**Testimony for the Health, Education, Labor & Pensions Subcommittee on
Primary Health & Retirement Security**

**At a Hearing Entitled:
Avoiding a Cautionary Tale: Policy Considerations for Artificial Intelligence in Health
Care**

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Statement by Christine J. Huberty, Attorney

Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR)

Dear Mr. Chairman and Members of the Subcommittee:

My name is Christine J. Huberty and I have served as an attorney at the Greater
Wisconsin Agency on Aging Resources (GWAAR) since 2015. The Elder Law and Advocacy
Center at GWAAR provides free legal services to adults over age 60 under Title IIIB of the
Older Americans Act. As an advocate for senior residents of Wisconsin, part of my job is to
provide legal assistance to individuals experiencing healthcare coverage denials. The purpose of
my testimony today is to share how the use of Artificial Intelligence (AI) in healthcare causes
patient harm and administrative burdens.

On May 25, 2023, Jim, age 81, was hospitalized for pneumonia secondary to COVID-19.
Jim had a history of COPD, and was at the time undergoing chemotherapy for B-cell lymphoma.
Prior to getting COVID-19, Jim lived with his spouse, was independent in all activities of daily
living, and did not need supplemental oxygen. Therefore, Jim's doctors recommended that he
transfer from the hospital to a Skilled Nursing Facility (SNF) for short-term rehabilitation. His
doctors and therapists recommended daily skilled therapies for 30 days.

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Jim's insurance provider contracts with a company that used proprietary technology to compare his care needs with millions of other patients. This technology said Jim should only need 14.2-17.8 days at a SNF.[1] Jim received a denial on day 16, with coverage ending two days later, just as the algorithm predicted. Jim went home on day 25 not because he was well enough, but because he was afraid of the mounting out-of-pocket costs. Jim's doctors and therapists did not agree with the algorithm's predicted discharge date, nor did they agree with Jim's own decision to return home so soon. *AI directed Jim's care.*

The subcontractors using the algorithm argue that the predicted length of stay is used as a guide only, and medical reviewers (humans) make all final denial decisions. This may be the case, but if so, these humans ignored things in Jim's medical records such as:

- He was unable to safely swallow by himself, and in fact had a choking episode just days after he was admitted;

- His oxygen saturation remained at unsafe levels;

- He was at risk of falling and lacked the strength and activity tolerance to participate in chemotherapy;

- He could not climb the three stairs required to get into his home;

- He required assistance of at least one if not two people with getting in and out of bed, toileting, bathing, and dressing; and

- The direct words: "Currently not safe to return home with wife."

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[1] naviHealth nH Predict Outcome Tool (attached).

Throughout Jim's medical records, the reasoning for discharge was not because it was medically appropriate, but because his insurance denied coverage based on the algorithm. Jim's family helped him appeal twice, which was ultimately successful. Meaning, the algorithm got it wrong, and a human did not catch the mistake until it was challenged.

Some reports show that only 1% of denials are appealed, with 75% of those overturned.[2] Our agency, which serves Wisconsin only, has seen the number of these denials increase from 1-2 per year to 1-2 *per week,* with a 90% success rate with appeals. In 2023, 30.8 million people were enrolled in Jim's type of insurance nationally.[3] This means that use of an algorithm for this one narrow patient experience is churning out hundreds of thousands of incorrect denials that go largely unchallenged, leaving patients and their families to suffer. When I called Jim's family for permission to share his story, they told me they knew of four other individuals this had happened to in the past two years. None of those cases reached our agency.

If Jim had stayed in the SNF the full length of time his doctors advised, it would have cost him over $3,600 due to the denial. Even more troubling is that Jim's health suffered as a result of his early discharge, and several members of his family needed to take time off from their own jobs to help provide care.

I am only able to share Jim's story because he had family advocating for him. On his own, Jim may have remained in the facility, drained his assets, and been forced to take Medicaid, which then shifts the costs to the state. Insurance providers often cite potential eligibility for Medicaid as a reason for a denial in medical records. It is not unrealistic to imagine that if Jim had returned home on his own when he did, he would have been quickly readmitted to the

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[2] Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018). https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf

[3] KFF, *Medicare Advantage in 2023: Enrollment Update and Key Trends* (Aug. 2023). https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

hospital or died. He certainly would not have been able to navigate the appeals process by himself from his hospital bed.

The effects of the use of the algorithm to guide discharges not only causes patient harm, but also negatively affects the facilities, which must submit near daily updates to the subcontractors regarding the predicted discharge date, and provide hundreds of pages of medical records when a patient appeals. Often, nurses and therapists are called to testify at federal hearings. This is on top of an already understaffed, overworked, and underpaid care system. As a result, many facilities are refusing to take patients whose insurance uses this predictive technology due to the administrative burdens it creates. This means that in rural areas, patients need to travel hundreds of miles for the care they need, only to be met with network restrictions when they get there. Also, if a patient is readmitted to the hospital after being discharged from the SNF too soon, the *facility* is the one penalized.[4]

Meanwhile, neither the insurance provider nor its subcontractors suffer negative consequences. The burden is on the *patient* to prove why the algorithm got it wrong. If the appeal makes it to the federal hearing stage, a judge will order the insurance company pay what it was supposed to pay in the first place, and the practice continues. Insurance companies rely on patients not appealing, or in many of our cases with elderly clients, dying in the process.

It is unrealistic to eliminate AI from the healthcare system. However, this algorithm has been used for years to direct patient care with devastating effects. If the machine itself cannot be dismantled, then patients should have, at a minimum, a clear view of its moving parts. Additionally, when it is obvious that the algorithm got it wrong and issued an incorrect denial,

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[4] JAMA Network, *Skilled Nursing Facility Performance and Readmission Rates Under Value-Based Purchasing* (Feb. 2022). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789442; CMS, *The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program*. https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing

patients need to be compensated, and insurance companies *and* their subcontractors must be penalized.

I want to thank you for the opportunity to speak about this important issue and I welcome any additional questions you may have.