution. She also claimed that since I was pre-approved at Yale for transplant, they would honor that, but not for anything unrelated to the transplant. The fear of unrelated complications made me more nervous. I consider Carolyn to be a great nurse case manager and resource.

I knew Senator Blumenthal initiated an investigation with United Healthcare regarding provider issues, so I asked for some assistance. I figured this would be easy because Carolyn did the ground work. All I wanted was something in writing from United Healthcare verifying this. I received numerous phone calls from United Healthcare after the Senator and his office got involved. They (United Healthcare) were eager to help and find solutions, but not consistent. Nobody reinforced what I was told by my nurse case manager, and my window to choose another plan now closed. The uncertainty of this confirmation elevates my anxiety even more. This problem consumes me night and day.

I've received a confirmation letter from United Healthcare for a 90 day approval to see my nephrologist for 25 minutes and can request an approval for another 90 days, if need be. I'm not thrilled to deal with this problem every 90 days. Does this mean 25 minutes for each office visit, or 25 minutes in total? On more than one occasion Dr. Wiener has spent more than 25 minutes with me in a single visit. This only adds to my worries.

I was as also told that my insurance plan would allow me get a transplant out of state. Maybe I could register in NYC for a transplant. I give them credit for their effort and for thinking outside the box. The problem is that I've been "on the list" at Yale for almost two years. If I register in NYC, I would once again be on the bottom of the list.

I believe United Healthcare is discriminating against high risk patients, like myself. Hoping they will chose another insurance carrier and making their company more profitable. Even if they concede and reinstate providers they still win, because a vast majority of individuals affected by this have already switched insurance carriers.

I appreciate all the help from United Healthcare in effort and creativity, and I know they are eager to help solve my issues, but they can do better. In addition to trying to survive another day with this disease, now I have to worry about provider issues. This isn't fair.

I'm hope Senator Blumenthal and his colleagues apply more pressure persuading United Healthcare to promptly resolve this.

Sincerely,

Robert Buccieri

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