Coverage Denials in Medicare Advantage—Balancing Access and Efficiency

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Each year, millions of claims for medical services are denied by health insurance plans. Many denials may be justified as a necessary strategy to reduce wasteful spending from low-value care. However, denials may also delay diagnosis and/or treatment for patients, and appealing denials contributes to clinician workload and burnout.1 This tension is apparent in the Medicare program, where denials affect millions of beneficiaries who enroll in Medicare Advantage (MA). Although MA plans are required to cover the same services as traditional Medicare, these private plans are allowed to leverage utilization management tools, such as prior authorization, that traditional Medicare rarely uses.2 In 2021, MA plans denied approximately 6% of the 35 million prior authorization requests submitted. Although only 11% of these denials were appealed, the decisions were overturned in 82% of appealed cases.3 The regularity of reversals has raised questions about whether MA plans are deviating from their coverage obligations.

Assessing divergence in coverage policies is challenging because MA plans are only required to report aggregate information regarding denials. However, in 2022, researchers using data from a large insurer’s claims showed that one-third of MA beneficiaries experienced a denial for 1 or more services each year, with annual denials increasing by 15% over a 5-year period.4 Notably, nearly 15% of the 5.6 million denials—a full $150 million in denied spending—was attributed to MA policies that were more restrictive than traditional Medicare’s coverage rules. These data suggest that MA plans sometimes deny care that would have been approved by traditional Medicare. The Office of the Inspector General (OIG) corroborated this concern, finding that 13% of coverage denials by MA plans met coverage under traditional Medicare.5 Examples of service denials offered in the OIG report may be familiar to many physicians, including denying magnetic resonance imaging for soft tissue injuries until radiographic imaging has been performed and denying a mobility walker to a 76-year-old with postpoliomyelitis syndrome because he received a cane during the previous 5 years.5

Noting these disparities in coverage, the US Centers for Medicare & Medicaid Services (CMS) recently issued a final rule stipulating that benefits coverage for MA enrollees must be no more restrictive than traditional Medicare.6 The rule also allows for MA plans to develop their own coverage rules for services where traditional Medicare coverage is not fully established, but requires that these criteria be based on clinical evidence and made available to the public. Given that MA now covers half of Medicare beneficiaries, this rule may affect millions of patients.

Considerations for Policymakers

Successful policy implementation will depend on how regulators navigate the tension between reducing inappropriate denials of necessary services (the intended goal) and increasing inappropriate approvals of wasteful services (an unintended consequence). Aligning coverage criteria across traditional Medicare and MA carries the risk of increasing waste if some services being denied by MA plans are of low value, even if they would be covered by traditional Medicare.

As an illustrative example, traditional Medicare spends billions of dollars annually on the drug aflibercept despite evidence that the much cheaper bevacizumab is equally effective for diabetic macular edema.7 Although traditional Medicare lacks coverage restrictions in many of these cases, MA plans might require step therapy or substitute less costly medications with similar efficacy. These policies may explain why MA enrollees receive almost 10% fewer low-value services than traditional

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Medicare beneficiaries receive. Because this difference is partially driven by benefit design, the new rule may obstruct efforts to reduce low-value care, undermining the US Congress’ original intent with MA, which was to increase efficiency through private plans.

Another risk of considering traditional Medicare’s coverage policies as the criterion standard to which MA plans should conform is that Medicare’s own rules are often unclear. Many Medicare coverage decisions are rendered at the local level by Medicare administrative contractors, which OIG has found to be using inconsistent criteria that vary widely across states. Consequently, if the new rule is to balance both access and efficiency, regulators need to look beyond policy alignment and ensure that underlying coverage criteria for all beneficiaries are developed using standardized evidence-based processes.

Recommendations

Given the lack of available data to describe MA claim denials, increasing transparency is a critical first step. Although the rule requires public disclosure of MA plans’ utilization review criteria, CMS should go farther by requiring that plans disclose both how often services are denied and why they were denied. Denial rates provide a more helpful signal of health care access across plans than do dense coverage criteria, and disclosure would help beneficiaries choose from among MA plans and it would foster healthy competition. In a survey, 85% of insured adults supported a requirement for health insurers “to tell regulators how often they deny claims and to disclose that denial rate to consumers.” CMS could publish this information on its Medicare Plan Finder website and require brokers to relay denial rates to clients.

Importantly, reporting should clarify the reasons for the denials (eg, clerical error vs clinically unnecessary) and whether the services would have been approved by traditional Medicare. In addition to informing patients, these data would facilitate research and ongoing monitoring of the relative prevalence of appropriate denials and inappropriate approvals, all of which have implications for access and efficiency. To ensure accuracy and promote compliance, CMS could leverage audits and fines similar to those used to compel insurer compliance with price transparency requirements.

Beyond encouraging disclosure, CMS must also consider how it will enforce coverage parity across the full range of services covered by Medicare. One approach is to build on the OIG report to assemble a list of services commonly denied by MA plans but consistently covered by traditional Medicare. This list would help MA plans to adjust coverage criteria more readily in the areas where it matters most and assess which of the common denials are appropriate or inappropriate. In addition, this information could assist in reevaluating the existing coverage criteria of traditional Medicare.

CMS can also discourage inappropriate denials through the Quality Star Ratings assigned to MA plans. Specifically, the Star rating domains—which already factor in the rate at which appealed denials are upheld—could include metrics for denial rates beyond traditional Medicare, as measured by CMS or its contractors. Although denial rates are not comprehensive metrics (eg, they do not capture services deterred by the threat of undergoing the prior authorization process), emphasizing denials in Star ratings would incentivize plans to thoroughly review and refine coverage policies because higher ratings attract enrollment and garner bonus payments.

Conclusions

The promise of the MA program was to provide added flexibility for enrollees layered atop a foundation of minimum benefits guaranteed for all Medicare beneficiaries. Yet amid growing enrollment in MA, many beneficiaries may experience denials for services that would have been approved by traditional Medicare. With its new rule, CMS has an opportunity to ensure that these beneficiaries have access to necessary care while also modernizing Medicare coverage policies to curtail wasteful spending.