



**Testimony of Kevin Lembo, State Healthcare Advocate
Before the Human Services Committee
In Support of Raised House Bills 5905 and 5910
March 11, 2008**

Good morning Senator Harris, Representative Villano, Senator Kissel, Representative Gibbons, and members of the Human Services Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. Our office is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I'm here to testify in opposition to **Raised House Bills 5905, *An Act Modifying the Definition of Preferred Provider Network and Clarifying Certain Provisions of the Charter Oak Health Plan*** and in support of **5910, *An Act Concerning Legislative Oversight of the Department of Social Services***.

I would like to focus on **Raised House Bill 5905** first, since it sets a very bad precedent in the regulation of preferred provider networks (PPNs), also referred to as PPOs. In the last several years PPOs have come to dominate the health insurance delivery system, which means more scrutiny of these networks is needed rather than less. With this bill, DSS is attempting to modify the definition of PPNs in order to exempt those operating in any public program from the requirements and substantial protections of the governing PPN statute. It appears to be consistent with DSS' attempt to take products that in most states are regulated as insurance, out of regulatory oversight with a purported goal of attracting more companies to bid. Unfortunately, DSS' attempts to exclude these preferred provider networks from insurance regulation undermine the protections the legislature enacted and result in a two tiered insurance system in which privately insured individuals and providers are vested with more security than those enrolled in public programs or new vehicles like Charter Oak. We hope you will reject DSS' attempt to exempt its products from the PPN statutes.

The PPN legislation, passed in 2001 and amended 2004 and 2006, was designed to protect consumers from bad behavior and practices of some PPNs. Managed Care Organizations often "rent" PPNs to make things easier, especially when the MCO does not have a particular kind of provider network established. With the PPN protections in place, consumers whose health care is provided through preferred provider networks do not lose the protections they would have had if they received care through their managed care organization directly. The DSS proposal, on the other hand, would eliminate those protections for people in Charter Oak, HUSKY, traditional Medicaid and SAGA. These

are vital accountability and protection statutes that need to be preserved for people in public and private programs and regulated by the agency that understands insurance – The Insurance Department.

One of the major issues prompting the important 2003 passage of strong PPN legislation was the Attorney General's ongoing investigation of PsychCare, Inc. PsychCare, Inc. was a *non-profit* corporation set up to bid on contracts with insurance companies for their mental health business. The owner of PsychCare, Inc. set up a for-profit corporation, Psych Management Incorporated, through which all of PsychCare's assets and responsibilities were funneled. The Attorney General found that the company arbitrarily denied mental health care with no oversight and that its chief stockholder accumulated luxury items for himself and his family at the expense of families trying to secure mental health care. As a result of the startling findings of his investigation, the Attorney General made clear recommendations on legislation that would ensure that those networks and other subcontractors working with MCOs were financially solvent, licensed and not set up with a primary goal of denying claims. That report is still available on the Attorney General's website at:

http://www.ct.gov/ag/lib/ag/press_releases/2002/health/pmi1.pdf

I urge you to read the report if you have any hesitancy at all about the importance of the PPN legislation, even with respect to nonprofit entities.

Among the items that would be eliminated if this bill passes is a provision that ensures financial solvency of the PPN. There is nothing in DSS' bill that would save this very important component of the PPN legislation. Some of the key protections in the PPN legislation include:

- PPN must be licensed – this ensures some integrity in engaging in business in CT
 - Financial information must be disclosed
 - Contractual arrangements must be disclosed including relationships with subcontractors
 - Network providers and geographical location must be disclosed
 - Provider availability must be disclosed
 - Sanctions anywhere in the U.S. must be disclosed
 - Names of owners of the PPN must be disclosed
- Provider selection criteria must be disclosed
- Requires PPNs to submit to inspections, financial and otherwise
- Imposes minimum financial requirements on PPNs for enrollee protection
- Includes hold harmless protections for enrollees in the event of a dispute of a claim between the PPN and a provider

- Includes protections for the right to appeal
- Imposes contractual safeguards on MCOs that contract with PPNs

In looking at 5905, one might not notice the damage that Section 1 of this bill does in exempting nonprofit preferred provider organizations from the regulatory definition contained in Section 38a-479aa of the general statutes and by the addition of language in Section 2(e) of the bill that would allow DSS to contract with “any organization authorized to do health insurance business in this state”. These two sections together significantly undercut substantial protections in insurance regulations. The licensing requirement of Section 2(e) does not save this bill since PPNs in Charter Oak and public programs would be exempt from licensing by Section 1. It should be said that any PPN currently conducting business in Connecticut must be licensed as a PPN, making this legislation unnecessary for the majority of PPNs. Given how much of the Charter Oak plan has been designed to avoid the insurance regulations to which it should be subject, we should not give away the store by allowing 5905 to go forward. We should not continue to allow the erosion of insurance regulations by exempting DSS insurance products from important consumer protections.

When testifying before the Insurance and Real Estate Committee in support of S.B. 917, which, as amended, became P.A. 03-169, An Act Concerning Preferred Provider Networks, in 2003,¹ then Insurance Commissioner Susan Cogswell said:

The Insurance Department supports SB917, An Act Concerning Preferred Provider Networks

There's been concern among many Doctors and the legislature that these entities are not adequately supervised or funded....

SB917 will bring additional accountability to PPNs and the HMOs that use them. We believe that the oversight of these entities should be comprehensive and similar to the oversight of other regulated entities like insurance companies and HMOs.

Such oversight would include solvency standards, reporting requirements and administrative remedies. SB917 will also allow the Commissioner to track, inspect, and penalize PPNs. Set minimum network requirements based on the level of financial risk, establish consumer protection provisions that prevent PPNs and their subcontractors from billing patients for months (sic) owed by the PPN or HMO. And mandate the sharing of financial risk and audited financial information between the HMOs and PPNs.

The Connecticut Association of Health Plans also supported the bill:

¹ Please note that the full transcript from the March 6, 2003 Insurance and Real Estate Committee is available on line at www.cga.ct.gov by searching transcripts for S.B. 917.

My name is Susan Halpin and I'm here before you today speaking on behalf of the Connecticut Association of Health Plans regarding raised SB917, An Act Concerning Preferred Provider Networks.

By way of the background, for your information, the Association is comprised of the majority of licensed health plans in the State including, Aetna, CIGNA, ConnetiCare (sic), Community Health Network, First Choice/Preferred One, Health Net, Oxford, United and Yale Health Plan....

With respect to the bill before you today, we full concur that the protections afforded to health plan members under current stature ought to extend members across eth (sic) full spectrum services regardless of whether it's a managed care entity managing the benefits of (sic) their designate subcontractor.

By virtue of their individual contracts, most health plans currently require that their subcontractors fully comply with all state laws and regulations, with respect to the administration of health care.

However, passage of this type of legislation will assure that such provisions are carried out in a uniform manner, that a clear structure is established to assure compliance and that the Insurance Commissioner is granted the regulatory authority needed to act in the event of noncompliance.

We also sup pore (sic) the intent of the provisions in the legislation that require subcontractors to meet specific solvency standards related to the amount of risk they accept.

Financial stability is critical to the business of insurance and to the availability of health care services and we share the Committees concern that any risk beating entity have the wherewithal to meet their contractual obligations.

And Christine Cappiello, Director of Government Relations for Anthem Blue Cross Blue Shield of Connecticut noted that:

To begin, Anthem Blue Cross Blue Cross Blue Shield supports, in principle, SB917.

We agree that strengthening oversight and clarifying responsibility around the practice of managed care organizations who utilize the services of subcontractor and risk bearing entities would help further protect the consumer.

Nothing has changed since passage of P.A. 03-169. The protections are still needed, even for consumers of nonprofits – note that Community Health Network of Connecticut, Inc. endorsed the PPN legislation through its membership in the Connecticut Association of Health Plans.

While I support language in 5905 that clearly states that each insurer under the Charter Oak plan will be subject to the Freedom of Information Act, insurer is not defined, and so needs to be broad in scope. However, given the major problem that

Sections 1 and 2(e) create, the FOIA language could be added as JFS language to another vehicle while 5905 is rightfully rejected in its entirety.

I support **Raised House Bill 5910** in its entirety. There are solid provisions in the bill designed to ensure that there is clear communication between DSS and the committees of cognizance. Specifically, we believe that is entirely appropriate to require that proposed regulations be submitted in advance of action by the Regulations Review Committee, to the Medicaid Managed Care Advisory Council and/or the Behavioral Health Partnership Oversight Council for review and recommendation.

It is also appropriate that sections 3 and 4 of the bill include specific authority for the review and recommendations of regulations by the Medicaid Managed Care Advisory Council and the Behavioral Health Partnership Oversight Council. These councils are comprised of advocates, providers, agencies and insurers and can give a consensus response to the proposed regulations. Practically, there are very few individuals who can access the Connecticut Law Journal for a weekly review of new regulations. Ensuring a wider review and comment on regulations prior to action by Regulations Review Committee provides the best means for communication and cooperation among all parties involved in these DSS healthcare programs.

Finally, we are happy to engage in a conversation about the most appropriate home for the Long-Term Care Ombudsman. Section 5 addresses a study by OPM to determine the appropriateness of placing the Office of the Long-Term Care Ombudsman within our office. I have spoken to the Long-Term Care Ombudsman, Nancy Schaeffer, and I think it's fair to say that we are both committed to the evaluations and finding the best solution for the citizens of Connecticut.

Thank you for your time today and I am happy to take your questions.

Attachment

Press Release, Attorney General's Office, and February 14, 2002.

CT Attorney General Connecticut Attorney General's Office

Press Release

Blumenthal Finds Anthem, Psych Management Denied/Limited Coverage To Vulnerable Patients

February 14, 2002

Attorney General Richard Blumenthal today released a report finding that Anthem Blue Cross and Blue Shield (Anthem) and Psych Management Inc. (PMI), the company it hired to manage behavioral health claims for some 600,000 enrollees in its managed care plans, arbitrarily denied medically necessary mental health care for vulnerable patients.

"This story is about a physician who sacrificed his patients for money and power -- abandoning his sacrosanct obligation to help them, or at least do them no harm. This story is also about a managed care industry operating without the most basic safeguards and protections -- an industry that ignores reprehensible conduct so long as it benefits the bottom line," said Blumenthal. "This report presents a picture of a physician driven by the promise of wealth to disregard health needs. More important, it starkly dramatizes the dark side and dynamics of the managed care industry, which not only permit but even encourage such failings."

In 1996, prior to its merger with Anthem, Blue Cross/Blue Shield decided to "carve out" the behavioral health management of its BlueCare plan to a subcontractor that specialized in behavioral health. Anthem selected PsychCare, Inc., a non-profit corporation founded by Dr. Peter Benet, a psychiatrist practicing in Hartford. Dr. Benet formed PsychCare for the purpose of bidding for the right to manage behavioral health coverage for Anthem's enrollees. PsychCare eventually had 33 "members" -- physicians -- each of whom contributed \$5000 to fund the initial operations of the non-profit.

According to Blumenthal, Dr. Benet then "devised a plan to bilk PsychCare of its assets and profit personally" by organizing a second, for-profit stock corporation, PMI. PMI entered into a "management contract" whereby PsychCare transferred all of its existing assets and business responsibilities -- including the Anthem contract and its provider network -- to PMI. PMI never compensated PsychCare for the transfer of its assets, approximately \$147,000. At the same time, Dr. Benet and his wife were given 2500 shares of PMI -- 25% of the outstanding stock -- essentially for free. Dr. Benet also received 3000 shares as a reward for his performance. Dr. Benet eventually came to own 6000 shares representing 42% of PMI's stock, giving him a controlling interest in PMI.

With a controlling interest in PMI, Dr. Benet's financial fate was inextricably tied to PMI's financial performance. Any cuts in services to enrollees, lower reimbursement rates for participating doctors and hospitals, and payments withheld to doctors would fatten PMI's bottom line and Dr. Benet's wallet. As PMI's Medical Director, Dr. Benet was responsible for mental health and substance abuse care coverage decisions. In this capacity, he coerced and manipulated PMI and its Board into making a series of questionable financial and coverage decisions, all to his personal financial benefit.

"As Anthem knew or should have known, PMI and Dr. Benet made decisions repeatedly causing denial of medically necessary coverage and care to Anthem enrollees," Blumenthal said. "Dr. Benet pressured PMI care managers to deny coverage based on arbitrary caps and guidelines, which in turn reflected Anthem rates of compensation and utilization. He promulgated arbitrary coverage rules having no relation to medical necessity of the claims involved. He also stood to profit, and did profit personally from the denial of coverage and care to the patients that Anthem and PMI were obligated to deal with fairly and in good faith."

In April 1999, \$100,000 in debt to the IRS and desiring to buy a home for his second wife, Dr. Benet persuaded PMI's board of directors to issue a dividend that he had reason to know, and had been advised by the CFO, PMI could not afford. Dr. Benet essentially hid from the Board preliminary financial reports for the first quarter of 1999, which showed a loss. He also failed to disclose that the amount owed to providers but not yet billed had yet to be determined for 1998. Instead, Dr. Benet told the Board that PMI had \$1 million in profit available for a dividend payment. The Board approved a dividend payment of more than \$440,000, including \$161,700 to Dr. Benet.

Because of the dividend, PMI was forced to improperly withhold approximately \$750,000 in reimbursements due to providers in 1998. The PMI Board decided not to inform providers about the decision to withhold the reimbursement. Eventually, Anthem learned that PMI had not reimbursed the providers and ordered Dr. Benet to release the reimbursement. The reimbursement was made to providers on September 7, 2000.

At the same meeting where the PMI Board chose not to inform providers about the reimbursement withhold, the Board gave Dr. Benet an additional 1,200 shares of stock on the grounds that his performance "had warranted recognition..." Dr. Benet also requested and received from PMI a \$45,000 advance on salary to help him in resolving a "real estate situation."

During 1999 and 2000, the PMI care managers came under increasing pressure from Dr. Benet to deny coverage and reduce utilization. He began meeting with care managers every day to review cases, particularly the status of enrollees who were psychiatric inpatients, and would pressure some managers two or three times a day in an effort to force them to restrict coverage.

According to care managers, Dr. Benet focused only on the number of days the patient was in the hospital and rejected the clinical information concerning why a patient needed to remain as an inpatient.

In addition, Dr. Benet:

- Promulgated arbitrary guidelines designed to reduce utilization, which became more restrictive over time. He would terminate coverage in cases he called "chronic" even when the enrollee involved was a child.
- Established, in writing, an arbitrary cap of nine covered intensive outpatient visits in 30 days for patients in need of substance abuse treatment. Coverage was also formally capped at one residential or intensive outpatient episode per calendar year. Dr. Benet's caps had nothing to do with clinical criteria and were seen by care managers as having no relation to the actual needs of enrollees.
- Employed a policy of "tapering" whereby care managers were required to taper down the amount of coverage being granted in particular cases. If coverage was granted for 12 outpatient therapy visits in a 3 month period, for example, PMI care managers were required to grant coverage for fewer visits in subsequent periods even though the patient involved might be more sick than he or she had been.
- Imposed an arbitrary limitation on coverage for inpatient care that paralleled the amount of compensation PMI was receiving from Anthem. Thus if Anthem was paying PMI an amount sufficient to pay for seven or eight inpatients at one time, Dr. Benet would become very concerned if the PMI inpatient census exceeded that number and would pressure managers to limit coverage.
- Authorized differing levels of coverage based on an enrollee's type of health care coverage. If Anthem and PMI "insured" the coverage -- paying all claims for medically necessary care -- Dr. Benet would authorize coverage for dramatically fewer days or visits than he would if the enrollee's employer retained the risk and paid claims out of its own pocket.
- Sought to admit patients into hospitals with the lowest reimbursement rates so that PMI would save money on those patients' care. These hospitals were also more likely to discharge patients faster. This practice particularly hurt children, who were often left languishing in emergency rooms for 24 or even 48 hours in hospitals that had beds for them because Dr. Benet was trying to locate a bed at a less expensive hospital, even though that hospital might be hours away from the child's family.

At the same time that he forced dramatic and harmful cutbacks in coverage and care available to patients, Dr. Benet spent extravagantly on luxury office space and furniture, automobiles, lavish parties, and redundant and over-priced new executives.

When radical cutbacks in PMI's coverage of medically necessary

care failed to stem the financial problems, Dr. Benet directed managers to "hold" checks due to be mailed to providers. PMI managers would cut checks to providers, but would place the checks in a locked box rather than mail them. By misrepresenting that payment to providers had been made, PMI was able to obtain reimbursement from Anthem under false pretenses.

According to Blumenthal, Anthem must share the blame for PMI and Dr. Benet's misdeeds.

"When Anthem subcontracts, it remains responsible for keeping the promises it makes to its enrollees. Any failure by PMI is also ultimately Anthem's failure," said Blumenthal. "Anthem in effect created PMI, trained its staff, dictated the terms of its contracts, provided all its operating income, and imbued PMI with a cost cutting business culture that became PMI's central goal. In an effort to cut its own costs, Anthem accepted a PMI bid that was so low it virtually guaranteed that PMI would deny coverage for medically necessary treatment. Anthem either knew or should have known of PMI's misconduct."

Dr. Benet was eventually forced out of PMI, in October 2000, after Anthem and the Board learned that he had been consistently lying to them. Despite his years of mismanaging PMI into a dangerous deficit, injuring enrollees, and lying to Anthem and PMI Board members, Dr. Benet received a \$400,000 golden handshake paid for by Anthem.

Perhaps more disturbing than the payout to Dr. Benet, Anthem continues to contract with PMI for its behavioral health carveout. In fact, Anthem re-selected PMI in the summer of 2001, when it put all three of its commercial behavioral health contracts -- BlueCare, State Employee, and Century Preferred -- out to bid "Although Dr. Benet is no longer with PMI, the arbitrary coverage caps and guidelines apparently are still in use by PMI and Anthem, conflicting with Anthem's contractual obligations. None of Anthem's contractual materials mention the arbitrary coverage rules employed by PMI or the tremendous pressure on and within PMI to cutback on medically necessary care," Blumenthal said. "In fact, Anthem's written promises and assurances, in light of the facts now known, are affirmative misrepresentations to patients concerning the coverage available under its plans, and the circumstances of plan administration."

Blumenthal has called on the State Department of Public Health to initiate proceedings to suspend or revoke the license of Dr. Benet to practice medicine on the grounds of "negligent conduct in the practice of medicine." He is also initiating litigation to ensure that Connecticut citizens enrolled in managed care plans administered by Anthem and PMI are protected from arbitrary and unfair coverage determinations liable to deny them medically necessary behavioral health care. In addition, Blumenthal is urging the legislature to enact a law protecting patients from carveout bias and misconduct, and ensuring that managed care companies are held accountable for their carveout's misdeeds.