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.

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.