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.