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INSIGHTS

Senate Homeland Security and Governmental Affairs Commitee Dives into Medicare Advantage Denials

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On May 18, 2023, the Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Investigations, held a hearing entitled "Examining Health Care Denials and Delays in Medicare Advantage.". Generally, the hearing was bipartisan in nature with lawmakers raising key themes regarding concerns over prior authorization and profits at Medicare Advantage plans.

WITNESSES

- Megan Tinker, Chief of Staff, Office of the Inspector General, HHS
- Dr. Jeannie Fuglesten Biniek, Associate Director, Program on Medicare Policy, Kaiser Family Foundation
- Christine Jensen Huberty, Lead Benefit Specialist and Supervising Attorney, Greater Wisconsin Agency on Aging Resources
- Lisa Grabert, Visiting Research Professor, Marquette University College of Nursing
- Gloria Bent, Medicare Advantage Enrollee

MEMBER OPENING STATEMENTS

Chairman Richard Blumenthal's (D-CT) opening statement focused on setting up the key themes for the hearing. He stated that the hearing was being held to protect seniors enrolled in MA who face unacceptable barriers in accessing care and treatment. The Chairman said that insurance companies are failing seniors and pointed out that MA companies must provide the same level of coverage as traditional Medicare, but in many cases, they are failing to do so. He pointed out that growing evidence exists that insurance companies are relying on algorithms instead of physicians to make decisions regarding authorization of care, while concurrently these companies are making massive profits. Sen. Blumenthal stated the committee sent letters to the largest MA providers asking for internal documents showing how decisions are being made to grant or deny care.

Ranking Member Ron Johnson (R-WI) issued a statement for the record but then largely spoke off the cuff. He was thankful for the committee's bipartisan work on this issue in the past. Sen. Johnson wanted to address MA issues without government action, and he stressed the importance of free market competition in health care. Finally, he stated he wanted to focus on the root cause of the issue and address it without an expensive "band-aid" option.

WITNESS STATEMENTS

Megan Tinker's opening remarks discussed the OIG's work on MA issues. She explained that just over 50 percent of Medicare enrollees are now in MA and that this represents a rapid expansion in the program. Ms. Tinker explained rapid growth calls for robust integrity measures. Most pointedly, she stated the OIG found that MA plans denied access of care even though coverage was needed and should be approved (in other words, these instances of care would have been approved by traditional Medicare). She concluded with stating that the OIG needs more resources to investigate cases in Medicare and Medicare Advantage and pointed to the fact that President Biden's budget calls for more money to increase oversight.

Dr. Jeannie Biniek's opening focused on the vast number of MA plans (43 total) beneficiaries can choose from and that potential lower cost sharing and benefits drive MA enrollees to these plans. She stated that according to MedPAC, insurers receive $2300 per person more than traditional Medicare for each enrollee. She explained that MA plans have lower costs because they utilize tools to limit care to include prior authorization for high-cost therapies leading to unnecessary gaps in service. Dr. Biniek also explained that better information is needed on prior authorization and how to contain costs in the program.

Christine Jensen Huberty spoke from her perspective as an advocate for seniors in Wisconsin trying to navigate and appeal MA denials of care for beneficiaries. She stated that MA plans routinely deny care for skilled nursing facilities. Ms. Huberty explained the initial denial is made by a third-party contractor using an algorithm, as opposed to the insurer making the denial. She further stated that at each additional level of appeals, denials are upheld by quality improvement organizations and that if approved, families are faced with additional denials along the way.

Professor Lisa Grabert focused her statement defending the benefits of MA organizations. She claimed Medicare beneficiaries want MA over traditional Medicare and reviewed the reasons why. Ms. Grabert dove into a utilization review discussion explaining that MA plans were created to shift financial risks from the taxpayer to plans (through utilization tools like prior authorization). She believes the average MA beneficiary should understand this and argued for consumerism in health care. Ms. Grabert discussed inpatient rehab facilities and the fact that IRFs have yet to be reformed.

Gloria Bent spoke about her personal experience as a MA enrollee and as a widow. Her husband was denied care from a MA organization for care in rehab and a skilled nursing facility. They were denied via a third-party company and explained how it was a barrier to deny her husband treatment for his melanoma. He was later in remission for a year when doctors found a lesion in his brain. The pathology confirmed it was melanoma. She further discussed how her husband's neurosurgeon wanted him transferred for physical therapy and occupational therapy, but acute rehab services were denied by a third-party company even though their physician deemed it appropriate. She further explained the impediments to care from the MA organization's third-party designate through four denials of coverage along the way. Her husband was discharged prematurely and later died due to lack of appropriate care. She could not understand why Medicare Advantage companies are looking at patients on paper or through the lens of an algorithm making the decisions on treatment over physicians.

MEMBER DISCUSSION

Only three members of the subcommittee were in attendance due to votes being scheduled on the floor. The conversation focused on the denials of coverage from MA organizations and the profits these companies are making on Medicare beneficiaries.

Chairman Blumenthal wanted to discuss the real-world consequences of a broken system. He asked Ms. Bent more about her experiences with denials of coverage for her husband's care and brought up the use of algorithms as the criteria for denying care as opposed to the perspective of the patient's physician. He stated that over 35 million requests for care, that 2 million were denied and only 11 percent appealed. Out of those who appealed, 80% were then granted care and were meritorious claims. It was affirmed that beneficiaries are never shown the algorithm that is used to determine a predictive length of stay which leads to a denial.

Sen. Blumenthal, upon returning later from a vote, went on to discuss with witnesses the new CMS rules around MA plans and prior authorization. He stated the rules tell him that MA must cover what traditional Medicare covers to which Ms. Tinker agreed. He then reasoned that it is a problem of enforcement and not a problem with the rules. He believes MA plans are flouting their obligations to treat patients and that a new rule is only as good as CMS enforcing those obligations for MAOs.

Sen. Blumenthal and Ms. Grabert entered a lively discussion on how MA plans are utilizing their profits. He asked if MA plans are taking their profits and putting them into dental coverage and other services to which Ms. Grabert agreed. He then stated that despite this, MAOs are making large profits. Ms. Grabert stated Congress could address these issues by looking at Quality Bonus payments under the Affordable Care Act. The Senator replied that the plans could just provide the coverage for Ms. Bent's husband as they promised they would do.

Ms. Tinker explained that MA plans are paid a capitated rate (single amount, per member, per month – regardless of services) – unlike in original Medicare. Therefore, these plans make more money for providing less care. Sen. Blumenthal stated the insurer makes more than double for each MA enrollee as opposed to employer sponsored plans.

Sen. Johnson wanted to identify a solution and to reintroduce consumerism in healthcare. He believes you can then have high deductible insurance plans without exclusions and put trust into the physicians and nurses to make the call regarding what level of care is needed. Ms. Grabert stated there is no consumerism in traditional Medicare coupled with a Medigap plan. She believes Medigap plans should be targeted. Sen. Johnson wanted to steer the conversation to controlling costs for traditional Medicare. Ms. Huberty explained that standards are applied differently between traditional Medicare and MA plans.

Sen. Marshall (R-KS) spoke about his experience as a physician having a surgical procedure canceled due to an insurance company denial. He submitted to the record the information of many patients denied from a variety of procedures to include chemotherapy, heart procedures, and breast cancer. He touted the Improving Seniors Timely Access to Care Act, as well as the Support Act and how his bill streamlines prior authorization.

We trust you found this summary useful. Please reach out to us with any questions.