Medicare Advantage insurers ramped up use of technology to deny claims, Senate investigation shows

The nation's three largest Medicare Advantage insurers increasingly refused to pay for rehabilitative care for seniors in the years after adopting sophisticated technologies to aid in their coverage decisions, a Senate investigation found.

UnitedHealth Group, Humana, and CVS Health targeted denials among older adults who were requesting care in nursing homes, inpatient rehab hospitals, and long-term hospitals. As of 2022, those three insurers were turning down roughly a quarter of all requests for post-acute care among their Medicare Advantage enrollees, according to the congressional report.

The report, conducted by the U.S. Senate Permanent Subcommittee on Investigations, extensively cites STAT's series last year that investigated the use of algorithms and artificial intelligence within Medicare Advantage plans. The series focused on how UnitedHealth and its subsidiary NaviHealth were using unregulated algorithms to predict when someone could be cut off from rehab care. STAT's investigation revealed, for example, how UnitedHealth pushed employees to abide by the algorithm's predictions, even if patients could barely walk and were not ready to go home.

Health insurers have relied more on using a process known as prior authorization, which requires clinicians to submit paperwork to justify that certain care is medically necessary. Insurers are able to save money by denying care or by diverting people to lower-cost settings, but clinicians contend the process has been abused to limit care and is overly burdensome.

The subcommittee found that a sharp uptick in denials of care to sick, older patients coincided with the increased use of algorithmic tools, including one from NaviHealth. It also found that decisions to use — or

not use — particular technologies were tightly correlated with projected impacts on the health insurers' profits.

"The data obtained so far is troubling regardless of whether the decisions reflected in the data were the result of predictive technology or human discretion," the report says. "It suggests Medicare Advantage insurers are intentionally targeting a costly but critical area of medicine — substituting judgment about medical necessity with a calculation about financial gain."

A Humana spokesman said in a statement that the report was partisan and "laden with errors."

"In fact, Senator Blumenthal's team declined to correct those errors and mischaracterizations that Humana identified after reviewing certain heavily redacted excerpts prior to the report's release," the statement said.

A spokesman for CVS also pushed back on the subcommittee's findings.

"The report significantly misrepresents CVS Health's use of prior authorization," the statement said. "Many of the documents cited are outdated, while others are drafts or were used for internal Company deliberations and therefore are not reflective of final decisions."

The statement added that CVS Health's prior authorization practices are routinely audited by the Centers for Medicare and Medicaid Services.

UnitedHealth said in a statement: "This majority staff report mischaracterizes the Medicare Advantage program and our clinical practices, while ignoring CMS criteria demanding greater scrutiny around post-acute care."

The denial rates and internal discussions exposed in the Senate report confirm the extent of coverage denials that were facilitated by the use of predictive technologies. UnitedHealth's integration of NaviHealth's algorithm, called nH Predict, overlapped with a marked increase in denials for patients seeking care in skilled nursing facilities. In the first full year of its use in 2022, UnitedHealth denied 12.6% of those nursing

home prior authorizations — a ninefold increase from 2019, according to the Senate report.

Sen. Richard Blumenthal (D-Conn.) led a hearing in May 2023, when he announced the subcommittee had asked UnitedHealth, Humana, and CVS for documents that "will show how decisions are made to grant or deny access to care, including how they are using [artificial intelligence]." Since then, the subcommittee's Democratic staff collected more than 280,000 pages of documents from the three companies, including meeting minutes and internal presentations.

UnitedHealth sits at the center of the Senate report, as both the largest Medicare Advantage insurer and the corporate owner of NaviHealth. UnitedHealth's rate of denials for post-acute services jumped from 8.7% in 2019 to 22.7% in 2022, according to the report.

The report also found that Humana and CVS relied heavily on AI and algorithmic tools in issuing denials. The subcommittee described the results of CVS's testing of a predictive model for inpatient admissions for the company's Medicare Advantage beneficiaries. The company found that a model built to "Maximize Approvals" jeopardized profits by approving too many cases the company felt should be denied.

Facing pressure to cut costs in its Medicare Advantage division, CVS in April 2021 began working with Post-Acute Analytics, a company that used artificial intelligence to reduce the amount of money spent on nursing homes. CVS initially expected that it would save approximately $4 million per year, but within seven months, the company projected that an expanded version of the initiative would save the company more than $77 million over the next three years, the report found.

The subcommittee's investigation also unearthed a presentation from a March 2022 meeting that stated CVS had "deprioritized" a plan to reduce the overall volume of prior authorizations, concluding that the cost was "too large to move forward."

The report went on to highlight Humana's practices surrounding denials. It found the company's denial rate for long-term acute-care hospitals, the most expensive type of post-acute care, grew by 54% between 2020 and

2022. The increase came after the company held training sessions devoted to justifying denials to providers.

Humana has contracted with NaviHealth to process coverage determinations for post-acute care services since 2017. The subcommittee found the company appeared to grant wide latitude to contractors to use predictive technologies, flagging an August 2020 policy document that said, “Certain third parties may utilize Artificial Intelligence systems in support of services being provide(d) to Humana and are covered within the scope of these guidelines, where applicable.”

UnitedHealth and Humana are each facing class action lawsuits from Medicare Advantage beneficiaries and their families over care denials. The Senate report zeroed in on UnitedHealth’s reliance on predictive tools to issue denials — and to respond to the fallout.

As NaviHealth’s denials increased in 2022, so did appeals from patients. Late in the year, a UnitedHealth working group formed to tackle the problem turned to a similar technological solution. It proposed to “leverage [machine learning] on the appeal population” to flag cases likely to result in an appeal. During a follow-up meeting in January 2023, employees discussed whether they could use the model to identify the trends driving appeals and find ways to reduce successful appeals.

The subcommittee’s report noted that the meeting took place after a year in which the company’s prior authorization denial rate for post-acute care had increased by 40%. “This suggests UnitedHealthcare’s efforts at making ‘the correct decision’ may have been targeted at those cases it determined to be likely to be appealed, rather than wrongful denials generally,” the report stated.

The Senate subcommittee is calling on the Centers for Medicare and Medicaid Services, which regulates Medicare Advantage plans, to collect prior authorization data specifically by the type of service and to conduct more rigorous audits of companies with high denial rates. The report also calls on the government to “expand regulations” to make sure insurance company workers aren’t bound by the tools insurers use to approve and deny care.

“Even if predictive technologies are solely used to approve requests, nurses and doctors reviewing cases may face pressure to rubber-stamp the recommendations of algorithms and artificial intelligence,” the report said.

In a statement, a spokesperson from CMS wrote, “CMS is committed to ensuring that all people with Medicare can access the care they need, whether that is through Traditional Medicare or Medicare Advantage. The statement added: “CMS continues to receive many inquiries about the use of prior authorization, and any additional changes to CMS policies would be proposed through rulemaking.”