TESTIMONY OF
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SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
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SB 6, AN ACT CONCERNING PRESCRIPTION DRUG AFFORDABILITY AND PROTECTIONS FOR CONNECTCIUT'S HEALTH CARE CONSUMBERS

Good afternoon. My name is Kurt A. Barwis, and I am President & CEO of **Bristol Health, Inc.** I am here to testify in support of SB 6**, AN ACT CONCERNING PRESCRITION DRUG AFFORDABILTY AND PROTECTIONS FOR CONNECTICUT'S HEALTH CARE CONSUMERS**

Bristol Health, Inc. is an independent integrated health system, providing innovative, integrated and individualized care for the community of Bristol, CT and its surrounding areas. Bristol Heath sits within miles of three large teaching tertiary care centers and an additional community hospital, creating a highly competitive landscape. Despite the geographic pressures and an approximately 72% government payers mix, Bristol Health has combined net revenues of $200.8 million. Bristol Health consists of Bristol Hospital (CMS 4 Star Facility), a 154-bed private, not-for-profit community hospital; Bristol Home Care and Hospice Agency (CMS 4 Star Organization); Bristol Hospital Multispecialty Group, a physician governed not-for-profit medical foundation comprised of 150+ physicians/advance practice professionals delivering 152,242 office visits; Ingraham Manor (CMS 4 Star Facility), a 128-bed, short-term rehabilitation and long-term care facility; Bristol Hospital EMS and the Bristol Hospital Development Foundation.

In FY 2022 Bristol Hospital discharged almost 6,000 patients, provided care to 31,711 emergency patients and system wide employed approximately 1,700 people in the greater Bristol area.

SB 6 focuses us on serious and important protection issues which can impact any of the 3.6 million people that live in Connecticut when they need care. My testimony is focused the Prior Authorization "PA" practices of insurance companies that are severely impacting timely access to care, blocking patients who require care from access, increasing the cost of care, causing physician burnout and moral injury and causing independent physicians and hospitals to seek employment/acquisition/consolidation. These practices often utilize internal-unpublished non-generally accepted clinical criteria. Access to insurance company PA staff is not available to meet patient needs on nights weekends and holidays.

The U.S. Department of Health and Human Services Office of the Inspector General ("OIG") issued a report on PA findings titled "Some Medicare Advantage Organization Denials of Prior Authorizations Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" April 2022. The following are excerpts from the audit report:

1) "A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits.
2) We found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules – in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service).
3) First, MSOs used clinical criteria that are not contained in the Medicare Coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that our physician reviewers determined were medically necessary.
4) Second, MAOs indicated that some prior authorization request did not have enough documentation to support approval, yet our reviewers found the beneficiary medical records already in the case file were sufficient to support the medical necessity of the services.
5) We found that among the payment requests that MAOs denied, 18 percent met Medicare coverage rules and MAO billing rules."

Clearly this independent authoritative audit found major issues that are consistent with testimony about MAO PA practices presented to the Insurance and Real Estate Committee in 2021 and 2023, as well as the testimony presented to the Public Health Committee in 2023. Moreover, the compelling audit findings validate the OIG's "central concern" about the potential incentive for MAOs "to deny beneficiary access to services and deny payments to providers in an attempt to increase profits." All one has to do is look at the profits these companies are publishing and for example the fact that one of the largest, Humana, is getting out of all other lines of health insurance to singularly focus on Medicare Advantage - to know that profits are bountiful at the expense of enrollees and providers.

It is important to note that what you get in response from the insurance industry concerning the use of PAs is not current and often subjective. For example they will selectively point to surveys, such as "physicians say that "X" percentage of the care they provide is unnecessary", while the full context and critical causation is completely omitted. Defensive medicine in this case being a primary cause - simply stated physicians are required to meet a standard of care and professional judgment or potentially be exposed to a career ending malpractice suit. The PA process is overriding physician professional judgment without ever seeing or evaluating the patient. The real question to be asked is, will we implement or modify the Patient Bill of Rights to protect patients from harm that results from an insurance company denying necessary care? Will we enact legislation to ensure that patients who are harmed have

the absolute right to sue their insurance company mirroring what exists for health care providers? As outlined in the OIG report (see number 3 above), PA denials often do not utilize or conform to widely accepted standards of care and professional judgment, so how is it equitable and fair that enrollees don't have a clear pathway and right to hold insurance companies that use PAs accountable for harm they cause? Unfortunately when patients engage and challenge denied PAs the answer they most often get is the denial was because the provider didn't provide enough documentation or appropriate documentation to support that the service or procedure was medically necessary. Moreover, this pushes all of the blame and liability back on the provider when that is most often not the case. Giving enrollees/patients a Bill of Rights that gives them a clearly defined and absolute right to sue an insurance company for harm as they can all providers will serve to hold them accountable for their actions, increase transparency and improve the reliability of the PA process. Surprisingly, in 2023 we exist in a Wild West world when it comes to the use of PAs – accordingly law and order is indicated – the insurance companies that use PAs inappropriately need to face real consequences for the patient harm they cause. Connecticut should strongly consider giving its citizens such rights and protections. .

Example of MAO PA Abuse at Bristol Hospital

Efficient emergency department flow is critical to ensuring that the arriving patient's immediate access to needed care is available. Emergency departments assess, diagnose, stabilize, treat and/or appropriately discharge the patient to home or admit the patient within their organization or to a post-acute care facility such as a skilled nursing facility. Emergency department flow is dependent on system capacities such as the intensive care, medical surgical, behavioral health or a specialty unit's ability to receive and care for patients. It is important to note that all of these departments need to be able to timely discharge patients to receive patients from the Emergency Department. More often, timely discharge is impacted by insurance company prior authorization requirements.

With respect to ED MAO patients that are deemed most appropriately transferred to a post-acute facility, the availability of beds is typically not the limiting factor; rather, the limiting factor is the need for an insurance prior authorization to move the patient successfully.

Factually, any delay in the system can and often does back up an emergency department causing crowding, long holds on stretchers and incoming access issues including but not limited to diversions to other emergency departments.

While the causes are multifactorial I would like to focus on one of the most significant, persistent and damaging ones, timely insurance prior authorizations "PAs".

Bristol Health, Inc. frequently encounters challenges in working with MAOs and securing timely authorization and payment for care we provide to our patients, which can result in unnecessary delays and increased administrative burdens. These

challenges often include misuse of utilization management programs, inappropriate denial of medically necessary services that would be covered by traditional Medicare, requirements for unreasonable levels of documentation to demonstrate clinical appropriateness, inadequate provider networks to ensure patient access, and unilateral restrictions in health plan coverage in the middle of a contract year, among others.

One of most significant delays in PA occurs when we are seeking a Skilled Nursing Facility "SNF" authorization when a patient is ready for discharge from an acute episode. The delay in authorization ranges from 2-3 days with an overall average of 1.6 for our fiscal year ending 9/30/2021 as detailed below.

Bristol Hospital Medicare Advantage Organization Patient Delays related to insurance prior authorizations - (specifically acute discharge waiting for prior authorization to SNF)						
	MEDICARE ADVANTAGE ORGANIZATION					
	MAO 1.	MAO 2.	MAO 3.	MAO 4.	MA5.	Totals
Total SNF discharges for FY 2021 (10-1-20 through 09-30-21)	47	241	93	14	70	465
# of Cases sent on Insurance waiver / No authorization requirement	17	22	36	0	8	83
# of Cases needing SNF level authorization	30	219	57	14	62	382
# of Cases delayed due to authorization process	22	136	28	13	56	255
# of days lost awaiting authorization (Avoidable NON-PAID Days)	**28**	**218**	**37**	**18**	**105**	**406**
Average Days Delay per case	1.3	1.6	1.3	1.4	1.9	1.6
Percent of total cases sent with no authorization requirement	36%	9%	39%	0%	11%	18%
Percent of total cases needing insurance authorization requirement	64%	91%	61%	100%	89%	82%
Percent of cases needing insurance authorization with delay	73%	62%	49%	93%	90%	67%

During FY 2021 some MAOs waived prior authorizations requirements due to the pandemic, for short durations. It should be noted that Bristol Hospital received only the DRG payment for each MAO patient. Accordingly, for those situations where we experienced discharge delays due to PA review, which totalled 406 days, we were paid nothing at all for those 406 days of care we provided while waiting for the PAs. Further,

100% of the authorization requests for these patients were approved with the exception of ones where we needed the denial for commercial or Husky. There were 21 initial denials, 7 of those were overturned by peer-to-peer review and the other 14 were transferred to a SNF under a secondary payer (either Husky or private pay).

The FY 2021 cost for the 406 days that Bristol Hospital, a nonprofit charitable organization, provided to MAO organizations based on our last filed Medicare cost report would be $525,676.62. Using our observation rate that cost would be $1,001,991. However, neither of these approaches captures the true incremental cost of providing care to patients that didn't need to be in our hospital. For example: the fact that we were and are in a severe national staffing crisis paying upwards of $190 per hour for a traveler nurse.

From a patient perspective these PA delays:

1) Presented added risks.
2) Lengthened the time that it took the patient to fully stabilize, improve and resolve their condition.
3) Forced patients to suffer through periods of ineffective treatment (in an acute care bed versus skilled) before permitting access to the most appropriate therapy.
4) Limited access to new arriving patients and for patients in our emergency department who urgently required an acute care bed. Factually, in December/January of 2022 when we were being overrun by very sick Covid patients we had as many as 10 patients in our acute care beds waiting for a PA while there were an equal number of patients in our emergency department waiting for an acute care bed.

Why are these specific acute to post-acute PA delays occurring?

1) MAOs know that a hospital cannot discharge a patient without a safe discharge plan.
2) Post-acute facilities will not take an MAO patient without a PA – they will not get paid if they do.
3) MAOs get paid a PMPM and are 100% at risk for the care a MAO patient receives.
4) Hospitals cannot bill a patient who is delayed by an MAO in a hospital bed unnecessarily. Further, to discharge and readmit the patient to an observation status is not appropriate or practical.
5) MAOs refuse to negotiate or renegotiate our contracts to agree to a reasonable per diem for delayed inpatient discharges due to delayed PAs. Our small system has zero leverage and the MAOs use this deceptive practice to improve profitability.
6) Given the significance of Medicare Advantage in the community served by Bristol Health, we cannot go non-par without causing confusion and access issues.

Connecticut Legislative Solution

Factually, 90 percent of the PA abuse at Bristol Health, Inc. is by MAO plans. The remaining portion is related to fully insured and employer sponsored plans. MAO plans enjoy a broad federal preemption with respect to states legislating laws, rules and regulations. The Centers for Medicare & Medicaid Services ("CMS") regulations state that the federal standards established for MAOs "supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency)." See 42 CFR 422.402. The Medicare Managed Care Manual Chapter 10 – MA Organizations Compliance with State Law and Preemption by Federal Law clearly further establishes these boundaries.

States' early attempts in this area by and large were focused on consumer protections from MAO false or deceptive marketing - which remains a consistent theme across the U.S. In fact the U.S. Senate Committee on Finance launched an inquiry in in August of 2022 and published a report on the issue "Deceptive Marketing Practices Flourish in Medicare Advantage." In every state that attempted to protect seniors from MAO deceptive marketing, federal preemption was asserted by CMS, and states were instructed to file complaints as opposed to enacting laws. However, states can require certification/licensure requirements for marketing representatives and MAOs must limit their employment of marketing representatives to only those who meet such requirements. Interestingly and somewhat related, CT does have licensure requirements for "Medical Management" companies. Similarly, MAOs must only use CT licensed Medical Management companies.

Given the broad federal preemption related to MAOs, any state solution must be carefully constructed. Accordingly, the language cannot adjust or impact the existing federal PA rules for MAOs. Specifically, states cannot for example limit what procedure, diagnostic test or treatment can be gated by a PA. We do believe, however, that the state can address the delays related to patient access to care as outlined in the data from Bristol Hospital above. This can be accomplished through legislation establishing administrative fees/cost to compensate for delayed hospital discharges and for the extreme burden and associated cost born by physician staff in navigating MAO PA procedures, which pulls physicians away from treating patients and thus limiting access to care.

These are not fees/costs related to a "covered service" and they are not modifying the rules related the use of PAs, they are simply a fee to cover administrative costs in a physician medical office and the cost of providing care for patients that are delayed by an insurance company, that are waiting for an insurance company to make a determination. On the hospital side in CT, we already have the ability to bill State Medicaid a per diem for certain behavioral health patients waiting for an appropriate level of care transfer.

Additional Points:

1) In terms of the cost of care in CT, this proposal actually "decreases the cost of care." The vast majority of PAs are currently required by MAOs. MAOs are paid per member per month by Medicare, not seniors living in CT.
2) The cost of PAs and PA delays is currently being shifted unchecked onto medical providers. Establishing a fee to cover the costs and administrative burden of the PA process will lead to improvements in PA efficacy.
3) It should be noted that larger systems are providing PA services to their affiliated and non-affiliated community based physicians when they send their patients for diagnostic tests, treatments and procedures at their facilities. Bristol Health, Inc. as a standalone, low cost provider does not have the resources to do this. Passing this legislation will help to keep Bristol competitive in the market.

An Act Concerning Patient Access to Care

Section 1. (NEW) (Effective July 1, 2023) (a) As used in sections 2 and 3 of this act:

(1) "Discharge delay day" means any twenty-four-hour period following the date and time on which a hospital requested authorization from a patient's payor to transfer or discharge the patient to a post-acute care provider following an inpatient stay, emergency visit or observation stay, provided the hospital did not receive a response from the payor on the request within such twenty-four hour period, and the patient's attending physician has determined that the discharge or transfer is medically appropriate;

(2) "Health care provider" means an individual physician, physician group practice, or medical foundation;
(3) "Home health care agency" has the same meaning as provided in section 19a-490;
(4) "Hospital" has the same meaning as provided in section 19a-490;
(5) "Nursing home" has the same meaning as provided in section 19a-490;
(6) "Payor" means any health insurer licensed in this state to administer a health benefit plan, as defined in section 38a-591a, and includes any third-party administrator acting on behalf of a health insurer licensed in this state; any utilization review company as defined in section 38a-591a and any preferred provider network as defined in section 38a-479aa;
(7) "Post-acute care provider" means any facility or institution providing post-acute care such as a nursing home, home health care agency or any long-term acute care hospital or rehabilitation hospital, including a chronic disease hospital as defined in section 19a-490; and
(8) "Prior authorization" means any form of prospective or concurrent review or other prior approval or precertification that a payor requires in connection with any health care item or service, including but not limited to, any medical service, procedure, surgery, prescription, diagnostic testing, hospital inpatient or outpatient service or a patient's transfer or discharge from a hospital to a post-acute care provider following an inpatient admission, emergency visit or observation stay.

Sec. 2. (NEW) (Effective July 1, 2023) (a) A payor shall reimburse a hospital at the rate of nine hundred dollars per day for each discharge delay day involving a patient who is covered by a health benefit plan administered by such payor.

(b) A payor shall reimburse a health care provider at the following rates to compensate for administrative time responding to the payor's requests related to prior authorization for any patient covered by a health benefit plan administered by the payor:

(1) Ten dollars for each request for information in connection with any initial prior authorization review and

(2) Forty dollars for an individual physician's participation in any peer-to-peer process conducted by a payor in connection with a prior authorization review.

Sec. 3. (NEW) (Effective July 1, 2023) On or after July 1, 2023, no payor shall require prior authorization for a patient's transfer or discharge to a nursing home or other facility that is a post-acute care provider following a hospital inpatient admission, emergency room visit or observation stay when, prior to such hospital inpatient admission, emergency visit or observation stay, the patient was a patient or resident of the nursing home or other facility to which the patient will be transferred or discharged.

Thank you for your consideration of our position.

For additional information, contact Kurt **A. Barwis, FACHE** at (860) 585-3222.

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