From: cid.webmaster@ct.gov
To: Ratefilings, cid
Subject: Health: Golden Rule Insurance Company - File Number: 201502349
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Do not increase their rates.

From: cid.webmaster@ct.gov
To: Ratefilings, cid
Subject: Health: Golden Rule Insurance Company - File Number: 201502349
Date: Wednesday, July 15, 2015 6:55:54 PM

I am a solo physician provider, board certified, 4 years medical school, 4 years residency preceded by 4 plus years to accumulate the undergraduate requirements to be eligible to apply to medical school, and my hourly rate of reimbursement determined by the insurance industry is less than what my plumber, electrician and cpa make per hour.
As an individual proprietor and employer I am paying for health insurance through the exchange and our health insurance rates have already increased from 2014 to 2015. Now the insurance companies want to increase the rates again.
Yet the amount of money the insurance companies deem appropriate for my time spent face to face with patients, alone or with their families, certainly have not increased. The reimbursement rates are ridiculously low already in spite of public remonstrating about wanting physicians to spend more time with patients. Insurance companies won't authorize reimbursement to a physician for TIME spent with patients.
Only physicians who are performing 'procedures' often using physician assistants for most of the follow up get paid. (I can attest to that as I was patient who recently needed surgery for my hand following an accident). It is humiliating at best to get a bill for a surgical physician's assistant costing twice as much money for 15 minutes or less of their time than I get paid for 60 minutes of face to face time as a psychiatrist.
Insurance companies should not be rewarded by allowing them to increase their rates to subscribers, at the same time that they are putting up more and more barriers to health care.
There is rampant abuse that is escalating.
Each year I have to spend more time advocating on behalf of my patients to get insurance companies to authorize recommended treatments and try to get paid for my services, while reimbursement rates are stagnant and insufficient.
Examples:
1. Requiring PA (prior authorization) for a change in the milligram strength of a medication that I already spent 25 minutes on the phone 2 weeks prior in procuring a pa for the medication at a lower milligram strength, even when attesting on the original pa to the insurance company that the medication is new to the patient therefore a tapered increase in dose was anticipated and planned. I am not referring to a pa for a dose that exceeds recommended limits.
2. The insurance's convoluted phone system, as all of my staff can attest to, in order to get a human being on the phone is another major obstruction.
It takes on an average at least 20 minutes of time just to reach a human being who MAY be able to
-address a PA for a medication (the pa forms online in 90% of the cases don't apply to many psychiatric medication)
-identify an in network provider to make a consultation with on behalf of the patient or
-identify the correct company managing psychiatric medications or claims when the information on the patient's insurance card does not correlate with the actual company who is managing psychiatric medications or claims. Looking for what company manages a patient's mental health benefits on line if it isn't published on the patient's card, doesn't yield results (yes this really does happen). You have to submit a claim to the company indicated on the patient's insurance card, then WAIT for the claim to be denied. The insurance company doesn't even have the courtesy of telling what company does manage the mental health claims in their denial. That brings us back to the long, long voice message system put in place by the insurance companies.
3. Insurance companies deny me the ability to bill a patient if the patient fails to follow their contractual guidelines without any possible control by me. If a patient sees a therapist in another office on the same day as their appointment with me, their insurance company denies payment for my service, including from the patient. I certainly don't supply the same service as a social worker or psychologist. Are orthopedic surgeons denied payment if their patient is seen by a physical therapist in another office on the same day? I think not. I can certainly educate the patient to this situation, which I do, but if the patient ignores or doesn't remember that advice, their insurance carrier refuses even to allow me to bill the patient for the patient's error. How is that fair?
5. Prolonged times processing claims leads to accumulation of debt incurred by the patient attributable to their deductible; it also makes it much more difficult to track patients even when having to resort to

using collection agencies. Two months required to bill the patient before referral to collections, may follow 2 plus months that the insurance carrier takes before officially reporting what the patient owes for the services provided. Insurance contracts forbid a physician to collect deductible monies until the insurance company has processed the claim, but it often takes insurance up to 8 weeks to do that, even though I am utilizing electronic claim and reimbursement methods.
There is not even a mechanism to report to insurance carriers patients who fail to pay their deductible owed for services provided. Patients simply go to another provider and start the process all over.

The income from my practice cannot bear further reductions and impediments to payments, while my costs of procuring health insurance rises as does the cost of all the other services I have to pay for. (almost ALL of those services involve billing and reimbursement from insurance companies, including the bulk of money spent on staff salaries) The only alternative to my practice failing is to start cramming patients into my schedule- i.e. double book patients or book patients for so little time each that I essentially become only a walking prescription pad. This solution is repugnant to me and my patients. I am running my office in as lean a manner as is possible; I am at maximum efficiency.
I implore the health insurance commission to stop the health insurance industry from increasing policy rates. And while this may not be relevant to the current hearings, I implore the health insurance commission to try and get the health care industry to reduce the barriers they erect and continue to erect more each week, between care that is prescribed and procurement of that care. I actually received a fax pa form from an insurer that boldly stated it only paid for 'medically necessary treatments' followed by a list of almost every antidepressant, including all generic antidepressants, which the insurance company will not cover without a prior authorization. So antidepressant medication is presumed to be 'not medically necessary'. Let the insurance company tell the family of a suicide victim that an antidepressant medication, one that costs pennies, is not medically necessary. If this is not a blatant barrier to access, not to speak of discrimination for the mentally ill, than I don't know what is.
Dr. M. Leonhardt

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A rate increase this is absurd. I currently am self insured and not eligible for a premium credit through access health. I found this out when I filed my 2014 taxes; apparently the premium credit I was approved for at the beginning of the 2014 year I now have to pay back to the tune of over $11,000. this cost on top of my premium of $822 for two people, this is afforable please!!!!! And this HSA policy being the only policy I could barely afford we basically can't even use due to the high deductible $6000. per person???? Health insurance was suppose to be more affordable with the ACA? in fact my premiums increased with less coverage. I think it might be cheaper for me to pay the no insurance penalty and might have no choice if this rate crease is approved.