Dear Commissioner Houdek,

We greatly appreciate the time that your team spent listening to us and our respective members and hearing about the payer challenges they continue to face. As organizations representing hospitals and health systems across Wisconsin, we write today to continue the dialogue and call attention to mounting issues within the insurance industry that we would like to work together with OCI to address. We understand there are limits to both your resources and authority as governed by current Wisconsin law. As such, we stand willing to assist you and the legislature as it may be needed to develop better ways to hold insurers accountable for the care that covered individuals/patients expect and need, as determined by their health care provider.

Below is a list of examples that demonstrate some of the challenges we would like to address:

- **Claims payment issues *(delays, denials, appeals)***

Example: Insurer appeal processes are often cumbersome, slow and seldom yield meaningful results. Automatic denials have become the norm across insurance companies, who often take months to process, review and decide on the appeal at the detriment of a hospital's cash flow. Ten to twenty percent of a rural hospital's workforce is now in the finance department to deal with payers on their delays, denials and appeals.

- **Prior authorizations *(conflicting info, lengthy holds, turnaround time, approving only to deny at point of claim*)**

Example: One of the biggest areas of concern is when the insurer denies payment of a claim for an inpatient stay, and instead pays only for "observation" care. What this means is that a physician has determined that the patient should be admitted into the hospital, but the insurance company, after the fact when paying the claim, determines that the patient should not have been admitted but should have only been held for "observation." This can occur even when the patient has been in the hospital for days, and often occurs after the insurer has already pre-approved an inpatient stay.

- **Credentialing Issues *(delays, duplicative info, denials effecting access to care)***

Example: Members have had problems getting new doctors/providers credentialed with some insurance companies. In one example, they initially denied a dermatology provider, a Podiatrist, and a Urologist. After extensive back-and-forth, the hospital was successful in getting each provider credentialed. After past OCI complaints were submitted, members of the health plan visited the hospital in what they viewed as an attempt to intimidate and retaliate against it for filing complaints with OCI.

- **Swing bed placements and skilled nursing care denials**

Example: Care team decides that the patient's acuity care level would allow the patient to step-down in the level of care to a swing bed. The insurance company denies the swing bed transfer and requires the patient to be transferred to a skilled nursing facility

(SNF), sometimes up to a 60-mile radius, which creates additional burden on the hospital, whose staff must assist the patient in the search for an appropriate bed. When the hospital staff is unable to find a SNF bed for the patient in the community (and beyond) the insurance company may relent on the transfer to a swing bed, but then often denies or reduces payment after service. Beyond the burden to the hospital, this additionally burdens the patient and their family in moving them outside of their community.

- **Not Following Continuity of Care Requirements**

One hospital sent three examples (and indicated there were more) of services provided for mom/baby where the patients had continuity of care agreements, but the insurer processed all claims as out-of-network. This means the patient would have to pay a much higher out-of-network rate, despite being under the impression that the care was in-network, something that appears to violate the spirit (if not the actual law) of *The No Surprises Act.* In at least one case, the insurer asked the provider to go back and reprocess the claim in-network which would have been incorrect (which is potentially fraudulent?).

- **Lack of Pre-Emptive Notice for Contractual Changes**

Example: Insurance companies will change care and reimbursement practices and requirements with little or no notice, which is overly burdensome and results in denying and/or slowing down payments. Ex., Sept. 1st introduction of UHC Rehab Portal

Our Request: We understand that OCI is not tasked with resolving "contract" disputes between parties, however, the type and volume of issues that our hospitals are experiencing have reached unprecedented levels and seem to be indicative of a broader, systemic issue amongst payers that is negatively impacting patient care.

We think it is important that OCI be made aware of these concerning trends and together we can come up with some possible options to address these patient care and access challenges. We would like to meet again with OCI to discuss how we can partner to remove this unnecessary bureaucracy from the health care system, leading to better outcomes for Wisconsin patients. Potential areas for further discussion include:

1. Holding focus groups with Providers
2. Restarting and posting Market Conduct Surveys Reports to be more public
3. Discussing different practices OCI could investigate to help change insurer behavior as well as necessary rulemaking or legislative authority.

Sincerely,

Tim Size
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