Letter 3 with response

[redacted]

2021 MAY 13 AM 9:31

May 10, 2021

Health Insurance Board
Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707

Re: Problems with United Healthcare's Medicare Advantage Plan

Dear Members of the Health Insurance Board,

I am writing to let you know of problems I have had with UnitedHealthcare's Medicare Advantage Plan, in the hope that my experience will be useful as you consider whether to continue to offer this option to members. The issues relate to reimbursements for visits with an out-of-network provider and fall into three areas: misleading marketing, repeated failure to pay justified claims except upon appeal, and poor member support.

When it was first offered, UHC's Medicare Advantage plan was attractive to me because of its nationwide coverage. At an August 13, 2018, ETF-sponsored information session at which a UHC presenter explained the plan, it was clear that out-of-network coverage with a $0 copay was an important element in UHC's marketing strategy. After the presentation, I spoke with a UHC representative about my particular needs: I explained that I see an out-of-state specialist who accepts only Medicare, not any other form of insurance, including UHC. The representative assured me that my visits to this specialist would be fully covered, without any problem. That assurance was a deciding factor in my switching my health insurance from Quartz to UHC.

However, contrary to the marketing promise, receiving full reimbursement for my three subsequent visits to this specialist's clinic has been difficult.

- My first claim was initially only partly reimbursed, on the grounds that UHC was obligated to pay only the "Medicare-approved amount" (a term never mentioned in the August 2018 information session and not found in the plan's Evidence of Coverage), rather than fully covering the visit and and lab costs. That decision was reversed after I submitted a written appeal, and I was fully reimbursed.
- My second visit was also only partly reimbursed, on the same grounds, even though in my claim documents I cited the positive resolution of my previous claim. I filed another written appeal, which was also successful.
- My claim for reimbursement for my third visit, which referenced my two previous claims, was entirely denied, on the grounds that "provider opted out of Medicare - services not-covered," a statement which is simply not true. Here, again, my written appeal was successful.

In sum: my first claim should have been fully reimbursed from the start; and after the first successful appeal, there is no reason that the claims for my next two visits to the same provider should not have been paid in full, without my having to file two additional appeals.

While the outcome of my three appeals was positive, the successful resolutions were achieved largely in spite of, rather than because of, UHC customer support. For example:

- Representatives at the ETF-member support line provided contradictory information. When I called *before* my initial specialist visit to get instructions on filing for reimbursement, representatives confirmed what I had been told at the information session: that I would be fully reimbursed. But *after* the visits, when I received only partial reimbursement, representatives insisted that UHC was obligated to pay only the Medicare-approved amount and that I was responsible for all charges beyond that.
- A verbal grievance I submitted about the discrepancy between the partial reimbursement I received for my first claim and the full reimbursement I'd been told to expect was dismissed, without any notification to me.
- Four written requests to the UHC Appeals and Grievance Department for claim-related, explanatory documents that I am entitled to see have gone unanswered for months.
- Many attempts to get clarification by phone from three Appeals Representatives to whom I was referred have failed: the first representative was unfamiliar with the appeals process, for the second representative I was provided a non-working phone number, and the third did not respond to any of the voicemail messages I left for her over the course of two months.

There was one happy exception to this otherwise dismal record of member support. When I called to check on the status of my verbal grievance, the representative I reached encouraged me to pursue full reimbursement, informed me about my right to file a written appeal, and guided me through the process. Thanks to her I was able to submit a successful first appeal and to understand how to appeal the second and third claim denials. Were it not for my good fortune in getting her on the phone, I would have accepted having to pay over $600 out of pocket, based on my earlier conversations with other representatives.

Before changing to United HealthCare, my visits to this specialist were fully paid by Medicare, without my ever seeing a bill or filing a claim. In joining UHC, I understood that I would need to file claims for reimbursement for these visits, but I was led to believe that this would be a straightforward process. Instead, I've spent hours on the phone and on paperwork in efforts to recoup my out-of-pocket costs and in futile attempts to communicate with UHC appeals personnel, as cases have dragged on for weeks or months. I believe that UHC's performance in dealing with my out-of-network claims falls well short of ETF's expectations for member service.

Sincerely,

Carla J. Love

Carla J. Love
Member ID [redacted]

STATE OF WISCONSIN
Department of Employee Trust Funds
A. John Voelker
SECRETARY

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June 16, 2021

CARLA LOVE MID: [redacted]
[redacted]
[redacted]

Dear Ms. Love,

Thank you for reaching out to the Department of Employee Trust Funds (ETF) and the Group Insurance Board (Board) regarding your difficulties with claim payments under UnitedHealthcare's (UHC's) Medicare Advantage plan in the State of Wisconsin Group Health Insurance Program. As the Deputy Director of the Office of Strategic Health Policy in the Department of Employee Trust Funds (ETF), I have been asked to respond to you. A copy of your letter will be shared with the Board.

We regret the difficulties you experienced with your Direct Member Reimbursement (DMR) claims with UHC. To understand why you've been experiencing difficulties, it is important to understand how provider reimbursement works for Medicare. There are two types of Medicare providers:

1. Participating Providers enrolled in Medicare and who accept Medicare Assignment; in other words, they agree to charge no more than the Medicare-approved amounts.

2. Non-participating Providers enrolled in Medicare but decide not to accept Medicare Assignment. In this instance, Medicare limits what the provider may charge the beneficiary/member, which is called a "Limiting Charge," when they choose not to accept Medicare Assignment. A Limiting Charge equals 115% of the non-participating fee schedule amount and is the maximum the non-participating provider may charge a beneficiary/member.

In the case with your provider, there were multiple claims where the provider billed amounts over the Limiting Charge, which goes against Medicare guidelines and is a practice that is frowned upon. When a member submits a claim requesting DMR, UHC's policy is to pay the Medicare allowed amount. Upon your appeal, UHC reached out to the provider regarding their billing practice and were unable to resolve with the provider, therefore UHC reimbursed you up to the provider's billed amount to take you out of the middle.

UHC informed us that for two of your three DMRs in 2019 and 2020, they followed this process and after your appeal, the claims were paid in full. For the most recent DMR in the fall of 2020, they erroneously denied the claim, classifying it as being provided by a doctor who does not participate with Medicare. Upon appeal, they realized their error and again, paid the claim in full.

We understand your concerns over the additional steps you are being asked to make in order to get your claims paid appropriately. We discussed your case with UHC to see if process improvements could be made but are confident the process is working correctly. Please be aware that Medicare rules supersede those of our contract with UHC, so if Medicare won't permit changes to this policy, we may not be able to change this process.

Thank you, again, for reaching out to ETF. We appreciate the feedback we receive from members for future considerations to the program. We hope this information is helpful. If you have further questions, please contact me at brian.stamm@etf.wi.gov or via phone at (608) 267-4554 or Arlene Larson, Manager of Federal Programs, at arlene.larson@etf.wi.gov or via phone at (608) 264-6624.

Sincerely,

Brian Stamm, Deputy Director, Office of Strategic Health Policy
Department of Employee Trust Funds

CC: Arlene Larson, Federal Health Programs & Policy Manager, ETF
Kia Yang, UnitedHealthcare