NEW YORK STATE ASSEMBLY
COMMITTEES ON HEALTH AND INSURANCE
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TESTIMONY OF MICHAEL A. SEDRISH, MD
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Honorable Members of the Assembly,

Thank you Chairperson Gottfried and Chairperson Grannis and Members of the Assembly Committees on Health and Insurance for affording me this opportunity to testify before this joint hearing regarding consolidation in the health insurance industry and its impact on health care services, patients, and providers, issues of the greatest importance to the citizens of the State of New York. I am Michael Sedrish, Director of Utilization Management, MediSys Health Network, a practicing physician for 30 years. I have also been actively involved in health care policy and quality of care issues for many years.

I am deeply concerned with the prospect of further empowering abusive managed care companies to continue profiteering at the expense of the good of society. During the last several years there has been ample evidence to suggest that further consolidation within the health insurance industry will further facilitate the growing abuses of placing barriers which limit the appropriate access and delivery of care, controlling health care providers' decision-making processes, and the ability of providers to provide those services. In his March 22, 2006 New York Times Op-Ed entitled "The Doctor Will See You Now for Exactly Seven Minutes," Dr. Peter Salgo lamented the fact that publicly traded HMOs began restricting doctors to an average 7-minute "encounter" with each "customer," a policy instituted to keep shareholders happy.

My own opinion is that permitting any further consolidation within our currently dysfunctional and undeniably dangerous managed health care-dominated industry will without doubt further compromise all providers' capacity to offer quality care, the level

of care each of you would demand for your families, precipitate an unsustainable fiscal crisis, and serve to facilitate further abuses of defenseless providers and patients. My opinions are the result of 30-years of experience as a primary care physician, member of the Medical Board and Attending Physician Staffs at New York City medical centers, Medical Director of an ERISA Taft-Hartley Trust Fund and of coalitions of ERISA Trust Funds, member of the Board of Trustees of a non-profit health care quality foundation, and until recently as an insider within the administrations of several managed care HMOs.

According to the Center for Health Transformation our government must succeed in meeting at least minimum 21st Century standards of health system effectiveness. The nature of a science- and technology-based entrepreneurial free market is to provide more choices of higher quality at a lower cost. Their analysis is that the 21st Century model must achieve effectiveness, accuracy, speed, flexibility, lower cost, and greater achievement, all original promises of managed care but now long ignored and forgotten in the insatiable quest for profit. Citizens expect good government to demand the same standards that they have come to experience in non-health care industries, e.g. cell phones, the Internet, e-ticketing, and overnight delivery, all of which maximize consumers' level of knowledge and choice while at the same time improving quality and reducing costs.

In the early 1990s the decision was made to hand over a public trust, the multi-billion dollar health care industry, to business people. Businesses are in business to generate profits. When obstacles to profit arise, social conscience and principles are often sacrificed to assuage the demands of shareholders and as we have recently discovered to feed the greed of executives. In recent years we have repeatedly witnessed the inability of industries to be trusted to regulate themselves. It is painfully clear that you get what you <u>inspect</u>, not what you <u>expect</u>. If our government compromises, we are all compromised. We are today presented with the opportunity for public servants of vision and courage to step forward and rectify a failure of government to protect its citizens and a public trust.

As President Abraham Lincoln said, “As our case is new, so must we think anew, and act anew. We must disenthrall ourselves, and then we shall save our country.”

Managed Care, originally devised as a means to control health care spending, appears to be a failed experiment. In the early 1990s health care economists such as Uwe Reinhardt, James Madison Professor of Economics at Princeton University, predicted that after a short period of stabilized premiums achieved by means of cutting payments to all providers by the maximum possible amount, no further savings would be possible and inflation would resume.

In the US health care spending now continues to rise at the fastest rate in our history. In 2004 (the latest year data are available), total national health expenditures rose 7.9 percent -- over three times the rate of inflation. Total spending was $1.9 TRILLION in 2004, or $6,280 per person, 4.3 times the amount spent on national defense. Total health care spending represented 16 percent of the gross domestic product (GDP).

U.S. health care spending is expected to increase at similar levels for the next decade reaching $4 TRILLION in 2015, or 20 percent of GDP.

In 2005, employer health insurance premiums increased by 9.2 percent - nearly three times the rate of inflation. The annual premium for an employer health plan covering a family of four averaged nearly $11,000. The annual premium for single coverage averaged over $4,000.

The consolidations of recent years within the health care industry have produced fewer but far more powerful health care businesses with control of growing market share and the ability and willingness to control patient access, provider fees and even health care decision–making. These mega entities are anxious to exercise expanding control over an increasing percentage of patient lives and providers’ receivables. Their increasing power has been characterized by an insatiable quest for extracting ever-increasing profits without any legal requirement or sense of moral obligation to contribute to the community from which it extracts its enormous profits, profits large enough to have been

able to pay 1 individual CEO an annual package worth $1.6 billion in 2005. In fact, on January 30, 2006 Weiss Ratings stated that HMO profits would exceed $14 billion in 2005, up 21.2% from 2004. This profiteering continues unchecked at the same time that our State government is committed to decrease by monumental amounts the Medicaid dollars it pays to hospitals. Profit resulting from good business practices is to be applauded, but weakening hospitals financially from unethical and illegal standard operating procedures is unacceptable and clear cause for good government to act definitively.

We witness on a daily basis an almost sociopathic willingness by HMOs to ignore laws and regulations originally promulgated to protect consumers and providers. Their ability to avoid effective regulatory enforcement and meaningful penalties, including the possibility of revocation of their license to operate within our State, has only emboldened these HMOs. Avoiding payments to hospitals and other providers of care by placing barriers to appropriate care, refusing payments (i.e. denials) or indefinitely delaying payments for appropriate services already provided in good faith, refusing to recognize inquiries or to fairly negotiate, are just some of the consequences which without doubt have severely compromised the availability and quality of health care as well as patient and provider satisfaction. Their demonstrated standard business practices and policies have progressively crippled hospitals struggling to continue to provide excellent care in the face of decreasing reimbursements and increased costs of operation. Few people could argue with the statement that hospitals anywhere in the world are without any doubt the most noble of institutions, whose missions are uniformly and exclusively to attend with skill and compassion to all who come to their doors seeking help, only giving to their communities and to society.

The MediSys Health Network hospitals have begun to document and catalogue daily examples of clear violations of Public Health Law as well as other unethical business practices committed by these increasingly powerful, bold, and independent managed care companies, most notably HIP Health Plans of New York with their financially incentivized delegated entities Health Care Partners/Heritage, Cogent, and the acquired

Vytra Health Plans, the UnitedHealth Group including its acquired Oxford Health Plans and AmeriChoice, and Aetna, the former US Healthcare, so infamous for pioneering many of these abuses.

MediSys has been unable to collect hundreds of thousands of dollars in pre-2006 undisputed debt from Health Care Partners, not licensed to operate as an HMO in New York but acting as a delegated Utilization Management entity under HIP's New York State HMO license. This same HIP delegated entity has an inpatient denial rate which is 12 times higher than any other managed care insurer, refuses to return telephone calls from doctors and nurses, and retroactively changes approved days to denied days just prior to rejecting claims.

Cogent, another HIP contracted entity operating under HIP's NYS license at Brookdale Hospital, routinely evaluates and makes the decision to admit HIP-insured patients from the emergency room, and then issues an admission denial citing a lack of medical necessity! They frequently discharge patients on Friday evening without prior notice and without discharge plans having been clarified, knowing that placement could not occur before Monday, only to deny payment for the entire weekend while continuing active care! Among other frankly outrageous denial practices, Cogent frequently orders tests on patients at the end of the day and subsequently denies that entire day because the test had not been completed the same day it was ordered, disregarding the fact that the patient was acutely ill and required inpatient care regardless of the test! Although clearly prohibited by Public Health Law, Cogent doctors and nurses themselves issue denials essentially at the bedside of the very same patients that they are managing, while pretending that these exact denials came from HIP Medical Directors.

Aetna refuses to pay hospitals for care received, when forced to pays at much lower and inadequate old contract rates, insists that patients be transferred to other hospitals regardless of patient safety, and misleads patients about their plan benefits.

Our Utilization Management Department identifies dozens of indisputable violations of Public Health Laws, including Article 49, Titles l and ll, and the 1997 Prompt Pay Law occurring on a daily basis as standard business practices of these New York State licensed entities, especially HIP, Oxford, Aetna, and Blue Cross, all seemingly operating without fear of oversight enforcement or meaningful penalty. Common illegal practices of these HMOs include: 1) not being accessible to accept clinical reviews or requests for Reconsiderations, Expedited appeals, or authorizations for post-discharge services, 2) authorizations for admissions having been given but then denied because of a lack of authorization, 3) concurrent reviews given but those same days denied for an alleged lack of clinical reviews having been received, 4) Attending Physician telephone calls to the Medical Directors not being returned, 5) late receipt of notification of denials, 6) retrospective reviews given but then denied for no review having been given, 7) denial notification and appeal rights not given to the patient or physician, 8) review reconsideration timeframes not met, 9) appeals and allowable appeal timeframes illegally declared to have been exhausted due to an Attending Physician Reconsideration or Expedited Appeal request, 10) Notice of Denial of Medical Coverage not issued as required, 11) denials for discharge planning delays when authorizations for post-discharge services were not issued by the same denying HMO for days, 12) and a written appeal decision not rendered within the required timeframe and subsequently unwilling to reverse the original denial and pay the claim as required by law.

These tactics, and many, many more, have the calculated effect of 1) circumventing the lawful protections and rights afforded patients, their families, their providers, and their hospitals to receive insurance benefits and provide and receive necessary care in the most appropriate setting, 2) a fair and honest medical necessity determination, 3) timely denial information and appeal rights, 4) lawfully mandated reconsideration rights, and post-discharge appeal rights processes, and 5) fair and timely payments for services provided.

These business practices also have as their purpose denying and obstructing patients', families', physicians', and hospitals' from exercising their legal rights and protections to present additional information to the HMOs' denial staff for the purpose of obtaining

approvals for appropriate and necessary health care services which have already been provided in good faith, thereby facilitating their avoidance of making deserved payments for the singular purpose of illegally boosting the HMOs' profits. Make no mistake about it; these unregulated managed care monsters usurp legally guaranteed patient, family, provider, and hospital rights in their unchecked quest for excessive and undeserved profits in their very carefully calculated and purposeful manner. Their unethical practices also result in providers and hospitals being made to unnecessarily expend precious resources to collect what they are rightfully owed.

For example, patients and Attending Physicians never receive timely denial notification letters containing the reasons for the denial and their rights to a Reconsideration, expedited appeal, or standard appeal, and severely shortening the Public Health Law-required timeframes. The hospital frequently does not receive notice of a denial with their appeal rights until many days or weeks later, often long after the patient has been discharged, in a letter dated days or weeks earlier

Attending Physicians' telephone calls to HMO Medical Directors for the legally stipulated colleague-to-colleague clinical discussion called Reconsideration almost uniformly go unanswered.

HIP Health Plans of New York defies Public Health Law by providing financial incentives to physicians who are providing direct care to inpatients to deny inpatient hospital admissions and days.

<u>These HMOs frequently ignore 4901(2)(j)</u>, regarding required telephone access for clinical reviews, obtaining authorizations, Reconsiderations and appeals and to ensure that expedited appeals can be handled 24/7 and responded to within 24 hours.

<u>These HMOs frequently ignore 4901(2)(m)</u>, failing to assure that their utilization review agents, contractors, subcontractors, subvendors, agents and employees affiliated by

contract or otherwise with such utilization review agent will adhere to the standards and requirements of Titles 1 and 2.

These HMOs frequently ignore 4902(1)(b,d,e,f), requiring that a utilization review agent consistently and immediately notify enrollees, an enrollee's designee and their provider of denials, and make available to enrollees and providers a written description of standard, expedited, and external appeal rights and procedures, and assure that reviews and determinations are conducted within the required timeframes and to ensure that an expedited appeal is responded to on a twenty-four-hour-a-day, seven-day-a-week basis.

These HMOs frequently ignore 4902(2), which requires that each utilization review agent must assure adherence to the requirements of Public Health Law by its contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent.

These HMOs frequently ignore 4903(3), requiring that a utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment and provide notice of determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information. (Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date).

These HMOs frequently ignore 4903(6), which requires that in the event of an adverse determination rendered without attempting to discuss the denial with the enrollee's health care provider, the health care provider must have the opportunity to request a reconsideration of the adverse determination and that the reconsideration should occur within one business day of receipt of the request. Furthermore the Reconsideration may not preclude the enrollee from initiating an appeal of an adverse determination.

These HMOs frequently ignore §4904(1,2) requiring HMOs to establish and abide by processes that facilitate the filing within 24-hours and urgent resolution within 48-hours of an enrollee, an enrollee's designee and their health care provider’s request for an expedited appeal process, via telephone or facsimile, for urgent appeals of a denial involving required continued care. Expedited appeals may not preclude a subsequent standard or external appeal.

These HMOs frequently ignore 4904(3) requiring that a utilization review agent must establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than forty-five days after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination, provide written acknowledgment of the filing to the appealing party within fifteen days and of a determination within sixty days.

These HMOs frequently ignore 4904(5) which states that failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

These HMOs frequently ignore 4905(4) which stipulates that a utilization review agent shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on: (a) either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or

(b) any other method that encourages the rendering of an adverse determination.

These HMOs frequently ignore 4905(15) prohibiting that a health care professional providing health care services to an enrollee shall be prohibited from serving as the clinical peer reviewer for such enrollee in connection with the health care services being provided to the enrollee.

These HMOs frequently ignore 4910(2) which provides that an enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider, shall have the right to request an external appeal, and that the enrollee shall have 45-days to initiate an external appeal after the enrollee receives notice from the health care plan or such plan's utilization review agent of a final adverse determination or denial.

In addition to the above violations of Public Health Law there are constant examples of how these HMOs of growing influence behave as though they are an industry exempt from laws, regulation, and oversight, inappropriately delaying payments long past the legal limit, retroactively changing authorizations and approvals without cause, hardly ever returning telephone calls as required, and allowing non-physicians to make adverse determinations, among other illegal behaviors.

Several months ago HIP and their own collection agent notified MediSys that it had unilaterally and without discussion decided to immediately “take back” over $100,000.00 in emergency room fees for hundreds of ER visits dating back to March 2003 that it had reclassified as low-level visits with medical decision-making of low complexity without ever having reviewed a single emergency room medical record!

This month payment for 13 inpatient admissions were entirely denied by HIP due to authorizations for these emergency admissions allegedly not having been obtained by hospital staff. Physician authorizations did however exist, even though no physician authorizations are required for emergency admissions. After 2 days on the telephone a HIP staff member finally admitted to a hospital internal auditor that hospital authorizations had indeed existed but had been changed to physician numbers. They also told the auditor that the numbers could not be changed back to the hospital authorizations required for reprocessing of the claims.

We frequently experience denials of claims due to an alleged lack of medical necessity denial in spite of those days having previously been approved during the admission, once again robbing patients, families, providers, and hospitals of legally protected rights.

On a daily basis we receive denials of admissions due to a supposed lack of information received only to be obligated to repeatedly resend the information in question with the previous facsimile confirmation pages and argue for the approvals.

A new tactic being used by HIP, Oxford, Aetna, Blue Cross, and other HMOs is to automatically deny appropriate inpatient admissions when their insurance company would otherwise be responsible for the secondary benefits guaranteed under coordination of benefits rights, in spite of the primary insurer having approved the admission. The explanation usually given by the HMO nurse is "oh, it's just the secondary benefits, it doesn't matter." In reality, secondary benefits do matter very much to any struggling hospital, and obviously also to the HMO which immorally and illegally denies payment to raise their own profits. These HMOs also figured out that by the time the first insurer has paid their share and the secondary payer has rejected the claim for secondary benefits, it is already too late to file an appeal.

Make no mistake about it; the most difficult sources of denials are those that result from the managed care companies insatiable greed and willingness to blatantly ignore Public Health Law. As long as there are no significant punitive actions taken by the state's regulators these businesses will continue to defraud hospitals and consumers without fears of consequences. As long as this behavior is allowed to continue unchecked hospitals will remain defenseless and faced with ever-increasing percentages of inappropriate denials of medically necessary days.

As you are well aware, these insurance companies do not give timely notices of denials with the required appeals rights to patients, doctors, or hospitals, usurping their legal rights to appeal concurrently; their Medical Directors refuse to return telephone calls from Attending Physicians seeking a legally mandated Reconsideration; they frequently

allege that they did not receive clinical review information that was in fact sent concurrently and often refuse to rescind their denials even after receiving facsimile copies of these reviews along with their previous fax confirmations; they often postpone notifying the hospitals of a denial of a clearly medically necessary admission until after the patient has been discharged, to then refuse to discuss the matter at all, stating that we would have to go through the lengthy appeal process; they delay giving, sometimes for days, the required authorization numbers needed for discharge planning purposes, e.g. placement, medical equipment, required home care, transportation, visiting nurses, etc. HMOs have somehow been empowered to demand full capabilities from a hospital 24-hour-a-day, 7-days-a-week regardless of the cost to hospitals, while themselves being allowed to operate on bankers' hours, something which even bankers have discovered they could no longer get away with in our 21st Century science- and technology-based entrepreneurial free market. I could continue listing dozens of examples of their usual business practices of ignoring the laws.

Speaking or writing to the officers at these companies to reason with them has no effect whatsoever except to elicit empty assurances and promises that they have absolutely no intention of keeping. This is business, BIG business, and every day that they continue to get away with these calculated standard operating business practices means additional windfall profits won at the expense of innocent patients, families, doctors, and hospitals.

I assure you that the only way to stop their unfair business practices, the only effective methodology that these managed care companies understand is the real threat of losing their licenses to operate in the State of New York. Firm, consistent oversight and enforcement are required in addition to legislative reform.

I would also like to point out what I believe to be an error in the NYS PHL regarding utilization review determinations that facilitates HMO abuses. §4903(7) (2006) states that failure by the utilization review agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination. This should be

changed to state that if an HMO does not render a timely determination the days should automatically be deemed to be approved.

We see these and similar abuses of laws, regulations, ethics and morals on a daily basis, as do almost all other hospitals throughout the State. It is abundantly and painfully clear to any honest and partially perceptive observer that someone has left the foxes to guard the hen houses. Good government demands that there be further hearings, investigations, verification, the appointment of an Inspector General for Health Care Issues, and rigid oversight of the desperately needed health care reforms.

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