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Congressional Panel Highlights Improper Delays and Care Denials in Medicare Advantage Plans

On June 28, the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing shedding more light on some of the spurious practices of commercial health plans with a particular focus on the Medicare Advantage program.

The meeting included experts from the Government Accountability Office, Office of Inspector General (OIG), and the Medicare Payment Advisory Commission. OIG Assistant Inspector General at the Department of Health and Human Services Erin Bliss detailed new data her office had collected on improper Medicare Advantage denials. The OIG collected data from a random sample of 250 payment denials issued by the 15 largest Medicare Advantage organizations and found that 13% of prior authorization denials were for services that met Medicare coverage rules, meaning such denials likely prevented or delayed a significant amount of needed care. Furthermore, 18% of payment denials were for claims that met Medicare coverage and insurer billing rules, leading to improperly denied or delayed payments for services providers already delivered.

The Medicare Payment Advisory Commission (MedPAC) also found that health insurance plans improperly "up-coded" their encounter data with patients to generate additional payments from CMS beyond what would have been justified by the treating provider. Testimony from James E. Matthews, Ph.D., executive director of MedPAC, found that plans were paid 3.6% higher than would have been justified under traditional Medicare, even after a statutory coding adjustment that is supposed to account for this.

In a June 28 letter to the Subcommittee, the American Hospital Association (AHA) noted that insurer practices related to prior authorization and denials of coverage of medically necessary services is a major administrative and financial burden requiring health care providers to incur higher costs for staffing and technology.

The AHA letter also highlights that the burdens associated with these insurer requirements contribute to health care worker burnout and points to a recent advisory issued by the Surgeon General of the United States, *Addressing Health Worker Burnout*. "Unfortunately, administrative requirements, such as prior authorizations, can delay patient care and contribute to poor health outcomes among patients and health care worker burnout," the report states. It goes on to recommend reducing the overall volume of prior authorization requests and streamlining the administrative processes associated with such requests.

Enrollment in Medicare Advantage plans across the country has more than doubled since 2010 to over 24 million enrollees, or about 43% of Medicare beneficiaries with Part A and Part B coverage. In 2020 in Wisconsin, about 46% of the 1.2 million Medicare beneficiaries were enrolled in a Medicare Advantage plan.