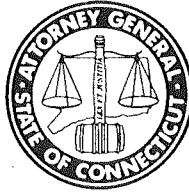


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***TESTIMONY OF CONNECTICUT ATTORNEY GENERAL  
GEORGE JEPSEN BEFORE THE UNITED STATES SENATE  
SELECT COMMITTEE ON AGING  
JANUARY 22, 2014***

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.