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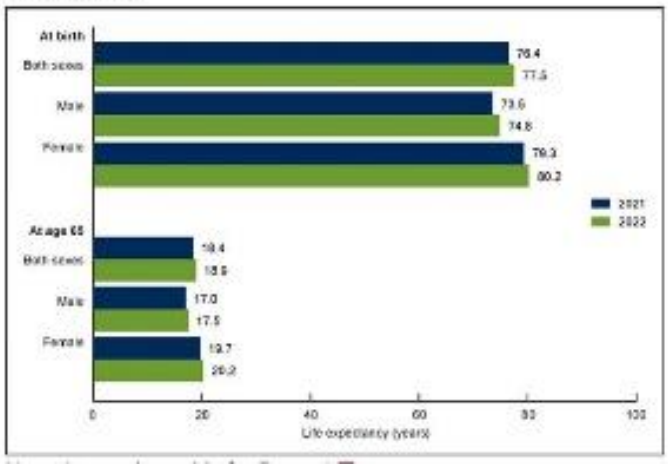
HEALING AMERICAN HEALTHCARE COALITION

From the Editor: The Change Healthcare cyberattack continues to impede cash flow for thousands of providers. Other updates include US life expectancy, the cost of claims denials and Medicare's coverage of Wegovy. Click on each headline to read the full article. During this March Madness offer, **TMR** subscriptions will be only $12.00/yr.; just $1.00 a month for crucial current health policy updates. You can subscribe here.

CDC: US life expectancy rises after 2-year dip, by Chelsea Cirruzzo, Politico, 3/21/24

TMR Topline – The CDC reports that US life expectancy increased for the first time in two years. Those born in 2022 can expect to live 77.5 years, up from 76.4 in 2021.

Figure 1. Life expectancy at birth and age 65, by sex: United States, 2021 and 2022



Life expectancy had dropped in 2020 and 2021, driven by Covid-19 deaths and drug overdoses, and remains below the pre-pandemic 78.8 years in 2019. While overdose deaths nearly quadrupled over the past two decades, they leveled out between 2021-22, to a rate of 32.6 deaths/100,000. Drug overdose deaths involving synthetic opioids, like fentanyl, increased 4.1%.

TMR's Take: Among all the OECD countries, life expectancy at birth averaged 80.3 years in 2021, led by Japan (84.5), Switzerland (83.9) and Korea (83.6).

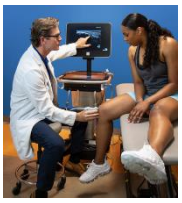
CHANGE HEALTHCARE

UnitedHealth unit will start processing $14 billion medical claims backlog after hack, by Leroy Leo, Reuters, 3/22/24

TMR Topline – Change Healthcare said it plans to restore its biggest clearinghouse platforms over the weekend and start processing $14 billion in claims. Health systems have been losing tens of millions of dollars a day from the Change outage.

Provider lawsuits pile up in wake of Change hack, by Andrew Cass, Becker's Hospital Review, 3/21/24

TMR Topline – Providers have begun to file lawsuits over the 2/21 cyberattack that has crippled hospitals, physician practices and pharmacies across the country. A proposed class-action was filed 3/14 by New Albany, Miss.-based Advanced Obstetrics & Gynecology alleging that the practice was cut off from over 100 services provided by Change including benefits verification, claims submission and prior authorization. Another proposed class-action lawsuit alleged that due to the companies' failure to maintain the security of their computer networks, the practice had to take out emergency loans with interest rates of 50% to meet payroll and pay other basic expenses.



How UnitedHealth's CEO personally supported a physician following cyberattack, by Jakob Emerson, Becker's Hospital Review, 3/21/24

TMR Topline – A Florida physician has shared how UnitedHealth Group's CEO, Andrew Witty,

personally stepped in to address cash flow challenges. *"My practice was losing money and was likely going out of business. I used personal money last week to make payroll,"* Chad Frank, DO, wrote on LinkedIn on 3/20. He emailed Witty detailing his practice's desperate situation, was set up the same day with Optum Pay and received an interest-free loan that is to be paid back 45 business days after Change's systems are fully restored. Witty's company has advanced more than $2 billion to providers. Meanwhile, an AHA survey found that 94% of hospitals have felt financial impact from the attack, more than half have reported a *"significant or serious"* impact, and 74% reported a direct effect on patient care.

TMR's Take: Apparently, Andrew Witty was listening during his 3/11 meeting at the White House when the company was urged to provide more emergency financial assistance to providers facing significant financial disruptions from the cyberattack on its subsidiary. The DoJ had sued to stop UnitedHealth Group's acquisition of Change Healthcare in February 2022, but the buyout was completed later that year. Witty received $23.8 million in 2022 compensation, 331 times what his average employee earned. **TMR** will continue to monitor developments.

Claim denials cost hospitals $20 billion a year, report shows, by Alex Kacik, Modern Healthcare, 3/22/24

TMR Topline – Group purchasing organization Premier polled 516 hospitals and found that 15% of claims, on average, were denied at a cost of close to $44 a claim, excluding related clinical labor expenses. Medicare Advantage and Medicaid plans had the highest denial rates. Overall, more than 54% of claims denied by insurers were ultimately overturned, costing an average of $47.77 per Medicare Advantage claim and $43.84 across all private insurance types. An average of 3.2% of denied claims had been pre-approved by insurers. Premier asked regulators to weigh patient experience and access measures more heavily in MA star ratings.

After Appalachian Hospitals Merged Into a Monopoly, Their ERs Slowed to a Crawl, by Brett Kelman and Samanth Liss, KFF Health News, 3/25/24

TMR Topline – Ballad Health, a 20-hospital system in the Tri-Cities region of Tennessee and Virginia, benefits from the largest state-sanctioned hospital monopoly in the US. In the six years since both states waived anti-monopoly laws allowing Ballad to be formed, ER visits for patients sick enough to be hospitalized grew more than three times as long and now far exceed the criteria set by state officials. According to Ballad reports released by the Tennessee Department of Health, the median admitting time for patients in Ballad ERs was nearly 11 hours.

When compared against the latest corresponding federal data from 2019 for 4,000 hospitals, Ballad ranks among the 100 hospitals with the slowest ERs. During the same time period, the Joint Commission collected ER waiting time data from 250 hospitals and found a median ER admitting time of 5 hours and 41 minutes, about five hours faster than what was stated in Ballad's annual report. Ballad Health spokesperson Molly Luton attributed the ER delays to two nationwide crises: a nursing shortage and fewer admissions at nursing homes and similar facilities, which can create a backlog of patients awaiting discharge from the hospital. Luton added that Ballad's median ER time for admitted patients has dropped to about 7½ hours since the company's latest annual report.

Medicare plans can now cover Wegovy for patients at risk of heart disease, by Yuki Noguchi, NPR, 3/22/24

TMR Topline – Medicare now will allow coverage for Wegovy, one of the new blockbuster weight-loss drugs, for enrollees in Part D plans to prevent heart attacks and strokes. In clinical trials, Wegovy was found to reduce risks of cardiovascular events by 20% in higher weight patients. That finding prompted CMS to change its Medicare Part D drug program to cover Wegovy, noting that this applies only for those patients struggling with both weight ***and*** heart disease. Medicare is prohibited from paying for weight-loss treatments. When prescribed solely for weight loss, seniors must pay out of pocket for the drug or use supplemental insurance. In other words, the injections, which can cost well over $1,000 a month, will not be covered for enrollees seeking only to lose weight. The new guidance also applies to state Medicaid plans, which also would be required to cover Wegovy for patients with both higher weight and heart disease risk. CMS may also require prior authorizations to ensure that it is being reimbursed only for the approved use.