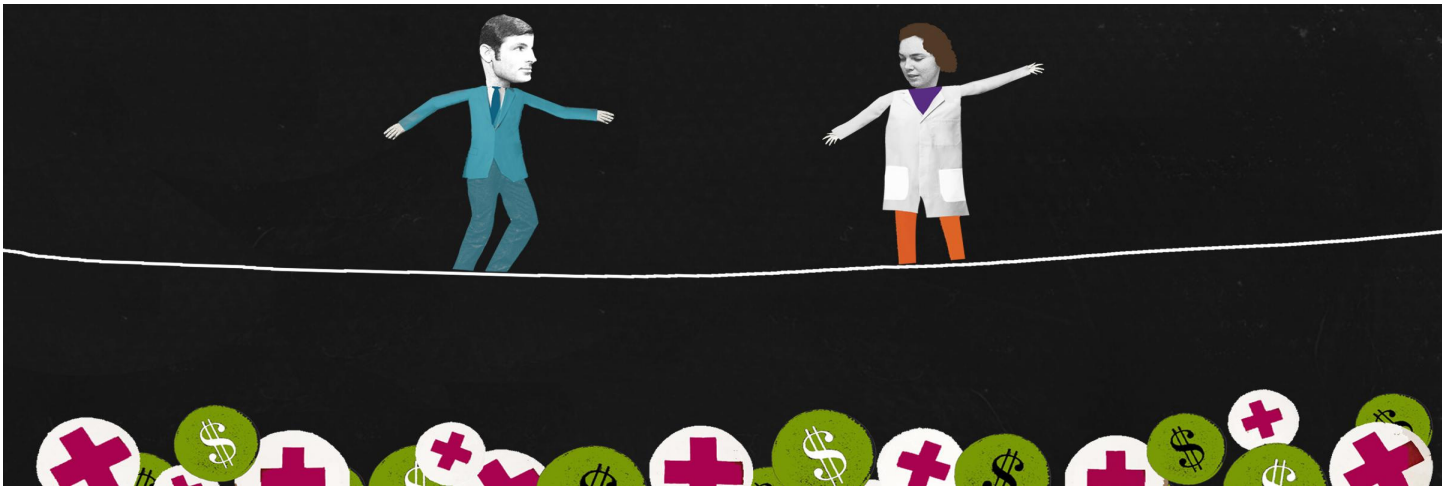

Expert forum: Physicians get real about payers

By Joe Cantlupe | February 27, 2019

Physicians have long had a rocky relationship with insurers, but in recent years goodwill seems to be drying up at a rapid pace. Many physicians have come to see insurers as faceless bureaucrats enthusiastically inundating them with box-ticking clerical work – forcing them to spend time at computers figuring out numerous codes, dealing with an array of insurance-related requirements, or scrambling for treatment authorizations instead of actually practicing medicine.

athenaInsight recently asked physicians what aspect of their relationships with insurers they wished they could change now. Over and over, they spoke of tangling with insurers over pre-existing conditions and financial and regulatory conflicts involving billing, audits, contracts, and reimbursement.

However, hope also rang out in the voices of many doctors who still believe that insurers and providers can work together, often with government regulators, to start resolving some of these longstanding obstacles that delay efforts to help patients and, on the macro level, achieve health care's triple aim. While some areas of conflict may take longer than others, negotiations are a start.

Here are edited excerpts from conversations with physicians on these issues; tweet your responses @ athena_Insight.

On pre-authorization

Dave Chaney, vice president of the Tennessee Medical Association: Payers are placing some prior authorization requirements on providers that unnecessarily add administrative burden without doing anything to improve patient care or reduce costs. We are currently in discussions with one payer in Tennessee, for instance, about medically assisted treatment as a benefit without pre-authorization.

Marilyn Singleton, M.D., an anesthesiologist in Oakland, California and member of the Association of American Physicians and Surgeons: This is a real problem. A

doctor's first contact is with a person who is a secretary of some sort with no medical experience. While the third-party payment system is not ideal for a patient-physician relationship, it is necessary for large expenses. The direct pay practices have helped all physicians learn ways to save money. Perhaps they will begin to trust physicians' judgment. Most physicians are working for their patients' benefit. Most physicians do not do procedures on their patients just to make money.

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Linda Girgis, M.D., a family medicine doctor affiliated with multiple hospitals in New Jersey and editor-in-chief of Physician's Weekly: This is a time-consuming process. Many tests that doctors do are no longer covered without a pre-authorization. We are often left with a patient who has a problem, but we are unable to do anything about it because the insurance company denies services. If I have a patient with low back pain, with some insurance companies I cannot do an MRI unless I do an X-ray first. An X-ray is a totally useless test for diagnosing disc herniations. Yet that is the only way I can get the MRI that the patient actually needs covered.

On pre-existing conditions

Girgis: I have seen what it was like treating patients before the Affordable Care Act. While I'm not a fan of the ACA per se, patients with chronic diseases were greatly harmed by pre-existing clauses. Many were unable to afford any insurance coverage. Providing coverage for only healthy patients services no one except insurance company profits. One thing that came out of the Affordable Care Act is that patients with pre-existing medical conditions cannot be excluded from healthcare coverage. Reimbursements to primary care physicians needs to be improved.

Danielle Ofri, M.D., physician at Bellevue Hospital and NYU School of Medicine, faculty member at NYU School of Medicine, and author of books on the physician-patient relationship: To me, the whole issue of pre-existing conditions voiding insurance coverage is straight-out unethical. The fact that you have been sick with something makes you ineligible to be treated for that sickness? It runs counter to every ethical tenet in medicine. There is hope regarding pre-existing conditions as long as the Affordable Care Act survives. To most doctors, this was a long-overdue ethical acknowledgement that all of our patients – by definition! – have pre-existing conditions.

Singleton: Pre-existing conditions could include children who are born with medical issues that will need lifetime care or short-term care but will haunt them throughout life. If the Affordable Care Act is modified to allow multiple varied insurance products, the insurers themselves could use a transparent authorization process, using tiered rates, or bonus points, for patients being healthy as marketing tools.

On billing

Ofri: I can't say that insurers are to blame for all the fallacies of EMR (electronic medical records). However, I do know that our EMRs were created to address billing, not patient care. As long as there are dozens of insurance companies with dozens of billing schemes and prior authorization requirements, it's going to remain a bureaucratic nightmare for doctors. At least in the paperwork department, the only way to simplify things is to have a single payer plan.

On narrow insured networks

Chaney: A patient may have a procedure covered by the health plan, but if he or she interacts with an anesthesiologist or radiologist, for example, while the patient assumes that is covered by the health plan, a patient is surprised to get bills later that the contract is separate with the hospital and private practice. It frustrates the patients and it frustrates the providers. The provider needs to collect something and has no avenue to do so but to go straight to the patient. The rate then is often higher than the network contract. We think the root cause of the problem is the undue leverage and influence of the health plans. If there were reasonable network terms that would no longer be an issue.

Karen Baird, certified professional coder (CPC), director of insurance affairs, Tennessee Medical Association: Group practices are offered a much [more] reduced rate than an individual. From a business standpoint, I understand that, but some of these contracts on

the group rate are 25 percent or less than individual contracts and that's a huge problem. It's really forcing many of these physicians to join a large group to maintain higher reimbursement, even against their better judgment.

On insurance contracts.

Kevin T. Kavanagh, M.D., retired physician, founder and board chairman of Health Watch USA, a patient advocacy organization: The majority of doctors are facility-employed and the billing negotiations are out of their hands. Private doctors are often paid less by private insurers. Since they cannot charge a facility fee, this results in almost a halving of their payment for outpatient services. That's been a huge driver of physicians going to practice with hospitals.

The overall concept of insurance companies paying different fees for the same service at different locations is one of the huge drivers in the inability of independent physicians to maintain a private practice. The private practice sector is shrinking to less than 50 percent of doctors. Making all insurance contracts with hospitals transparent, so before you buy the policy you know what you will be responsible for, would be of great help. Thus, all should know what the various insurance companies pay hospitals for various procedures. This would create market pressure to drive down prices.

On insurance audits

Chaney: In audits, we are pushing for more transparency between the payer auditors and the providers. Health plans have a responsibility to educate providers on why and how they are being audited to give them opportunities to comply. They should have written audit policies and hold their auditors to a high standard in terms of integrity and consistency. These simple and fair business practices would cut down on provider anxiety and improve payer-provider relations.

Baird: I've been contacted by numerous physicians who say they are concerned about increased payer audits. We're talking about coding, evaluation, and management documentation and they are really scrutinizing these physicians heavily. They are nitpicking for prospective and retrospective audits. Physicians have a responsibility to do the right thing, but the regulations can become overly burdensome. Physicians are being scrutinized for minor infractions. And they are not being told how to fix the issues; it's especially damaging for smaller practices.

Closing thoughts

There are a host of conflicting, long-running issues between physicians and insurers that go to the core of healthcare and must be resolved. A 2018 American Medical Association survey of 1,000 physicians reflects the need for reform: 92 percent of respondents said that prior authorizations have a negative impact on patient clinical outcomes. If insurers want to be credible partners in healthcare reform and the shift toward value-based care, they must first work to regain the trust of physicians.

Joe Cantlupe is a frequent contributor to athenaInsight