February 18, 2024
U.S. Senator Pete Ricketts
Committee Member United States Senate Special Committee on Aging

Hearing: Medicare& Medicare Advantage: Challenges and Opportunities with Enrollment
Friday, February 23rd, 2024, at 10:00 AM CT
Douglas County Health Center
Omaha, Nebraska

Good morning, my name is Dr. John Trapp. I am the Vice President of Medical Affairs and Chief Medical Officer for Bryan Health, a six hospital locally owned and governed Nebraska health system, and a pulmonary, critical care physician. I have been in clinical practice in Nebraska for 25 years. I will begin by thanking Senator Ricketts for his attention to this issue and providing a venue by which we may share our concerns about Medicare Advantage and their practices with all of you. Today I will outline a couple of our concerns, namely that abusive practices by insurers offering Medicare Advantage programs put vulnerable patients at risk and negatively impact hospital capacity, all while reducing payments to those who are actually providing the care.

In a Modern Healthcare article published February 16th, the author Caroline Hudson summarized many of the MA plans well, "Medicare Advantage plans generate billions of dollars for payers as they woo members with $0 premiums and supplementary benefits." At its inception MA's intention was to allow for highly coordinated, proactive, population-based care that would reduce health care costs over time – something we can all agree on. In reality, the financially driven interests of the insurance companies have resulted in MA programs becoming the most profitable arm of many of the major insurance companies at the expense of the patient, taxpayers and the Medicare trust fund.

The Medicare Payment Advisory Commission (MEDPAC) projects that the federal government will pay MA plans $88 billion more this year than if those same beneficiaries would have been covered under the traditional Medicare program. Yet these additional funds are not going to providers. Just the opposite. Most physicians will receive less in 2024 as their Medicare Advantage fees are tied directly to the Medicare provider fee schedule, which will be cut 3.4% this year, culminating in a roughly 10% cut over the last four years.

At Bryan Medical Center, traditional Medicare reimburses us approximately 80% of our actual costs, meaning that we lose more than $90 million dollars per year on the Medicare patients we care for (including MA). Our contracts with MA plans call for reimbursement rates that are at least 100% of Medicare. However, due to inappropriate denials as well as delays in preauthorization and payment we receive less than what traditional Medicare would have reimbursed. For one of the most prominent MA insurers in the country, we receive only 88% of traditional Medicare reimbursement despite fighting their tactics every step of the way expending numerous resources to fight through unfair tactics where the advantage always lies with the insurer.

More important than the impact on reimbursement, prior authorization and denial practices have at times overwhelmed hospital systems and created a log jam that impacts vulnerable patients and hospital capacity. Bryan Medical Center is located in Lincoln, Nebraska, has 664 licensed beds, and is often full. We consistently serve patients from all of Nebraska's 93 counties and surrounding states. On a Friday morning earlier this month we had 40 patients boarding in the emergency department, waiting for a bed upstairs. Several beds could have been made available except that a number of patients were effectively stuck at Bryan awaiting authorization by Medicare Advantage plans to be discharged to post-acute facility such as skilled nursing or long term care.

Finally, I'd like to spotlight the reason we are all here, patients and the delivery of quality care. These are the stories of two real life patients from the last several weeks at Bryan Medical Center. Patient A has been accepted to a long term care facility, their MA plan requires authorization for them to move to the next, most appropriate level of care. They no longer need to be in the hospital. The authorization was submitted to their health insurance plan on January 26th, 2024. On February 1st, our care transitions staff called the insurer asking for an update – their reply "We have 10 more days to make a decision". Ten days of delay to receive the rehabilitative care they need, ten days of being unable to leave the hospital, ten days of unreimbursed care, ten days of frustration – this is what happens when patient's select MA plans thinking they will have timely care and access to expanded benefits. Rather, they are at the mercy of their health insurance plan not what their doctor thinks is best for them. The hospital is not getting paid to care for this patient because the patient no longer requires acute care. The insurance company is getting days and weeks of free nursing care for their patient, at the expense to the patient's wellbeing, their family, and the hospital while making record profits.

Patient B has been waiting for authorization since February 12th, for the subsequent three days our capacity management director has emailed the MA insurance company and called multiple times trying to get an answer – they do not respond. The nursing facility that has accepted the patient cannot take them over the weekend, so if we don't get authorization by Friday, February 16th, the patient won't be able to discharge until Monday at the earliest. This results in even more days the patient is in the hospital for no reason, disallowing another patient with acute medical needs from accessing care.

Now the insurance companies will tell you that they will pay for the delayed days, this is simply not true. The patients they will pay for are one – a limited group and two – require another authorization for the excess days. The hospital is further burdened in recouping costs because the MA plan wasn't efficient in processing the authorization the first time.

Why does Bryan continue to accept Medicare Advantage? Because taking care of those who need us is our first priority. But the current tactics of large national insurers, who hold the power, must be reined in for the sake of both the vulnerable and those of us who take care of them. The current model is not sustainable as the insurers claim record taxpayer funded margins, and the hospitals and healthcare providers subsist in the aim to fulfil our mission of care. MA plans are selling patients a bill of goods they cannot and choose not to fulfill.

Thank you for the opportunity to share but a small picture of the ways Medicare Advantage is impacting Nebraskans. Our state's story is not unique, these behaviors are impacting American's nationwide. As you hear from myself and others today, I ask that you be moved to take action. I would welcome any questions you may have for me at this time.