December 2024

TAA Data Atlas

Q4 Series: Payer Dynamics

Focus Area: *Payer Dynamics*

Concerns surrounding healthcare affordability continue to dominate media headlines, research publications, and policy conversations. These narratives include pains borne by individual patients and hardships felt by employer sponsored plans and have recently brought focus to issues including medical debt, charity care policies, price transparency, site-neutrality, and other critical policy issues. At the core of these concerns is either a lack of understanding, or a pervasive misunderstanding (or a combination of the two) about the dynamics between providers and payers in the healthcare ecosystem.

The Data Atlas was made to be a versatile tool to deploy, reference, cite, and repurpose across various scenarios to provide greater clarity and education about commercial payers. The Atlas explores recent market statistics, research, and reports that highlight the relative sizes of commercial insurers and large health systems, and recent payer trends related to prior authorization, claim denials, and utilization of AI.

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How to Use this Resource

1. Support proactive and high-level policy conversations with journalists and policymakers on Capitol Hill.
2. Repurpose key data insights into presentations, talking points, and written materials to support ongoing conversations and strategic engagements.
3. Deploy high-value data to bolster policy agendas and amplify conversations across broader advocacy channels.
4. Use data to lead strategy and shape advocacy plans with community leaders and key allies.

General Market Stats

Overview: This section examines the stark contrasts in financial performance and growth between health systems and commercial payers, highlighting payer dominance, profit trends, and operational disparities.

- **Focus Area:** Comparative analysis of payer and health system revenues and profit margins.
- **Type of Evidence**: Quantitative data and market trends.
- **Publication Details:** 2012–2024 data from industry reports and financial disclosures.
- **Data Source(s)**: Public filings, earnings report, and industry analyses (referenced herein).

Executive Summary:

While nonprofit health systems face heat over community benefit obligations, **top commercial payers have quietly scaled into industry titans**, posting eye-popping gains that rival the discretionary spending levels authorized in FY2024. TAA's review of filings data (2012-2023) chronicles a decade of payer ascendancy, calling for a deeper probe into the true power brokers shaping the healthcare economy.

Key Findings:

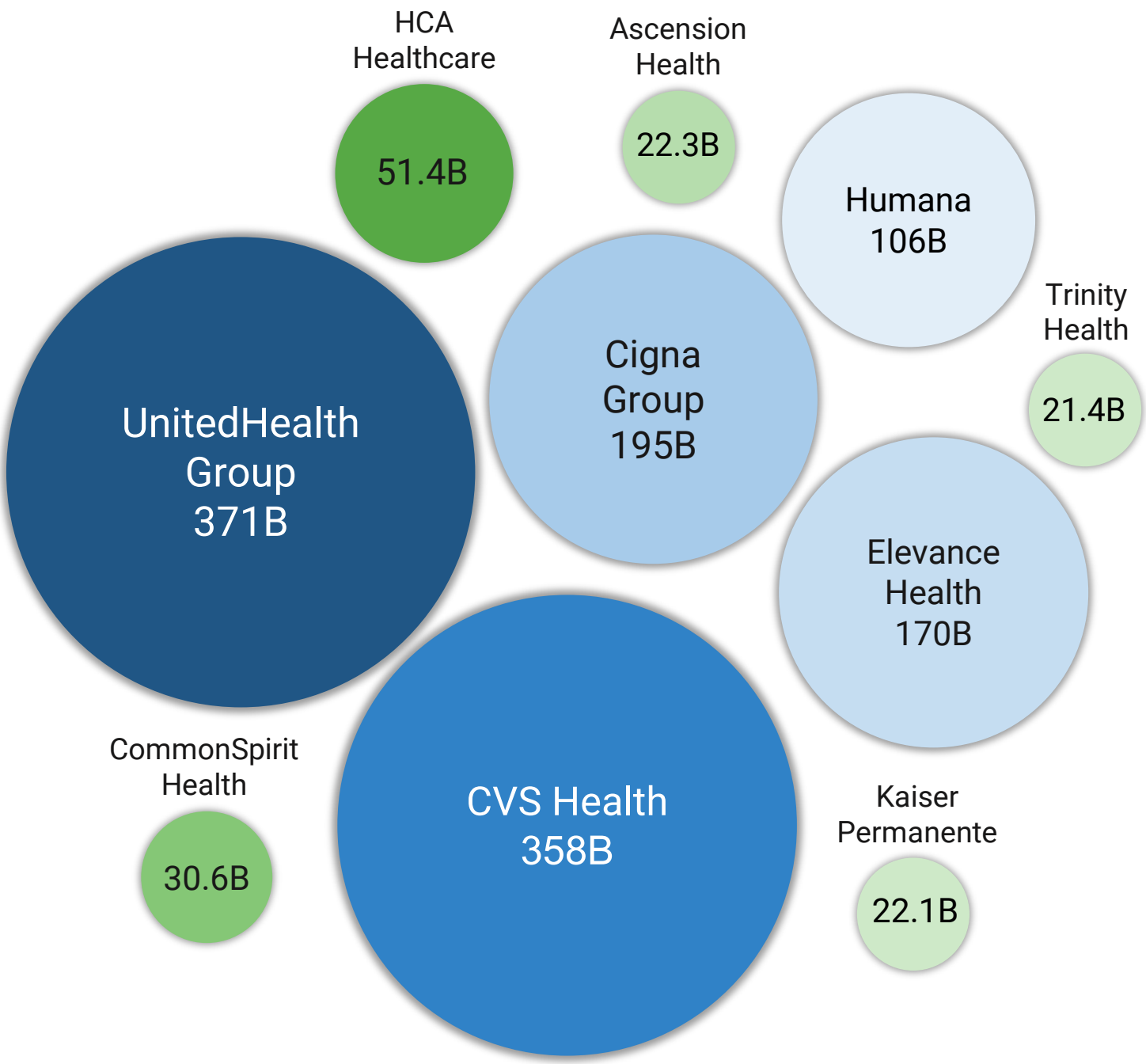
1. **The Biggest in the Room:** Commercial insurers overshadow health systems, with the largest payer generating $371B in revenue in 2023 – 7x that of the largest health system.
2. **Trillion-Dollar Titans:** The combined 2023 revenues of the five largest payers ($1.2T) dwarfs the five largest health systems by a factor of eight.
3. **Decade of Growth:** Between 2012 and 2022, top payers saw revenue increases exceeding 130%.
4. **Profits First**: Over the same decade, Cigna's profits grew 5-fold, while UnitedHealth's income from operations tripled, signaling record-setting gains.
5. **Margins Stuck in Time**: While payers boast record profits, recent data from The Health Management Academy suggests health system margins are at a razor-thin 3% post-pandemic.

Why This Matters:

Large health systems are criticized for their size and use of market dominance to drive up prices ("big is bad"), an argument that is not supported by data that compares relative sizes of health systems and commercial insurers. Health systems are also painted as "bad actors" by other segments of the industry.

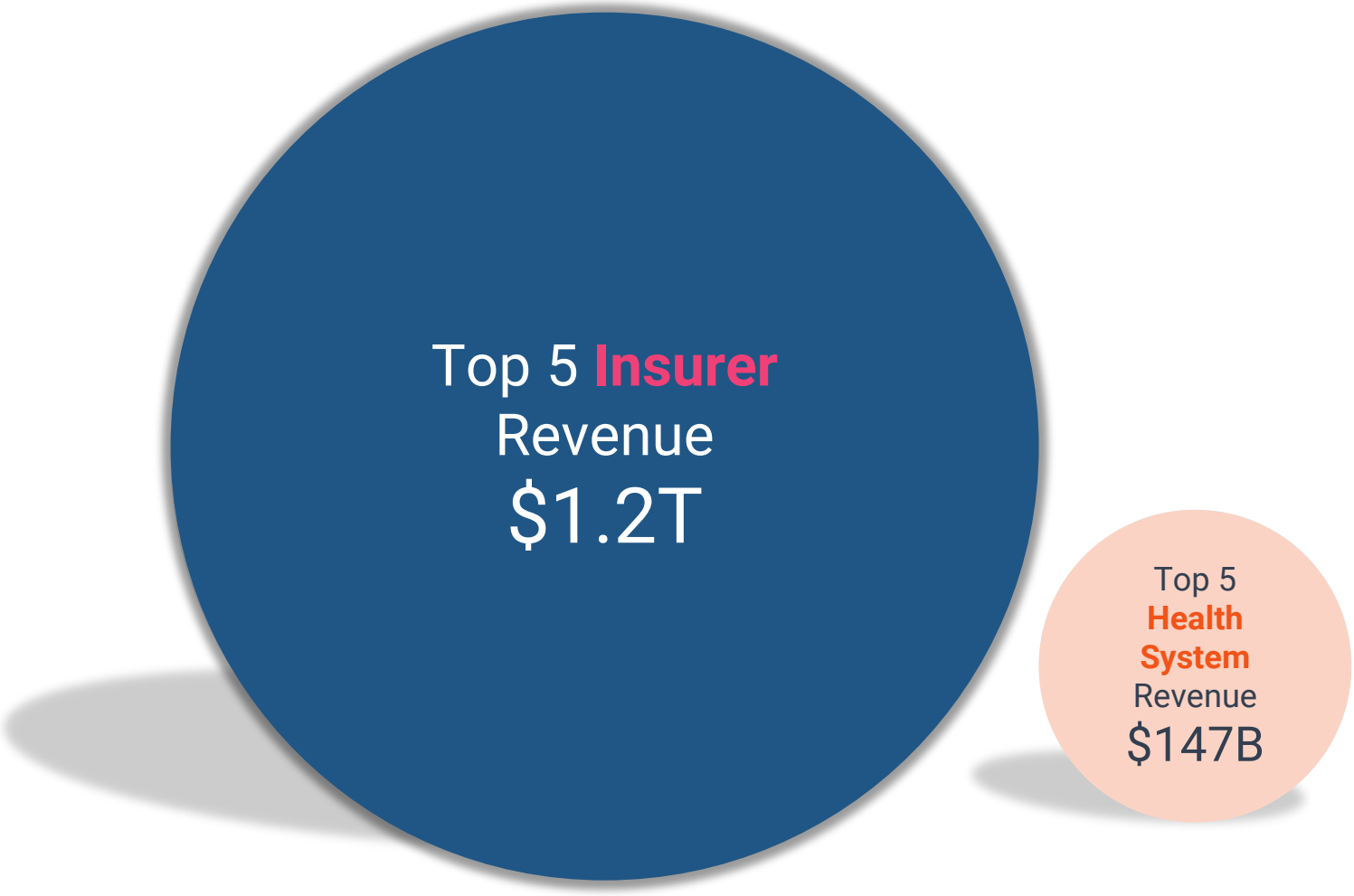
The remainder of this document details the ways in which payer companies engage in questionable behavior – through prior authorization, claims denials, and overreliance on AI algorithms – to bolster their businesses at the expense of patient care.

Commercial insurers dwarf even the largest health systems.



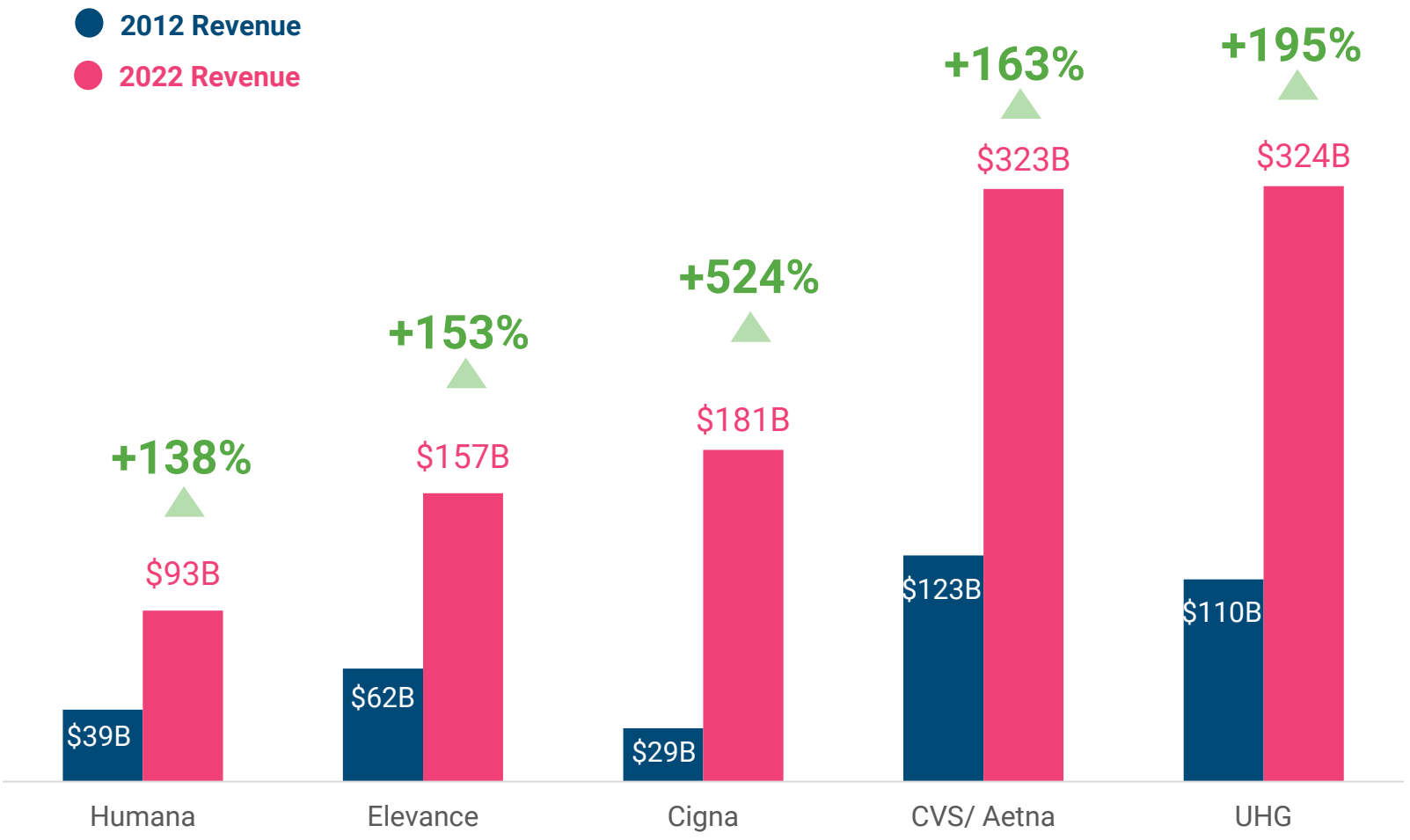
Visual comparison of the top 5 commercial payer companies and top 5 largest health systems (inclusive of both for-profit and non-profit organizations) by 2023 revenue. Data sourced from Definitive, Statista, and year-end earnings reports.

Revenue of 5 largest health insurers is 8x that of the 5 largest health systems.



Visual comparison of the combined revenue of top 5 commercial payer companies and top 5 largest health systems (inclusive of both for-profit and non-profit organizations) in 2023. Data sourced from Definitive, Statista, and year-end earnings reports.

Between 2012 and 2022 payer revenues have increased drastically, up to 524%.



Data Sources: CVS, Pitchbook, UHG Q4 2022, The Health Management Academy research and analysis.

In the same decade, payer profits (income from operations) have also increased drastically. **Cigna reported over 500% growth** from $1.3B in 2012 to $7.3B in 2022. **UnitedHealth Group also saw massive gains** in income from operations citing a 300% increase from $9.3B in 2012 to $28.4B in 2022.

Talking Points:

Data from The Health Management Academy would suggest that health systems' margins are hovering around 3% post-pandemic. TAA executives are encouraged to use their own health system data – revenue, margin, and growth (or lack thereof) – to draw sharp comparisons to the data from payer organizations.

While health systems are often referred to as "large," commercial insurers are true sector giants; payer companies dwarf even the largest health systems.

In 2023, the $1.2T revenue juggernaut of the top 5 insurers towers over the total earnings of the top 5 health systems by a factor of 8.

The largest payer groups have seen massive growth in revenue over the last decade.

The five largest payers have also enjoyed massive profit gains in the same time frame.

- *At $371B, the **largest payer is more than 7x** the size of the largest health system at $51.4B.*
- *UnitedHealth Group, CVS Health, Cigna, and Elevance each out-earn the **combined revenues of the 5 largest systems**.*
- *For context, $1.2T matches the FY2024 federal budget approved by Congress and signed into law by President Biden.*
- *Between 2012 and 2022, each of the **largest 5 payers had revenue growth greater than 130%.***
- ***Cigna Group reported over 500% growth in income** from earnings from $1.3B in 2012 to $7.3B in 2022.*
- ***UnitedHealth Group also saw massive gains in income from operations** citing a 300% increase from $9.3B in 2012 to $28.4B in 2022.*

Prior Authorization

AMA Prior Authorization Physician Survey Report

Overview: AMA gathered insights from practicing physicians regarding their experiences with prior authorization (PA). It sought to quantify the extent to which prior authorization processes negatively affect patient care and physician workload, while also evaluating the clinical and financial consequences of these delays.

- **Focus Area:** Impact of prior authorization on care delivery and physician workload.
- **Type of Evidence:** Quantitative survey data from practicing physicians.
- **Publication Details:** Survey conducted in December 2023. Report released in 2024 by the American Medical Association (AMA).
- **Data Source**: Institutional Report (Gray Literature).

Executive Summary:

AMA's 2024 survey reveals a system bucking under the weight of administrative overload, with prior authorization and bloated claims adjudication pipelines creating chokepoints in care delivery. What was billed as a cost-control tool has now devolved into a driver of bureaucracy and care fragmentation, sidelining patient value and overtaxing care institutions. Evidence points to a widening fault line between the promised value of authorization and the cascading burdens they've sustained in practice.

Key Findings:

1. **Care Delayed, Harm Delivered:** 94% of physicians say prior authorization delays care, driving extra office visits (68%), ER trips (42%), and hospitalizations (29%).
2. **Deadly Red Tape:** 1 in 4 doctors report serious adverse events linked directly to prior authorization delays.
3. **Burnout by Bureaucracy:** Doctors are spending 12 hours weekly on an average of 43 prior authorization requests, robbing time away from patient care and driving self-reported burnout rates to as high as 95%.
4. **Appeals Are a Dead End**: Over half of physicians skip appeals, calling them futile. Only 15% trust that insurer "peers" have the necessary expertise to make informed determinations.
5. **A Burden Across the Board:** More than half of doctors rank prior authorization as a "High" or "Extremely High" burden.

Why This Matters:

Findings point to a shared conclusion: prior authorization is a system-wide pain point. Excessive paperwork, rising costs, and delayed treatments are straining physicians, fueling burnout, and forcing patients to abandon critical care plans.

For health systems, this evidence drives renewed calls for payer accountability. The report lays bare inadequacies in claims regulation and oversight of payers' business practices.

Takeaway #1:

Preapproval delays erode care safeguards and drive clinical burnout, threatening the sustainability of health systems as key care providers.

The Narrative:

- Prior authorizations are undermining clinical workflows, pulling providers away from patient care, and fueling burnout.
- AMA data confirms prior authorizations pull critical resources from frontline care and require investment into non-clinical staff to manage claims approvals.

Supporting Stats:

1. Physicians spend an average of 12 hours a week navigating requests, averaging to 43 prior authorizations per doctor.
2. Over 1 in 3 (35%) of practices have staff exclusively assigned to managing prior authorization tasks.
3. 75% of health systems have added fiscal staff in the past three years to handle denials, with nearly 87% of CFOs noting these dynamics harm their ability to provide optimal care. (Source: Bridging the Payer-Provider Divide, HFMA, 2024)

Executive Talking Points:

- **"At our system alone, the sheer volume of hours and full-time staff required to manage prior authorization cases is staggering."**
- "We're talking about (insert site-specific PA statistic) a (insert timeframe or related scaling metric)."
- "That's enough to discourage even the most committed professionals, let alone deter the next generation of physicians from pursuing careers in medicine."
- "**A patient's condition doesn't pause while we're caught in negotiations** over what should be a given in modern healthcare."

Takeaway #2:

Care delays endanger patient safety and overwhelm hospitals and health systems with preventable cases that erode capacity and care continuity pathways.

The Narrative

- Prior authorization acts as a gatekeeping tool that compromises patient safety and subvert care interventions.
- Nearly one in four physicians link authorization hold-ups to patient harm and higher-acuity case loads that could have been prevented.

Supporting Stats:

- Over 20% of physicians report that prior approvals led to life-threatening events or required intervention to prevent permanent harm.
- AMA data confirms preapproval delays are derailing stable treatments—59% of doctors say it destabilizes patients who were previously well-managed.
- 48% of doctors say they often don't appeal denials because patient care can't wait for health plan approvals.

Executive Talking Points:

- "When over 20% of providers are reporting life-threatening outcomes linked to pre-certification delays, the conversation shifts entirely."
- **"We're no longer talking about cost-containment or healthcare waste; we're talking about preventing harm."**
- "As care providers, our oath is to heal, not to haggle with insurers over pre-approvals while lives hang in the balance."
- **"Let's be clear—this isn't just red tape anymore. It's a public health crisis."**

Takeaway #3:

Restrictive pre-approval systems are driving patients into acute care setting for progressed conditions that erode margins and undermine efforts to provide high-value care at low cost.

The Narrative:

- Prior authorization delays are a key driver of preventable emergency visits.
- Prior authorization delays also create hurdles that push patients to pay OOP for prescriptions.
- These trends are straining clinical networks, amplify inequities in access to care and medications, and disrupt progress toward integrated care excellence.

Supporting Stats:

1. 87% of physicians report that prior authorization leads to higher overall utilization of healthcare resources.
2. A strong majority report that the number of PAs required for prescriptions (83%) and medical services (82%) has increased over the last 5 years.
3. 79% of physicians report that delays or denials at least sometimes lead patients to pay out of pocket (OOP) for medications.

Executive Talking Points:

- "When 1 in 4 physicians report hospitalizations and even permanent injury tied to pre-approval delays, we have to ask—**who is prior authorization really helping?"**
- "Prior authorization isn't just a barrier—it's a patient risk multiplier."
- "Whether it's Cigna, Anthem, or BCBs, over half of physician's report payer protocols are grinding care delivery to a halt and straining care teams."
- **"We're caught between a rock and a hard payer."**

94% of doctors cite care delays linked to pre-certification.

Another 24% link red tape to serious adverse events.

69% report delays led to **ineffective initial treatment.**

29% say delays lead to a patient's **hospitalization.**

13% say delays led to **life-threatening events.**

13% of cases required action to avoid **permanent harm.**

Practices lose 12hrs weekly to pre-approvals, with doctors juggling 43 cases on average.

That's over **600 hours** *a year* lost to insurance workflows.

Now over **30% of practices** say they rely on dedicated staff ***to keep up*** with pre-certification demands.

Nearly 60% of doctors cite authorizations as a factor in destabilizing care for stable patients.

A further 78% cite approval barriers driving patients to **forego care plans altogether.**

Claims Denials

Social Determinants of Health & Insurance Claim Denials for Preventive Care | JAMA

Overview: The study examined over 4 million preventive service claims provided to 1.5 million patients, focusing on claim denials and out-of-pocket (OOP) costs across various demographics. Data was evaluated for denial rates across socioeconomic and demographic groups, with reasons categorized into specific benefit denials, billing errors, coverage lapses, and others.

- **Focus Area:** Disparities in insurance claim denials for preventive care based on SDoH's.
- **Type of Evidence:** Cohort study of over a million privately insured patients using claims data covering preventive services delivered from 2017-2020.
- **Publication Details:** Published in JAMA Network Open, September 2024.
- **Data Sources**: Proprietary claims and remittance data detailing denial reasons, and patient demographic data sourced from external datasets. (Peer-Reviewed Literature).

Executive Summary:

Emory University researchers looking at links between SDoH and claim denials find that patients from marginalized backgrounds were disproportionately denied ACA-protected services due to coding errors and misclassified coverage. Study findings expose breakdowns in cost-sharing safeguards, drawing attention to potential biases in payer adjudication and billing frameworks.

Key Findings:

1. **Double Jeopardy for Low-Income Patients:** Patients earning under $30K face twice the denial rate of higher earners, absorbing higher median unpaid bills per claim (13%+ than wealthier peers).
2. **Education Gap in Billing Equity:** Patients with a high school degree or less had a denial rate of 1.79%, compared to 1.14% for college graduates, a 57% relative difference.
3. **Racial Bias in Denials:** Asian patients endured 2.4x higher denial rates and shouldered median unpaid bills 46% higher than their White counterparts.
4. **Preventative Services Under Fire:** Preventive services like diabetes (3.06%), depression (2.84%), and cholesterol screenings (1.75%) lead denial charts. Depression screening denials stemmed largely from "specific benefit exclusions" in 59% of cases.
5. **Claims Denied, Care Delayed:** Only 32% of denied claims are resubmitted, leaving patients to foot 93% of unpaid bills, a median of $412 for low-income households.

Why This Matters:

An analysis of **millions of claims reveals minoritized patients are locked out of preventive care** while hospitals shoulder mounting costs and bureaucratic bloat tied to payer denials and coverage gaps.

For health systems, this study amplifies calls to curb payer infractions and other discriminatory practices that erode pathways to ACA-exempt coverage protections.

Takeaway #1:

Residual costs not covered by insurers function as a silent deterrent for minority groups that fuel a cycle of disparity and unmanaged chronic illness.

Supporting Stats:

1. Only 32% of denied claims were resubmitted by providers, leaving two-thirds unresolved.
2. More than half of denials for contraceptive administration (58.8%) and depression screening (59.1%) stemmed from benefit exclusions.
3. Diabetes, depression, and cholesterol screenings exhibited some of the highest denial rates, signaling barriers to care for high-prevalence disease states.

The Narrative

- Uncovered costs for chronic disease screenings disproportionately burden minority groups.
- This creates cost-prohibitive barriers to early intervention that perpetuate comorbidity risks.
- Claim discrepancies are symptomatic of larger systemic failures and highlight gaps in private payer accountability.

Executive Talking Points:

1. "When 93% of denied claims leave patients with unpaid balances, **preventive care is no longer preventive—it's punitive.**"
2. "Every abandoned treatment plan isn't just a lost opportunity for care—it's a ticking time bomb for preventable hospitalizations and disease."
3. "Every denied claim that goes unresolved is a missed opportunity for preventive care and a driver of inefficiency in our system."

Takeaway #2:

Claims disparities for marginalized patients signal entrenched biases in insurance practices that widen disparities and erode health equity commitments.

Supporting Stats:

1. Patients with a high school diploma or less experienced 56% higher denial rates compared to those with a college degree. Similarly, billing errors for the least educated were nearly twice as common as for the most educated.
2. 73% of health executives report that claims denials have increased in 2024, up significantly from 42% in 2022. (Source: Experian State of Claims, 2024)

The Narrative

- Lower-income and less-educated patients are nearly twice as likely to face barriers to care due to negligible errors and hollow benefit designs in commercial plans.
- These policy shortfalls funnel patients into cycles of unmanaged illness and insurance disparity—raising questions about the integrity of benefit workflows and their ill-suited health impacts.
- These trends—whether rooted in systemic workflows or algorithmic design—demand greater scrutiny of adjudication processes and oversight to safeguard public health and health system equity goals.

Executive Talking Points:

- "Barriers to preventative care push patients towards advanced-stage conditions that inflate costs for emergency treatments and long-term disease management. "
- "When low-income patients face nearly double the rate of claim denials for preventive care, **we are not just denying services; we are compounding health disparities."**

Takeaway #3:

Denied claims saddle vulnerable populations with avoidable costs and simultaneously challenge the ACA's promise of affordability.

Supporting Stats:

- Unpaid bills for denied services were higher for lower-income patients (median: $412) compared to higher-income patients (median: $365).
- The median out-of-pocket cost for denied preventive claims was $630.
- Racial and ethnic minorities faced highest average costs, with Asian patients at $522 and Hispanic patients at $464, compared to $357 for non-Hispanic White patients

The Narrative

- Claims processing failures by payers undermine ACA protections against cost-sharing for preventive care.
- Unexpected out-of-pocket costs drive patient mistrust and worsen disease progression, increasing strain on health systems.

Executive Talking Points:

1. "Insurance **denials that burden vulnerable patients** with unexpected costs **are antithetical to the goal of the ACA."**
2. "When insurance denials turn preventive care into a financial gamble, **we're shifting the cost of health equity onto our most vulnerable**."
3. "Insurers bypass the ACA's protections by denying preventative care claims for at-risk, high-need, marginalized citizens."

Denied claims left 93% of patients with unpaid bills, including many for ACA-protected services.

Minority patients faced higher average costs.

Asian patients paid $165 more than White patients for the same care, and low-income patients saw 13% higher bills.

What this data suggests:

A single mother with a history of depression earning <$30K faces disproportionately high odds of a denied mental health screening due to coverage gaps. With only 32% of claims resubmitted for appeal, she could be forced to pay up to $412 out-of-pocket.

Claim denials hit hardest for chronic care-related services.

Diabetes: -3.06%

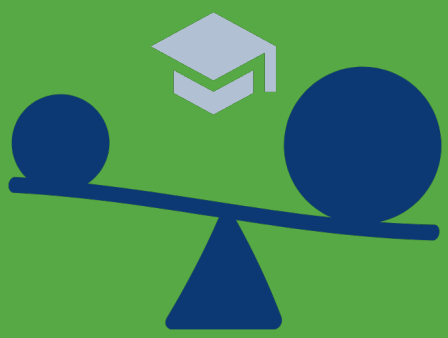
Depression: -2.84%

Cholesterol: -1.75%

59% of denials for **depression screenings** were due to "specific benefit exclusions."

Patients with only a high school diploma faced higher denial rates, too.

Similarly, billing errors for the least educated were nearly 2x as common as for the most educated.



Payers and AI

Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care

Overview: On May 17, 2023, the Senate Permanent Subcommittee on Investigations (PSI) launched an inquiry into the barriers facing seniors enrolled in Medicare Advantage (MA) in accessing care. PSI's Majority staff report reveal how the nation's top MA insurers – UnitedHealthcare Group (UHC), Humana, and CVS – exploit prior authorization to reduce costly post-acute care stays and inflate their profits.

- **Title:** 2024 Senate HSGAC Majority Staff Report on Medicare Advantage Practices
- **Focus Area:** Congressional report exposing MA insurers' refusal of care for vulnerable seniors, the role of predictive technologies, and the financial incentives influencing denial rates.
- **Type of Evidence:** Congressional investigation report based on 280K+ pages of documents obtained from UHC, Humana, and CVS to date.
- **Publication Details:** Released Oct 17, 2024, Senator Blumenthal (D-CT), Chair of the Senate (PSI).
- **Data Source**: Government Report (Gray Literature)

Executive Summary:

A Senate investigation reveals Medicare Advantage (MA) insurers weaponizing AI algorithms to flag and deny claims for post-acute care. Subcommittee findings point to payers leveraging gaps to implement questionable cost-cutting initiatives that leave high-risk beneficiaries underserved and underinsured. Major players, including **UnitedHealthcare (UHC), CVS, and Humana**, were seen deploying these technologies to protect billions in profits by avoiding coverage for eligible services.

Key Findings:

1. **AI Rears Its Greedy Head:** MA insurers targeted post-acute care for cost-cutting, issuing denials at rates up to 16x higher than their overall denial rates.
2. **Automated Models, Manual Targets:** UHCs AI models fueled a 9-fold (172%+) increase in SNF denials between 2019 and 2022. Over the same period, its overall denial rate remained stable, suggesting a focused tactic to void high-cost stays to cushion savings.
3. **The MAth isn't Matching:** CMS cited that over (56%) of audited MA contracts had denials that did not meet Medicare coverage rules.
4. **Training to Deny:** Insurers like Humana and CVS trained staff to resist appeals and use pre-written denial templates, even for services meeting Medicare's medical necessity requirement.
5. **Prior Loss, Prior Auth:** CVS subjected 57.5% more post-acute care requests to prior authorization despite only a 40% growth in enrollment.

Why This Matters:

Congressional inquiry into MA show top payers exploiting regulatory gaps with predictive algorithms that preemptively reject high-cost claims at suspect rates. These practices sidestep oversight mechanisms and enable payers to leverage regulatory blind spots to pad profits with little recourse for patients and providers.

For health systems, this intensifies the storm—forcing hospitals to swallow financial shortfalls, untangle discharge bottlenecks, and increased strain on efforts to close equity gaps in care delivery.

Takeaway #1:

Under the guise of efficiency, MA insurers have replaced medical necessity with cost-cutting algorithms, leaving patients trapped in a bureaucratic tangle that profits from their suffering.

Supporting Stats:

1. Humana's post-acute care denial rates skyrocketed 16-fold, leveraging aggressive cost-reduction tactics even on appeals.
2. CVS projected saving millions by denying post-acute care requests and prioritizing cases with high denial probabilities to protect profit.
3. Criteria for admission to LTAC hospitals are not spelled out in the Medicare Benefit Policy Manuals. As a result, MA insurers typically use third-party providers of medical necessity criteria when making determinations.

The Narrative

- Major insurers operating MA plans have amassed billions in profits through aggressive underwriting and questionable AI practices.
- Limited CMS access to service-specific data further obscures these disparities, allowing denials for high-cost services to go unnoticed.
- MA insurers are *quietly* denying coverage for eligible services, exploiting CMS' flawed reporting frameworks. These compliance ambiguities have allowed top MA plans to game the system and offload costs to hospitals and health systems.

Executive Talking Points:

1. "We're seeing top insurers relying on predictive algorithms to preemptively target post-acute claims for denial at 3 to 16 times higher than other services. "
2. **"If CMS can't track the data, insurers can dodge accountability."**
3. "Insurers are exploiting the system by betting on patients' silence. They've trained their staff to resist even provider-driven appeals. That's not efficiency—it's a business model."

Takeaway #2:

Automation in claims processing is eclipsing clinical judgment and reducing care decisions to algorithms engineered to mollycoddle insurer margins.

Supporting Stats:

1. CMS found evidence of tools being used by MA insurers to dictate care determinations, such as reducing LOS or steering patients to less costly options.
2. Humana promoted hospice care as a cost-saving alternative to long-term acute care hospitals, suggesting focused tactics to void high-cost, resource-intensive stays despite need.
3. UnitedHealthcare's internal committees approved automation technologies despite knowing they increased denial rates. Testing showed faster review times but also higher adverse determination rates.

The Narrative

- Shifting vulnerable patients into less intensive settings, regardless of clinical appropriateness, reflect a deliberate strategy to dignify payer margins over clinical necessity.
- Automated systems indiscriminately flagged claims with minimal oversight, leaving patients with fewer care options and health systems to absorb the fallout from delayed recoveries and readmissions.

Executive Talking Points:

1. "These predictive technologies used by major **MA insurers are blurring the lines between medical necessity and cost-saving**, with limited transparency or oversight. "
2. "Every claim denied means a hospital left holding the bag, a patient waiting longer for care, and a system stretched beyond capacity. "
3. "Investigations show Medicare Advantage works harder at denying care than delivering it. **So, who's truly gaining the 'Advantage' in this system?"**

Takeaway #3:

Unjustified service denials expose inequities in post-acute and elderly care, prompting questions about MA payer transparency and compliance.

Supporting Stats:

1. Internal policies at Humana enabled contractors like naviHealth to heavily influence critical care decisions. Automated tools like 'nH Predict' prioritized algorithmic outputs over human oversight, flagging cases likely to be denied without adequate review.

2. Investigators claim MA insurers delay or deny up to 18% of prior authorization or payment requests for services that would otherwise be covered under Traditional Medicare.

The Narrative

- The AI systems used by payers are engineered to escalate denials and predict appeal failures, hampering care approvals and fair payment.
- Post-acute care denial rates surged while overall rates stayed flat, masking inequities and creating a false sense of fairness.
- Rising denials strain provider finances, amplifying losses and pressuring health systems to sustain high-cost services for resource-intensive patients.

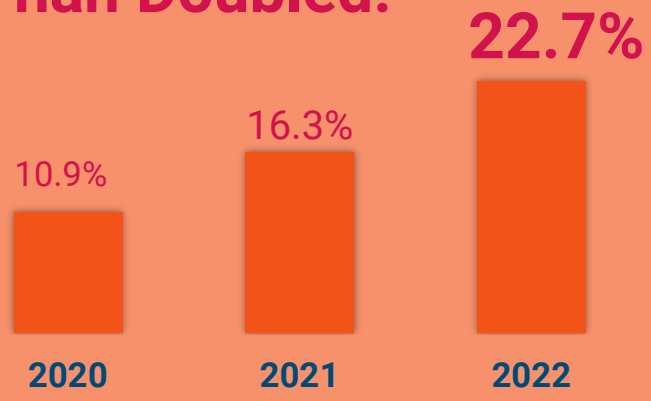
Executive Talking Points:

1. "We can't overlook the human cost of MA negligence. These algorithms don't just pad profits—they actively siphon from the frail and elderly."
2. **"This is, in essence, a 'rob grandma to pay Humana' kind of villain narrative."**
3. "Claims automation without accountability is a recipe for denying care to those who need it most"
4. **"For MA to fulfill its promise, payers must be held accountable to the same care standards as traditional Medicare—our seniors deserve better"**

CVS leveraged AI models under it's 'Post-Acute Analytics' initiative to optimize utilization, projecting $77 million in cost savings.

In April 2021, CVS executives identified this initiative as the largest opportunity to meet a $19.5M Medicare savings target, prioritizing rapid deployment to influence upcoming CMS bids.

UHG's Prior-Auth Denials for Post-Acute Care More Than Doubled.



Automated processes fueled the surge, per PSI investigation.

Humana staff raised red flags over pushing hospice as a substitute for LTAC.

Internal docs reveal staff flagged worries over steering patients to hospice to sidestep pricey LTAC stays, citing unclear guidelines and risks of appearing insensitive in denial letters.

CMS regulations fail to curb AI's undue influence on human reviewers, leaving gaps in accountability.

Since 2005, CMS required insurers to report utilization patterns but excluded service-level details.

For questions, comments, or inquiries please contact TAA Director of Health Policy Research, Maria Fernanda Gutierrez, at mgutierrez@hmacademy.com.

Disclosure

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