New Medicare Advantage rule is boon for providers, drag on insurers

By Tara Bannow, Feb. 5, 2024

Starting this year, private Medicare plans have to cover their members' hospitalizations at the higher inpatient rate if their doctors predict they'll have to stay beyond two midnights.

It's the same rule — appropriately called the two-midnight rule — that traditional Medicare has followed for a decade. After it came out that Medicare Advantage plans were routinely denying coverage for necessary services, the federal government decided they ought to be held to the same standard, at least when it comes to hospital care.

As hospitals and health insurers release their profit projections for 2024, it's become clear that this change — largely overlooked when it was announced — could have a marked effect on companies' finances. For patients with MA plans, it could mean better access and smaller out-of-pocket costs after a hospitalization.

"We believe ultimately it's going to benefit our patients," Bill Rutherford, the outgoing finance chief of HCA Healthcare, said on the company's earnings call last week. "And we think over time there will be moderate positive results for us."

Doctors typically deem patients as either in need of inpatient care or what's known as observation, which is considered outpatient care even if the patient is hospitalized for multiple days. Medicare made it official last spring: MA plans have to cover a patient's hospital stay at the more expensive inpatient rate in three situations: if their doctor expected them to stay for longer than two midnights, for shorter stays on a case-by-case basis, and for procedures Medicare only covers as inpatient. Until this year, plans could more easily reject inpatient claims and pay hospitals at the lower, outpatient rate.

Experts said in a perfect world, patients wouldn't be treated differently depending on how their hospital stay is categorized for billing purposes. In reality, though, there could be cases where the inpatient title affords better access. If a MA plan denies coverage for inpatient care before the patient is admitted, the hospital may treat them in an outpatient setting instead, said Michelle Millerick, the American Hospital Association's senior associate director of health insurance and coverage policy. For a scheduled procedure, an inpatient denial could mean the procedure gets canceled, Millerick said.

Patients could also have an easier time paying their medical bills. Inpatient care is more expensive than observation. If a plan refuses to cover a stay as inpatient and instead pays at the lower observation rate, the patient could be on the hook for a bigger bill,

depending on how their MA plan is structured. And some MA plans don't cover nursing home care unless the patient had an inpatient stay, Millerick said.

There are early indications the rule will be a boon for hospitals and a drag for insurers. HCA, the country's biggest hospital chain, is projecting much higher 2024 profit than analysts had predicted. Meanwhile, Humana, the country's second largest MA insurer, forecasts half as much profit as analysts expected this year. Its finance chief said on Humana's earnings call she's looking into whether the new rule is an "underlying cause."

How much the rule truly helps patients and providers depends on how MA plans respond. If they continue to argue inpatient stays weren't necessary, it won't have a meaningful effect, said Jared Holz, a health care equities specialist with Mizuho.

"To me, it's a bit of a wait-and-see how it pans out over the next couple of quarters," he said. "I would doubt it has a big impact this year. Over a year or two we may see it start to creep in."

The question of how insurers will respond is already a source of heated debate. MA insurers released guidelines last year explaining their plans for complying with the new two-midnight policy. Hospital lobbying groups quickly raised alarms to Medicare, arguing the guidelines prove insurers intend to flout the law. Insurers disagree. Medicare said it's reviewing the concerns.

The rule allows MA plans to audit admissions they suspect weren't necessary. At the heart of the disagreement between hospitals and insurers is the extent to which insurers can use internal criteria when they do that rather than traditional Medicare's criteria and its coverage decisions for particular services. The rule says MA plans can use their own criteria when situations arise for which there aren't existing guidelines.

The AHA, the industry's top lobbying group, argues the rule only allows for that in limited circumstances. That's because when it comes to inpatient hospital care, Medicare criteria is fully developed, Millerick said.

"The Medicare fee-for-service program and its auditors for the last decade have been using the two-midnight rule as the standard for whether inpatient care is appropriate," she said, "and they haven't needed to supplement that with additional criteria."

Edward Hu, UNC Health's system executive director of Physician Advisor Services, agrees with the AHA. He said he doesn't think Medicare intended to give insurers free rein to use different criteria from traditional Medicare, but instead wanted to leave open the possibility of using their own in limited circumstances.

"If you allow a complete set of criteria to be used in lieu of the admitting physician's expectation, you've not improved the law, you've changed it," Hu said.

UnitedHealthcare, the country's biggest MA insurer, wrote in an explainer that the rule allows plans to use internal criteria when there aren't established criteria for a certain case. In UnitedHealth's case, the company said Medicare "expressly allows" it to use its own decision support tool, InterQual. InterQual is part of Change Healthcare, which UnitedHealth bought in 2022 after the U.S. Justice Department lost its bid to stop the $13 billion deal.

The AHA has raised concerns about UnitedHealth owning InterQual, which is one of two major decision support tools insurers use. UnitedHealth has an incentive to write guidelines that deny claims, which in turn will attract more insurer customers, the AHA argued. Optum, the UnitedHealth unit that houses InterQual, didn't respond to a request for comment.

Robert Hirsch, vice president of regulations and education for R1 Physician Advisory Solutions, takes a more nuanced view of the situation. A doctor himself, his job is to help doctors fight payment denials. But even he acknowledges an awful lot of the medical care that's provided isn't appropriate, citing the example of a neurosurgeon in Washington state found to have falsified diagnoses and performed unnecessary surgeries.

"Medicare Advantage plans should have every right to audit all admissions regardless of length of stay to make sure they're clinically appropriate," Hirsch said. "I wish I could say we can trust every hospital but the truth is, some are motivated by other factors."

And while Hirsch doesn't think MA plans will violate the two-midnight rule, he expects they'll "find ways to nuance it to keep their profits high."

Chip Kahn, the CEO of the Federation of American Hospitals, a trade group that represents for-profit hospitals, maintained that hospitals won't admit patients unless they have strong reason to do so.

Kahn said Medicare's intention in applying the two-midnight rule to MA plans was to make sure those patients are treated the same as those covered under traditional Medicare, not in accordance with insurers' own rules, which he said are not transparent.

"The physician should be the arbiter here, not some black box," Kahn said.

END