State of Connecticut

GEORGE JEPSEN
ATTORNEY GENERAL

Phone: 860-808-5314
Fax: 860-808-5387

Hartford

November 22, 2013

Douglas J. Edwards
Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Boston Regional Office
JFK Federal Building, Room 2375
Boston, MA 02203

Dear Mr. Edwards:

Thank you for your response to my November 6, 2013 letter expressing concern about UnitedHealthcare's ("United's") termination of hundreds of physicians from participation in United's Connecticut Medicare Advantage Plan. I appreciate your assurance that CMS is "working diligently with UHC to ensure that its physician network remains adequate and potential for serious beneficiary harm is not realized." Respectfully, however, I remain deeply skeptical that there is sufficient time for CMS to identify, and if necessary address, network adequacy problems before the end of open enrollment on December 7, 2013.

United continues to refuse to disclose the number of beneficiaries whose doctors have been dismissed from the Plan network. We have received reports suggesting that as many as 10,000 elderly and disabled Connecticut residents have been notified in the past week that, effective February 1, 2014, their physicians will no longer be available to treat them. The affected beneficiaries have only a few days before the Medicare Advantage enrollment period ends on December 7, 2013 to decide to remain in United's Medicare Advantage Plan or switch to a different company's Advantage plan. Needless to say, this decision is significant, highly personal and difficult, and Connecticut's affected Medicare beneficiaries deserve sufficient information and time to consider it.

Accordingly, I urge you to reconsider my request to extend the open enrollment period to affected members. In rejecting this request, your letter notes that beneficiaries retain the ability to disenroll from a plan after the end of open enrollment. This provides beneficiaries insufficient protection as it does not afford them the ability to choose another Medicare Advantage plan, and instead merely allows them to revert to standard Medicare, which in most instances offers a lesser benefit.

I remain concerned for additional reasons whether CMS or United has in place specific and adequate measures to avoid harm to enrollees. Over the past week, my Office received copies of notices, apparently mailed by United to enrollees on November 15, 2013, informing enrollees for the first time that they will be losing their doctors. The letters set out the names and addresses of

different network doctors, together with the statement that "We... have found another primary doctor that might fit your needs. ...If you think this doctor is a good choice for you, you do not need to do anything." We have no assurance, however, that CMS has required United to demonstrate that these "new" physicians are able to care for the approximately 10,000 affected beneficiaries. For example, do these doctors have the capacity to accept new patients and are their specialties equivalent to the beneficiaries' previous physicians?

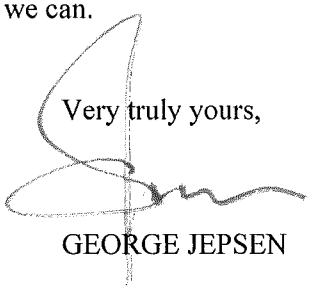
In your letter you also state that "... UHC must ensure that there is no disruption in care for enrollees who are undergoing treatment or are hospitalized, and we are working with UHC to ensure that this requirement has been met." Such assurances are certainly appropriate and necessary, particularly considering that United's November 15, 2013 notice to patients makes no mention of ongoing treatment or hospitalization.

I welcome your statement that "... if CMS finds deficiencies in UHC's network, the agency will require UHC to ensure adequate coverage by allowing enrollees to continue to see non-contracted providers at in-network cost sharing until UHC corrects its network deficiencies." My office stands ready to assist CMS in identifying network deficiencies so that CMS can put in place the transitional protections you have described. I have directed my staff to monitor, to fullest extent of our authority and ability, if UHC Medicare Advantage Plan enrollees in Connecticut are safely transitioning to new and appropriate in-network physicians. To that end, my office will continue to work with physician associations and patients to determine the impact of these terminations on Connecticut's enrollees.

In sum, I remain very concerned about the magnitude of United's provider terminations, the scope of beneficiary dislocations, and the short time period within which beneficiaries must make decisions about whether to remain or leave the UHC Medicare Advantage Plan. For these reasons, I believe "deficiencies in UHC's network" are very likely. I also continue to believe that an extension of the open enrollment period is necessary and appropriate in this case.

Thank you again for your letter and for your efforts to protect Connecticut citizens from the damage that may be caused by United's physician termination initiative. My staff and I are eager to assist those efforts in any way we can.

Very truly yours,



GEORGE JEPSEN

cc: U.S. Senator Richard Blumenthal
U.S. Senator Christopher Murphy
Congresswoman Rosa DeLauro
Congressman John B. Larson
Congressman Joseph Courtney
Congressman James Himes
Congresswoman Elizabeth Esty

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building
Room 2375
Boston, Massachusetts 02203
(617) 565-1232

Division of Medicare Health Plan Operations

November 21, 2013

Mr. George Jepsen
Office of the Attorney General
State of Connecticut
55 Elm Street, P.O Box 120
Hartford, CT 06141-0120

Dear Mr. Jepsen:

Christie Hager, the Region I DHHS Regional Director, referred your recent inquiry to us for response. Your concern was about mid-year provider contract terminations at United Healthcare (UHC), a Medicare Advantage Organization (MAO). You asked that The Centers for Medicare & Medicaid Services (CMS) scrutinize the provider termination initiative to determine the impact of the terminations on UHC's ability to maintain an adequate provider network for covered in-network services in Connecticut after February 2014.

The agency shares your interest in ensuring that the UHC provider networks, as well as those of all our contracting MAOs, meet the standards of adequacy and accessibility for Medicare beneficiaries enrolled in those plans. Thus, we are currently reviewing UHC's networks against CMS standards in each county affected by UHC's multi-state network changes. In addition to reviewing county-specific contracted provider data, we are working closely with UHC to investigate individual allegations from the provider industry and other stakeholders about inadequate sub-specialties or other barriers to access to care for members. We have recently received a few member complaints and we are in the process of addressing them with UHC.

As part of normal business, if CMS finds deficiencies in UHC's network, the agency will require UHC to ensure adequate coverage by allowing enrollees to continue to see non-contracted providers at in-network cost sharing until UHC corrects its network deficiencies. Until that time, UHC would pay non-contracted providers rates equivalent to what they would have received under Original Medicare.

Generally, MAOs have the flexibility to establish and manage contracted provider networks as long as their networks are adequate and in accordance with CMS regulations and program guidance. MAOs may change the conditions of provider participation at the time of provider contract renewal. CMS regulations require providers and MAOs to provide at least 60 days

written notice to each other prior to terminating a contract without cause. UHC reported to CMS that it issued providers notice of a February 1, 2014 termination date on October 2, 2013, exceeding the 60-day notice requirement.

As these provider terminations take effect, UHC must ensure that there is no disruption in care for enrollees who are undergoing treatment or are hospitalized, and we are working with UHC to ensure that this requirement has been met. We would also note that, consistent with CMS requirements, UHC has a process for providers to appeal their terminations and is reviewing and processing those appeals.

CMS also oversees member notification requirements to beneficiaries regarding provider terminations. CMS regulations require MAOs to make a good faith effort to provide written notification about a terminated provider at least 30 days prior to the effective date, to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. If the termination involves a primary care professional, all enrollees who are patients of that provider must be notified. UHC has reported to CMS that it mailed notices to the affected members in Connecticut on November 14 and 15, 2013, which is more than 30 days in advance of the February 1, 2014 termination. In this respect, UHC has met the member notice requirements.

In addition, CMS requires that MAOs send an Annual Notice of Change (ANOC) to its members outlining changes 15 days before the beginning of the Medicare Annual Coordinated Election Period (AEP). The ANOC includes, when applicable, a statement that indicates there are changes to the provider network and that the provider directory is included with the mailing or is located on the website.

CMS also requires MAOs to send annually the Evidence of Coverage (EOC), the contract between plans and enrollees that includes details about their healthcare coverage for the contract year. The EOC must describe what happens when a provider leaves the network.

Since provider networks may change at any time, and changes for the next contract year may not be reflected in a provider directory mailed with the ANOC, CMS requires the provider directory to indicate that it is current as of the date of publication and that some network providers may have been added or removed from the network after the directory was printed. Furthermore, MAOs must maintain a current provider directory on its website, and provide in the ANOC and EOC a customer service number so enrollees can receive up-to date information on provider networks.

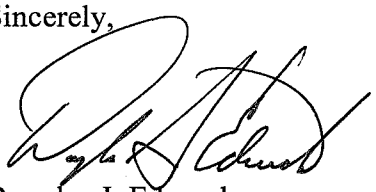
CMS appreciates your concerns about timely member notification of changes in the physician network, provider appeal timeframes that may extend the closure of contract negotiations beyond the open enrollment period, and the potential for physician network inadequacy resulting in harm to beneficiaries. For those reasons, we are working diligently with UHC to ensure that its physician network remains adequate and the potential for serious beneficiary harm is not realized. We continue to monitor complaints and inquiries from members regarding access issues for root cause analysis and resolution by UHC and for an in-depth assessment of its management of operations. We have encouraged MAOs to avoid implementing network changes at times other than the end of the contract year.

Finally, you asked that CMS consider an extension of the AEP for UHC members who may be adversely affected by these network changes. We do not believe that a special enrollment period is warranted at this time, but will continue to monitor the situation in case the circumstances change. In addition, during the Medicare Advantage (MA) Disenrollment Period, which runs from January 1 through February 14 of each year, Medicare Advantage enrollees have the opportunity to leave their MA plan and return to Original Medicare.

As follow-up to your letter, I have asked my staff and the oversight staff across the country to continue close monitoring and to determine whether or not there are additional beneficiary protections or other measures we might implement to minimize mid-year network changes and the subsequent confusion and disruption they may cause Medicare beneficiaries. Moreover, we are working closely with all CMS components and the DHHS Regional Director to focus our communications with this national health plan to effectively address the concerns of local physicians and plan members.

Thank you for your concern and I hope this reply addresses the issues you raised. If you have additional questions, please contact Marva Nathan, Branch Manager at (617) 565-1234.

Sincerely,



Douglas J. Edwards
Associate Regional Administrator

cc. Christie L. Hager, DHHS Regional Director, Boston
Ann Duarte, Associate Regional Administrator, CMS-San Francisco
Danielle R. Moon, Director, Center for Medicare, CMS