FACT SHEET

Federation of American Hospitals

MANAGED CARE ABUSE PUTS AMERICA'S SENIORS AT RISK

THE PROBLEM

Medicare Advantage (MA) was intended to introduce private sector efficiency and innovation to the federal Medicare program, and plans are required to provide the same benefits and services to beneficiaries as those covered in Medicare Parts A and B. In reality, MA plans are increasingly using narrow networks, excessive prior authorization, and other tactics that delay and deny patients' access to needed health care services they would appropriately receive in Traditional Medicare. Further, unlike in Traditional Medicare, MA has no standard definition of prompt pay, leading to more delays and denials that undermine access to hospital care.

Managed care abuses can increase out-of-pocket costs, delay patient recovery due to inadequate post-acute care, bury patients and providers under wasteful paperwork, and leave providers on the hook for arbitrarily denied services.

As MA enrollment now surpasses that of Traditional Medicare,[1] **it's crucial for Congress to hold managed care plans accountable and ensure that MA is living up to its promise of providing timely, essential care to seniors.**

Excessive Delays and Denials. **94%** of physicians say prior authorization delays access to patient care and has a negative impact on health outcomes.[2] Managed care companies use unregulated algorithms and questionable guidelines to deny patient care.[3]

Restrictive Networks. MA plans deliberately limit the number of contracted providers in their networks – particularly behavioral health hospitals and services, inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs) – making it more difficult for patients to access necessary services in their community.

Roadblocks to Post-Acute Care. A recent Senate investigation found some insurers denied patients access to post-acute care at three times the rate of all other denials.[4] For many seniors, rehabilitation care following a hospital stay is critical to ensuring they can continue to live independently.

Denying Payment to Increase Insurer Profits. MA plans are denying payment for inpatient hospital care at a higher rate than all other plan types[5] to lower their own costs, but seniors on MA should have access to the same inpatient benefits as those in Traditional Medicare.

Providers Buried Under Unnecessary Red Tape. Nearly **15%** of all claims submitted to private payers are initially denied,[6] yet **83%** of prior authorization denials are ultimately overturned on appeal.[7]

THE SOLUTION

Lawmakers and regulators must act to hold plans accountable.

- **Crack down on insurers arbitrarily down-coding payment** when a patient meets the clinical criteria and the claim is supported by the medical record.
- **Strictly enforce MA plan compliance** with Traditional Medicare benefits and services, like the Two-Midnight Rule, so America's seniors receive the care to which they are entitled.
- **Establish "Gold Card"** and similar programs that reduce the administrative burden on providers fighting prior authorization denials.
- **Rein in prior authorization** abuses and hold insurers accountable for arbitrarily delaying and denying care.
- **Strengthen network adequacy standards** in MA for post-acute care to ensure patients receive timely care in the right setting.
- **Establish a statutory prompt payment requirement** between Medicare Advantage Organizations (MAOs) and in-network providers, with reasonable requirements for prompt payment terms and penalties for failing to make payment on clean claims.

[1] "Medicare Advantage in 2024: Enrollment Update and Key Trends," KFF (August 8, 2024)
[2] AMA prior authorization physician survey (2023)
[3] "Not Medically Necessary": Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Care," ProPublica (October 23, 2024)
[4] "Refusal of Recovery," U.S. Senate Permanent Subcommittee on Investigations (October 17, 2024)
[5] "Who's picking up the check?" Crowe (February 2023)
[6] "Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims," Premier (March 21, 2024)
[7] "Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022," KFF (August 8, 2024)