American Hospital Association™
Advancing Health in America

Health Plan Accountability Update

November 2023

MEDICARE ADVANTAGE

CMS issues proposed rule for CY 2025 Medicare Advantage, prescription drug plans

The proposed rule includes consumer and beneficiary protections as well as policies to promote access to behavioral health, advance health equity and streamline certain operational processes in the MA program. AHA members received a Special Bulletin Nov. 8 on the rule.

AHA releases guide for monitoring 2024 Medicare Advantage rule compliance

AHA Nov. 14 released a guide to help member hospitals and health systems understand and hold Medicare Advantage plans accountable for policy changes effective in January under the final rule for contract year 2024 to increase oversight and better align MA coverage with Traditional Medicare. Members can access the guide here.

AHA supports bill offering providers gold card exemptions under Medicare Advantage

In an Aug. 28 letter to House sponsors, the AHA voiced support for the GOLD Card Act of 2023 (H.R. 4968) that would exempt qualifying providers from prior authorization requirements under Medicare Advantage plans. “America’s hospital and health systems support gold carding programs, which substantially reduce

administrative burdens and costs and streamline access to care for Medicare beneficiaries," AHA said in the letter.

Medicare Advantage, Medicaid managed care plans to draw scrutiny from HHS watchdog

The Health and Human Services Office of Inspector General Aug. 28 released a strategic plan to align its audits, evaluations, investigations and enforcement of managed care plans in Medicare Advantage and Medicaid. HHS OIG said it will evaluate each part of the Medicare Advantage and Medicaid managed care contracts, tracking them from creation to payments to renewals with a goal of promoting access to care for people enrolled in managed care, providing comprehensive financial oversight, and promoting data accuracy and encourage data-driven decisions.

CMS releases details on Medicare Advantage, drug plans for 2024

The Centers for Medicare & Medicaid Services Sept. 26 released premium and cost-sharing information for Medicare Advantage and Part D prescription drug plans for the 2024 calendar year.

CMS projects the average monthly premium for MA plans will increase by 64 cents to $18.50 while the average monthly premium for a basic Medicare Part D prescription drug plan will increase by $2.41 to $34.50, as previously announced. The Inflation Reduction Act will continue to limit monthly cost sharing for insulin products to $35 and reduce costs for adult vaccines.

Open enrollment for MA and Part D is Oct. 15 through Jan. 15.

OTHER NEWS

Proposed rule targets health plan mental health parity compliance

The departments of Labor, Health and Human Services and the Treasury July 25 released a proposed rule that seeks to ensure commercial health plans comply with the Mental Health Parity and Addiction Equity Act of 2008, which prohibits them from imposing more restrictive requirements on mental health or substance use disorder benefits than on medical and surgical benefits. AHA submitted a comment letter Oct. 13.

Health Insurance Barriers Delay, Disrupt and Deny Patient Care

“Health insurance should be a bridge to medical care, not a barrier. Yet too many commercial health insurance policies often delay, disrupt and deny medically necessary care to patients,” wrote AHA President and CEO Rick Pollack in an op-ed Aug. 8 in U.S. News & World Report. READ MORE

Perspective: Inadequate Health Insurance Coverage Drives Medical Debt – Four Solutions to Address This Significant Problem

“We must tackle the root of the medical debt problem: Ensuring all individuals are enrolled in comprehensive health care coverage with affordable cost-sharing,” wrote AHA President and CEO Rick Pollack Aug. 11 in a column examining the causes of medical debt and offering four solutions to fight the problem of medical debt. READ MORE

NAIC report calls for regulatory oversight of ACA preventative services requirement

A new report by the National Association of Insurance Commissioners’ Consumer Representatives released Aug. 14 calls for regulatory oversight to ensure insurers comply with the Affordable Care Act requirement to cover certain preventive services without cost-sharing. The authors reviewed how six individual market plans in different jurisdictions complied with a sample of four services health plans must cover without cost sharing and found that “the ways that insurers organize and expose information to providers and consumers is a meaningful barrier to effective understanding and use of preventive service benefits.”

The report recommends that state regulators analyze claims adjudication processes and assess drug formularies to understand whether plans are abiding by coverage and cost-sharing requirements; work with plans to ensure simple and transparent appeals processes for cost-sharing violations; hold plans accountable for educating consumers and providers; and promote uniform billing and coding guidance for use across plans.

In light of a recent federal lawsuit challenging the ACA requirement that most health plans cover certain preventive services without cost sharing, the report also recommends commissioners secure voluntary commitments from plans in their states to ensure continued access to these services without cost sharing and monitor and enforce transparency and notice provisions for any plan design change.

Federal court revives benefits denial class action suit against UHC Subsidiary

A three-judge panel in federal court the week of Aug. 21 partially revived a class action lawsuit against UnitedHealth Group subsidiary United Behavioral Health, reversing an earlier decision from 2020. Rehearing their initial decision in favor of UHG, the panel in the U.S. Court of Appeals for the 9th Circuit now ruled that some policyholders may be entitled to relief from United Behavioral Health because of an alleged breach of the organization's fiduciary duties under the Employee Retirement Income Security Act of 1974, along with wrongful denial of benefits. AHA and other stakeholders filed an amicus brief urging the panel to reconsider its earlier decision in favor of UHG.

NEW RESOURCES

- WEBINAR: Net Impact of Payer Denial Tactics on Hospitals
  Medicare Advantage payers run a for-profit business model, and any dollar they can avoid paying providers for care is a dollar they can count toward their profits. In this zero-sum game, your hospital's revenue integrity strategy needs to evolve at the same velocity as the payers' payment mitigation strategy. The Nov. 2 webinar discussed the range of tactics payers are using against providers and how we've partnered with hundreds of hospitals throughout the country to develop strategic programs and data-driven initiatives across the clinical revenue cycle (e.g., utilization management, documentation/coding, managed care/contracting, back-end revenue cycle functions) to combat these tactics.

WORTH A LOOK

- How Often Do Health Insurers Say No to Patients? No One Knows. Robin Fields, Propublica, June 28, 2023
- High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care, Department of Health and Human Services Office of Inspector General, July 2023
- How UnitedHealth's Acquisition of a Popular Medicare Advantage Algorithm Sparked Internal Dissent Over Denied Care, Casey Ross and Bob Herman, July 11, 2023
- Managed Care Strategic Plan, Department of Health and Human Services Office of Inspector General, August 2023

- Preventative Services Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented, National Association of Insurance Commissioners' Consumer Representatives, August 4, 2023
- Ford Sues Blue Cross for Price Fixing and Antitrust Violations, Today's General Counsel, August 10, 2023
- The Hidden Fee Costing Doctors Millions Every Year, Cezary Podkul, Propublica, August 14, 2023

TELL US YOUR STORY

We want to hear about your experience with commercial health plans and how inappropriate use of prior authorization, payment delays and other harmful policies are affecting your patients. We welcome submissions in writing or by video or image upload. We will not use any information publicly without your permission.

Login to our AHA member site, Health Plan Accountability page and scroll to the bottom to submit your story or experience. You may also upload documents, videos or other supporting material.

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