Testimony of Kenneth E. Raske before a Joint Hearing of the New York State Assembly Committees on Health and Insurance Regarding Consolidation in the Health Insurance Industry and its Impact on Health Care Services, Patients and Providers

December 1, 2006

Good morning, Chairman Gottfried, Chairman Grannis, and members of the Assembly Committees on Health and Insurance. My name is Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA). We very much appreciate the opportunity to testify before you on the subject of consolidation in the health insurance industry and its impact on health care services, patients, and providers.

The metropolitan New York area has seen great changes over the past several years in the number and nature of health insurers serving the area. These have included the conversion of Empire Blue Cross Blue Shield, the State's largest insurer, to publicly traded status and its subsequent acquisition by the nation's largest private insurer, Wellpoint, as well as the acquisition of Oxford Health Plans by the country's second largest insurer, United Health Group. There have been other consolidations through merger and acquisition over time and the current merger of HIP and GHI and its possible conversion to publicly traded status would be among likely future consolidation activities in the downstate region. Within a few years, I believe it is very possible that the metro New York area will be served primarily by just four health plans.

What are the implications of this activity? The disparity between the high profits of New York health plans and the poor financial condition of New York's hospitals is well known to you and is getting worse. Consolidation has exacerbated this situation because it has given health insurers increased market power with which to compel providers to accept contracts that may have inappropriate terms and payment rates and to be forced to endure arbitrary payment practices. It has also led to the dominance of national health insurers not domiciled in New York that are not as responsive to local network or community needs. The increased reliance of Medicaid and Medicare on private managed care companies to arrange and pay for care has also increased costs compared to the administrative efficiencies of the government fee-for-service programs and lowered hospital payments for serving these patients.

There have been many references lately to New York's broken health care system. What is really broken is the way in which many health plans arrange and pay for health care for their enrollees and the profits they have made as a result. The sheer quantity and variety of different insurers' payment practices and rules is mind-numbing and have added unconscionable administrative costs to the system. These distinct rules for getting paid are required not just by each individual insurer but by each of their sub-contracted behavioral health and other carve-out companies. Providers with the market wherewithal may find ways to protect themselves, but other hospitals who cannot are no less needed by their communities. Payment denials for medically necessary care have contributed to worrisome hospital losses and fiscal distress, and contracting practices with particular safety net providers have been shocking. The extreme disparity between health insurer wealth and hospital losses is a primary symptom of a health care system that is askew.

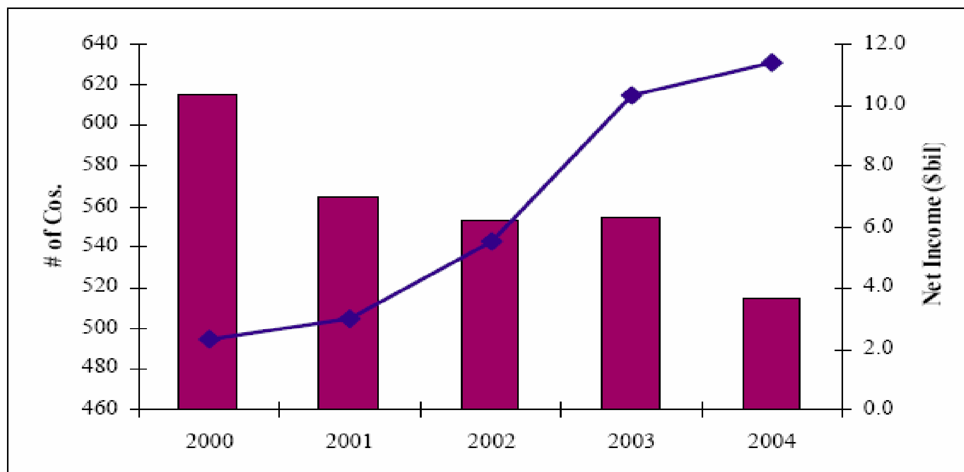
We therefore express our gratitude to you for holding this hearing to begin the discussion about how to fix our broken system. In my testimony today I will provide a brief context for the subject matter of this hearing, offer our thoughts on the specific questions you have posed and also offer broader suggestions related to trying to re-balance the system and protect health care for our communities.

Context

Health plan consolidation in our market has followed national trends as health plans have increased market share through acquisition of other plans. As noted, it has led to market dominance in the metropolitan New York area of national health insurers such as Wellpoint and United. Aetna, Healthnet, and Cigna are also significant presences. The merger of the major regional players HIP and GHI and their possible conversion to publicly traded status could set up the next major acquisition in our market. If there were another acquisition, it is likely to be made by a national health plan that is not domiciled in New York. The important topic of health plan consolidation that you have chosen to focus on today thus is accompanied another set of issues, namely, those posed by the dominance of national, versus regional, health insurers in our market.

Table 1, below, depicts national trends in health plan consolidation and profitability. It demonstrates why consolidation to gain market share has been an attractive strategy; net profits have risen steadily as the number of plans has decreased.

Five-Year Trend in Profits



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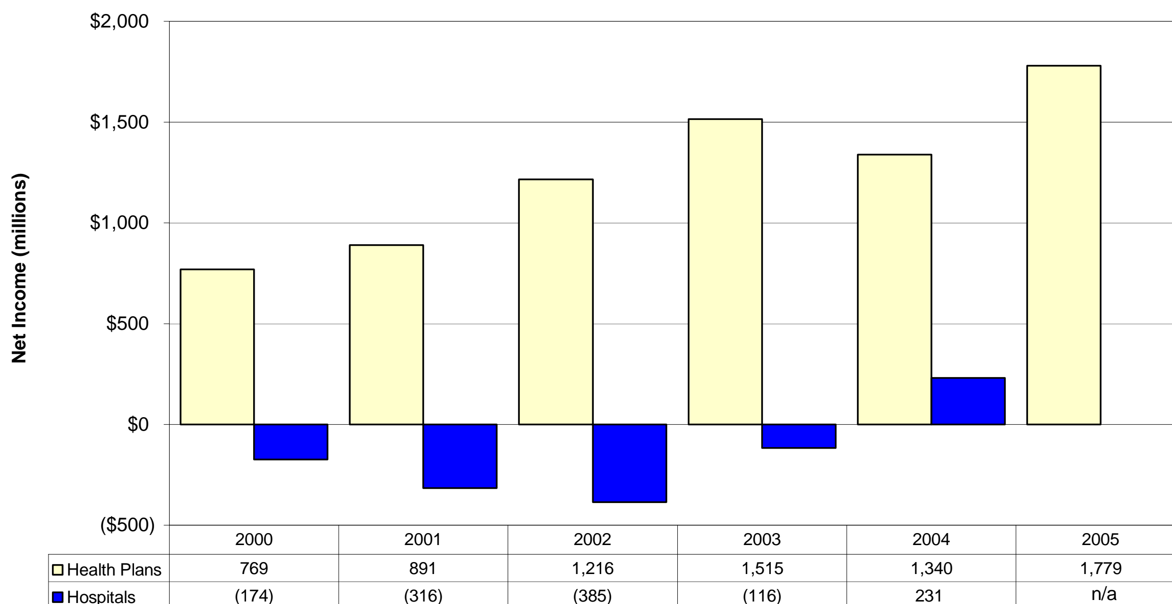
Source: Weiss Ratings, 8/8/05
Notes: Profits for the nation's HMOs increased 10.7 percent in 2004 to aggregate income of $11.4 billion compared with $10.3 billion in 2003. Profits increased more than 80 percent from 2002 to 2003.

Within New York State, the disparity between health plan profits and hospital finances has existed for several years and is growing. The financial picture shown on the table below represents the depletion of health care resources from New York's communities over time with no discernible improvement in access to or the quality of health care in our State as a result. If anything, hospital quality has suffered from persistent fiscal stress.

New York State Health Plan and Hospital Financial Condition
Net Income, 2000-2005



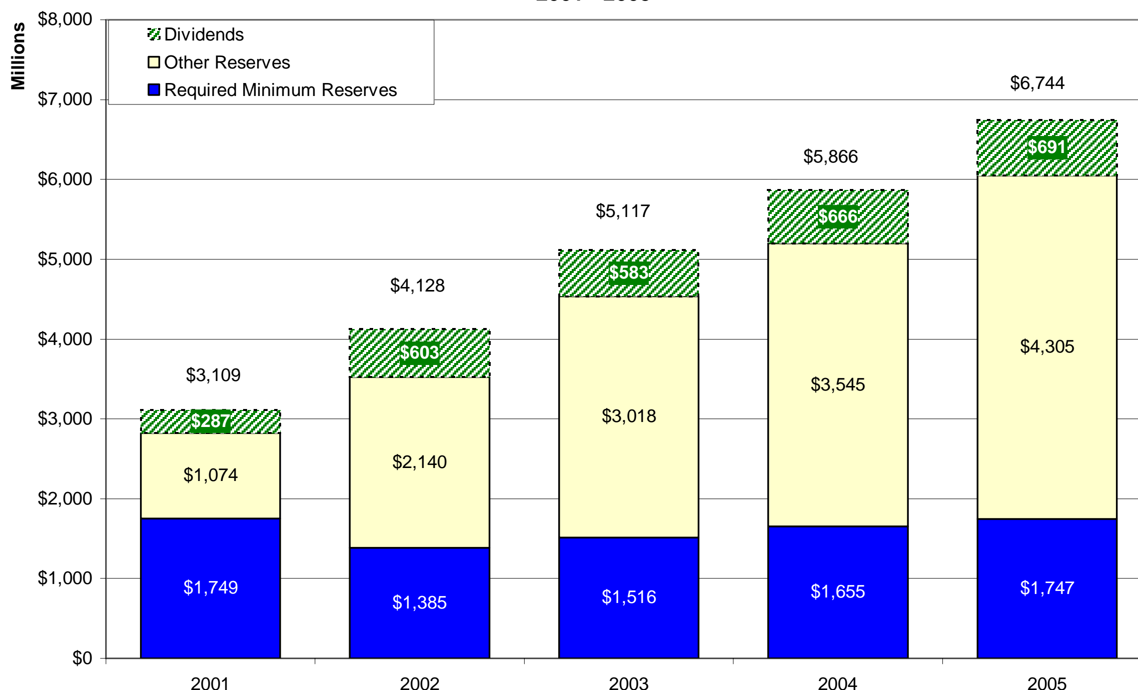
	2000	2001	2002	2003	2004	2005
Health Plans	769	891	1,216	1,515	1,340	1,779
Hospitals	(174)	(316)	(385)	(116)	231	n/a

Note: Figures do not include Prepaid Health Services Plans (PHSPs)
Source: New York State Hospital Institutional Cost Reports (ICR); New York State Insurance Department, Health Plan Annual Statements (NAIC Statements); data includes commercial PPO, HMO and indemnity.

Another indication of health plan profitability is shown on the table below, which depicts the growth in reserves of the State's major health plans over time. The health plans represented in this table are the main ones, representing 83% of total premium income, 85% of profits, and 88% of enrollees in the State. You can observe the astounding growth in total surpluses from 2001 to 2005, including surpluses above statutory reserve requirements. Part of these extra surpluses have been used to pay shareholder dividends, as shown by the top portion of the bars. Thus, in 2005, these plans had $5 billion in reserves above the statutory minimum, about $700 million of which were used to pay dividends.

We believe that all organizations require retained earnings for investment in their own growth. However, the amounts above statutory reserves that these plans have accumulated are extraordinary, particularly when juxtaposed against hospitals' losses. We suggest that when considering our recommendation below that health plans re-invest in the community health care infrastructure, you consider health plan profitability and the size of these reserves.

Growth in Health Plan Reserves Over Time
2001 - 2005



Note: Health plans included in this analysis: Aetna; Capital District Physicians Health Plan; Cigna; Empire; Excellus; GHI; HealthNow; HIP; Horizon; Independent Health; Oxford; United (including AmeriChoice); and Wellcare. Together, these plans represent 83% of total NYS premium income, 85% of total NYS net income, and 88% of total NYS enrollee member months.
Source: National Association of Insurance Commissioners (NAIC) financial statement filings.

Fundamental Principles

You have asked what regulatory or legislative steps should be considered to ease turmoil in the contracting process and ensure that providers can negotiate fair agreements with insurers.

The fundamental principles that we think should guide the answer include these: Providers should be paid for medically necessary services – every single time -- and payment should be made with a minimum of hassle and administrative cost. Payments should also be adequate to cover costs plus an amount sufficient to invest in information technology, medical advances, patient quality and access.

We also believe it is imperative that health plans contribute to and re-invest in the provider infrastructure to ensure continued access and quality of health care for communities and also to support investments related to improving quality and patient safety.

Below we identify special issues arising from health plan consolidation and make some suggestions to address them.

Issues Arising from Health Plan Consolidation

Consolidation, particularly when it involves national payers, presents the following challenges, among others.

- Increased market power. Consolidation has resulted in fewer health plans controlling larger numbers of enrollees and therefore has given plans greater market power. While State and Federal anti-trust authorities have thus far failed to be convinced that any of the mergers triggered concerns about monopsony power, there is no question that providers have felt the impact of the greater leverage of fewer payers in their markets. Greater leverage has meant that plans have been able to obtain hospital contracts that pay rates below costs, insert all-products clauses and most favored nations clauses or their look-alikes, and engage in payment practices that are cost-raising and result in under-payments or no payments. While all providers work hard to maintain adequate payment levels, those at the greatest disadvantage are those without market strength in the private sector, usually by virtue of their higher shares of Medicaid and uninsured patients. Lack of private payer accountability to hospitals serving low income and government-insured patients is a particular threat to the system.

- Unexpected revenue gaps. Consolidation may also bring with it unexpected revenue losses for providers because the acquiring plan may seek to consolidate its network into a lower-paying, acquired network, or may introduce novel and confusing products from new national affiliates into rates that were negotiated for a different purpose. When this happens, the balance of rate arrangements that a hospital has put into place to meet an overall revenue target for its own budget is disrupted and revenue losses can ensue, all as a result of a change in corporate structure rather than a negotiation.

  If a hospital has contracts with 15 plans, for example, it would be expected to calibrate its different negotiated rates so that the sum of total expected payments from the different plans meets a projected overall revenue target. The rates for each plan would be expected to vary based upon the plans' relative market leverage with the provider, the nature of the products it offered, and other factors. Plans with regional market share concentration would be expected to have lower rates than a national plan with a relatively small amount of business in the area, for example. Plans that are or were Article 43 corporations with State-mandated lower rates under the former NYPHRM system would be expected to have been able to carry forward those "legacy" differentials after NYPHRM's expiration. Other payers might pay higher or lower amounts based on the types of products they sell.

  When one plan acquires another, it also acquires the contracts held by that plan. In one instance, an acquiring plan notified physicians who held contracts with either the acquired or acquiring plan that the network was being consolidated. The doctors were offered a take-it-or-leave-the-network offer at the lower rate. This migration to the lower rate resulted from corporate consolidation rather than contract negotiation.

  Another example of how plan acquisitions may produce reimbursement surprises is when the acquiring plan introduces new and previously unknown products through the contracts that had been negotiated by the acquired plan for a different purpose. Had hospitals known about the novel product offerings introduced by new national affiliates at the time they had agreed to contracts with the acquired plan, they might have required different rates. However, there may or may not be an opportunity to address the problem in the present time and the new product offerings may produce revenue gaps. I should

note that it is not easy for a provider to detect new products coming through the portal of their negotiated rates but when they do, the products often are confusing and have features that have not been seen before.

At a minimum, it is essential that there be more transparency to providers about the products that are being introduced through inherited contracts so that there is an opportunity to respond.

- Loss of accountability. None of the national plans doing business in New York is headquartered here and there has been a loss of accountability and responsiveness to the local network. Local health plan executives are no longer the ultimate decision makers and those with decision-making authority are not located here. Many of our hospitals have noted that there is greater difficulty gaining resolution of problems with national plans, which can themselves be extremely complicated organizations with relevant component offices located in multiple states.

- Hewing to national templates. Consolidation also brings with it a desire to convert the acquired health plan's computer and other systems over time to a national platform in the interest of streamlining that health insurer's administrative costs. Any major systems change can be chaotic and problematic. However, when the local system has been working efficiently and meets the needs of the local network, conversion can also result in a less robust operation than what had previously existed.

  The desire for corporate standardization also may result in contracting practices that are driven by the desire to follow a national template designed to meet the needs of the payer rather than respond to regional needs and characteristics.

  Here is an example of how one national payer compelled hospitals to change their contracts to match the national template. The national payer uses Medicare DRG classifications when paying case rates. Its position was that if New York hospitals wished to be paid for medically necessary services, they had to switch their contracts from the New York AP DRG grouping system to use Medicare DRGs.

  The health plan stated that notwithstanding contrary provisions in its hospital contracts, its systems were unable to pay according to the New York State DRG system, the payment software for which is available commercially and which is used by Medicaid, regional plans, union benefit funds, and other national plans. Hospitals with contracts using the New York DRG system therefore did not receive accurate payments and were beset by arduous, manual claims analysis and reconciliation efforts. It appears that the health plan ultimately succeeded in compelling hospitals to contract according to its national Medicare DRG template but it caused turmoil, inaccurate payments for approved services, and intensive manual efforts by affected hospitals to recover the amounts owed. It goes without saying that if a hospital did not have the staff resources to devote to untangling these problems, it almost certainly lost money along the way. The unwillingness of this multi-billion dollar national insurer to purchase and install the New York DRG grouper and abide by its own contracts is an example of the administrative

burdens than can result from the presence of national payers. It also goes without saying that bigger is not necessarily better and that national payers can sometimes have the worst records for processing of payments.

- Increased costs related to Medicare and Medicaid. Medicare and Medicaid have relied increasingly on private health plans to pay providers for services rendered to beneficiaries. While managed care for government-insured populations, particularly Medicaid, has likely increased the quality of care when performed appropriately, there is little question that the migration to private contractors has actually *raised* administrative costs in the system. To the extent that these programs are conducted by provider-sponsored plans such as Pre-paid Health Services Plans (PHSPs), the effects are mitigated because the plans reinvest any surpluses from managed care into the provider system. For this reason, GNYHA endorses reliance on provider-sponsored health plans wherever possible. With respect to Medicare managed care, Federal pre-emption of State laws in many areas has unfortunately deprived both providers and patients of the protections of State regulation when a plan elects to rely upon such exemptions.

Our recommendations include the following.

Public Hearings

In response to your question as to whether public hearings on proposed merger and acquisitions should be required, we believe this would be helpful. We also recommend that the Attorney General's anti-trust analysis, findings and rationale with respect to any proposed merger be made public.

Merger and consolidations approvals should include specific conditions of the approval. When national plans are involved, we recommend requiring voluntary consent to be subject to State regulatory protections for providers and patients such as prompt pay laws and other protections, whether or not ERISA plans are the customers. All plans should be required to disclose to providers, electronically if possible, when new product offerings have been introduced into negotiated hospital rates and provide a detailed description of those products, but plans undergoing acquisition or merger should be particularly required to make these commitments as the risk is greater that new and confusing products will appear. Plans could also pay a consolidation fee to be deposited to support HCRA public benefits pools, particularly given the likely loss of accountability to the local health care system resulting from national plan consolidation.

Reinvestment

I am sure you are very familiar with the final report and recommendations of the Commission on Health Care Facilities in the 21st Century. The report contained extensive, momentous, and far-reaching recommendations to close, convert, downsize, and re-organize 57 -- or one-quarter -- of the State's hospitals. These recommendations represent the most extensive restructuring and reform of a health care system that have ever been proposed in the country and would cause extreme distress and consternation in the affected communities and among workers,

management, physicians, nurses, and other dedicated hospital staff. There are many issues raised by this report that are not the subject of this hearing, but I want to stress the following statement made by the Commission early on with respect to private payers:

> The relationship between private payers and the financial viability of the health care delivery system needs to be carefully examined. Reducing unnecessary hospital capacity and maintaining critical health services are as important to the insurance sector as they are to the public sector. As such, it is reasonable to expect those companies to participate in initiatives to promote financial alignment between payers and providers, and to participate in reinvestment strategies by reimbursing adequately while maintaining adequate reserves to meet current and future health care needs. [1]

We welcomed the Commission's acknowledgment that affected hospitals and their communities, and State government through the provision of restructuring funds, should not be the only participants in its recommended overhaul of the health care system, as well as its mention of the need for financial re-alignment.

In light of the disproportionate profitability and reserves of health plans compared to hospitals, plans must be required to re-invest in the health care system. It would be particularly appropriate to support initiatives that improve quality and access, and also to invest in priorities that the plans themselves have identified, such as electronic medical records, computerized physician order entry systems, and overall strengthening of the infrastructure.

State Oversight and Enforcement Powers should be Strengthened

We recommend that State regulatory and oversight powers be strengthened and exercised in a way that includes consideration of the importance of the health care provider infrastructure to the health of the State's citizens and the impact that plan actions have on that infrastructure. We believe that current enforcement powers and agency resources are insufficient for this task. Some examples include the following.

Prompt Pay Fines. Prompt pay penalties should be significantly increased, especially for repeat offenders that are the subject of complaints from multiple providers. We have found that the State Insurance Department (SID) is keenly interested in plans that are the subject of unusual numbers of complaints, but other than assessing the same prompt pay fines per verified complaint, they can do little about it. SID should be given much tougher powers to go after plans that repeatedly engage in payment practices that violate the prompt pay laws. These include requiring the insurer to develop a corrective action plan that includes the offer of a cash advance or periodic interim payment to providers.

Statements of Deficiency. When the Department of Health (DOH) issues a Statement of Deficiency (SOD) to a health plan, the insurer's corrective action plan should include a description of how the plan will make restitution to providers for past improper payment

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[1] "A Plan to Stabilize and Strengthen New York's Health Care System," Final Report of the Commission on Health Care Facilities in the 21st Century (November 2006), p. 74.

practices. DOH has issued SODs that have cited plans for egregious practices such as denying payment because a hospital failed to obtain pre-authorization for emergency services. The plan's corrective action plan should include mandatory restitution to make restitution to wrongfully denied providers as well as a requirement that DOH be able to verify that restitution has occurred. If there is no accountability for past wrongs, a plan could well make a business decision that it is worth the risk that it will be cited because it can engage in payment abuses, promise to correct problems going forward, and never have to pay back amounts it has wrongfully withheld.

When a health plan is the subject of more than one SOD in a particular period of time, or is cited for problems that were part of prior SODs, there should be stiff penalties and fines assessed. These fines should be meaningful enough to serve as a deterrent for bad behavior and should be deposited to HCRA public benefits pools as partial recompense for damage to the health care infrastructure. In one instance that we are aware of, a national plan's HMO was cited repeatedly by DOH for a variety of matters, including its lack of responsiveness to prior SODs. The plan's HMO enrollment was suspended, but as a practical matter this had no consequence because it simply shifted enrollment into another, recently acquired, HMO. We understand that one of the citations made by DOH was for a policy and procedure to disregard provider complaints unless the provider made at least two phone calls. The citation was a Pyrrhic victory because the plan was not required to identify and make restitution to all of the providers who never called back.

Enforcement and oversight should also be exercised over the carve-out companies used by health plans for behavioral health, radiology, physical therapy and the like. These sub-contractors further increase the administrative burdens on providers because they also have unique rules for billing and payment and our experience is that they often have little knowledge of New York State rules.

We note that it would be challenging for the State to track down every transgression that occurred and monitor every correction. At a minimum, therefore, the State should require each plan to report on the following information and make it public to enable all concerned parties to understand plans' payment practices.

- The volume and fiscal impact (pre- and post-appeal) of medical necessity denials
- The volume and fiscal impact (pre- and post-appeal) of technical denials, by plan.
- The volume of retrospective, post-payment audits, reasons for the audits, and outcomes

<u>Health Plan Contracts.</u> DOH should amend the HMO standard clauses to eliminate the current requirement that providers abide by any and all HMO policies and procedures, including whenever the plan changes them. This is an inappropriate interference with contractual terms and gives a plan carte blanche to change its rules in contravention of contractual requirements. It is reasonable to require providers to comply with changes that are required by the State, however, and the standard clauses can accommodate this legitimate goal by requiring providers to comply with changes that are required by State law, regulation, or directive when the plan notifies providers of the State requirement to which the change is tied.

All-products and most-favored nation (MFN) clauses and their look-alikes should be impermissible. All-products clauses force providers to accept losses for a particular line of business if they want to hold onto the other lines of business and are particularly harmful to providers when health insurers have market clout. Recently, we understand that some payers have been requiring hospitals to accept MFN clauses or equivalent provisions that trigger lower payments if the health plan determines that another plan is paying less. These are anti-competitive and should be banned.

External Appeals. SID should amend the external appeal regulations to give providers access to a fair and unbiased third party evaluation regarding the medical necessity of a service. They should do this by: (a) changing the definition of retrospective adverse determination and b) eliminating the requirement that the patient signature be obtained on the external appeal application, especially when the consumer has no financial liability.

Hospitals and other providers may initiate an external appeal in their own names only for retrospective adverse determinations, which SID has defined as determinations for which utilization review (UR) was initiated after health care services have been provided. This includes preauthorization, notification and clinical review between the payer and the provider. As a practical matter, however, UR is conducted on the vast majority of inpatient services at the time care is being provided which, under current regulations, deprives a provider of the opportunity to go to external appeal.

In the rare circumstance when a provider may be eligible to file an external appeal because a determination is issued retrospective to service, the provider is required to secure the patient's signature on the external appeal application. One might suggest that to make things administratively simpler, a hospital should obtain the requisite patient signature on admission. However, SID has also found this to be impermissible because the denial has not yet occurred and the patient might not understand what he is consenting to. From experience, providers that attempt to follow the current process and obtain a patient's consent after discharge report that the process is administratively burdensome and unduly restrictive.[2]

External appeal should ensure that the medical necessity determinations rendered by health plans to providers as well as patients are not arbitrary and capricious and can stand up to review by an independent third party. Current regulations and SID practices defeat this purpose.

Health Plans Should Pay for Medically Necessary Services

There is an imperative to ensure that health plans pay appropriately for care and the State should require payment for medically necessary care. Yet, payment for pre-approved, concurrently reviewed, medically necessary care is often denied or only partially paid. Some approaches to addressing this problem include the following.

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[2] Providers go to great lengths to contact the patient, explain the process, and obtain the patient's signature. Once the appeal is submitted, SID staff contact patients to verify that they meant to appeal and ask them whether they want to maintain the appeal given that they have no financial liability. Some patients then retract the appeal. If SID calls a patient and does not receive a return call, it also retracts the appeal.

1. If a provider requests pre-certification or eligibility verification, a health plan should provide it. When a verification of eligibility, pre-authorization, or pre-authorization is provided, these should be binding on the payer provided that the service is medically necessary.

Providers call health plans in advance of providing health care services to verify a patient's enrollment in the plan, his or her eligibility for service, and to pre-certify non-emergency services. Today, plans provide this information but attach the caveat that their verifications are not a guarantee of payment. This means that they may certify a service and then, after the service has been provided, deny payment because their records were not up to date and the patient was not actually enrolled, or the patient's benefits do not actually include the service that the plan pre-certified. Conversely, even though obtaining prior confirmation is not a guarantee of payment, if a provider fails to obtain it there might be a technical denial of payment on the grounds that the provider failed to follow an administrative requirement.

Providers try to obtain confirmation prior to the service. They rely upon the plan's information to provide the service in good faith because they do not have access to plan enrollment rosters to independently verify enrollment, or to the patient's benefits coverage to assure themselves that the service is covered. If the plan denies payment after the fact, providers are left with an unpaid bill for a medically necessary service that as a practical matter probably cannot be billed to the patient. This situation should be remedied by making prior confirmation of the service required if requested by a provider, and once made, a binding commitment to pay.

2. Technical denials should be reduced or eliminated

Hospitals that deliver medically necessary health care services to enrollees of health plans may nevertheless experience technical denials because they failed to meet the plan's administrative requirements. No provider should experience a 100% payment denial for an administrative error.

The lack of uniformity among different plans' protocols, as well as the absence of a standard of reasonableness for such administrative requirements, causes providers to incur burdensome administrative costs as well as inappropriate payment denials. State policy therefore should prohibit administrative payment denials for medically necessary services and should require that provider-health plan contracts reflect this prohibition. At least until all health plans have developed and apply a uniform, reasonable set of administrative requirements for notification, claims filing, authorization, pre-certification, referral, and other administrative processes, minimum provisions should apply.

For example, providers could have a margin of error for compliance with plan administrative protocols for medically necessary services. If the margin of error were 10%, this would mean that if a provider complied with the plan's requirements 90% of the time and the services were medically necessary, it would be paid for all of its claims, including the 10% that did not meet the plan's administrative requirements. This margin of error would be an acknowledgment that even best practice providers could only achieve a 90% compliance rate with a plan's

administrative protocols due to the lack of uniformity of protocols among plans and the absence of a standard of reasonableness for those protocols.

It should be noted that some payers have acknowledged that they have a known margin of error for claims payment accuracy. Therefore, even though a provider billing error may result in denial of 100% of the payment, there is no penalty to the payer when it pays the provider the wrong amount. Providers should not be penalized more than a portion of payment, if at all, for administrative errors.

Joint Negotiation

We believe that more flexibility is needed to recognize the right of providers to negotiate jointly. Traditional anti-trust analysis has permitted the consolidation of large health plan purchasers as being pro-competitive but has frowned on many configurations of provider alliances. Plans are seen as proxies for consumers and, as such, consolidation is viewed as helpful to competition.

We do not believe these analyses are well-suited to health care. The consumers who rely on hospitals consist of more than the paying customers of health plans; private pay patients comprise only about one-third of hospital business on average. Other consumers served by the hospital include those insured by regulated government payers such as Medicare and Medicaid, those who have no insurance at all, and communities at large who rely upon hospital emergency rooms, emergency preparedness readiness, trauma centers, and other services. Large health plans that squeeze money out of the provider system may be benefiting their customers if they pass those savings along in the form of lower premiums or better service but this does not benefit the other patients and constituencies served by the hospital. In particular, it serves no one's interests if a hospital becomes so financially weakened that it declares bankruptcy or becomes financially distressed.

We therefore support more flexibility with respect to how providers are able to negotiate jointly to offset the disproportionate market power now held by health insurers.

Provider Sponsored Plans

GNYHA is a steadfast supporter of provider-sponsored health plans, particularly for government insurance programs such as Medicare and Medicaid, because they return any surpluses earned from care management back to the provider system to support the uncompensated or under-compensated community missions of their sponsors. We believe provider-sponsored plans should be held to the same performance and accountability expectations as applied to all health insurers but that the State should not permit commercial or publicly-traded health plans perform Medicaid managed care in particular unless there are no provider-sponsored alternatives for that region.

Thank you for the opportunity to testify before you today. We look forward to working with you and your staffs as you try to identify workable approaches to these issues.