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The Valued Voice

Vol. 67, Issue 32 Thursday, August 17, 2023

GUEST COLUMN: Health Insurance Barriers Delay, Disrupt and Deny Patient Care

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Patients and clinicians suffer when insurers disregard medical counsel and impose inefficient administrative policies.

Over the last two years, 62% of the 1,500-plus patients surveyed say treatment has been delayed because of their insurance provider, according to a recent Morning Consult poll.

Health insurance should be a bridge to medical care, not a barrier. Yet too many commercial health insurance policies often delay, disrupt and deny medically necessary care to patients.

We've seen many examples of these actions from across the country highlighted in recent media stories.
For example, a 67-year-old woman who smoked most of her life was frustrated that the MRI she needed to determine her risk of lung cancer kept getting denied because her insurer deemed it unnecessary.
She was later rushed to the ER, where the doctors discovered a massive tumor pressing against her windpipe. The delays caused by prior authorization—getting insurance approval ahead of time for the medical care providers believe a patient needs— "limited her options," her son told Kaiser Health News, and less than six weeks later, she died.


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In another case, a college student in Pennsylvania with ulcerative colitis was flagged by his insurer as a "high dollar account" and denied treatment for the debilitating bowel disease—despite one of the insurer's own contracted doctors concluding that doing so would put him at risk. A lawsuit later uncovered recordings of insurance company employees mocking the patient, according to a ProPublica investigation, and strategizing about ways to justify denying the treatments.

Elsewhere, a newborn baby was denied coverage for care in a neonatal intensive care unit. In explaining the denial, the child's insurer wrote directly to the baby, "You are drinking from a bottle."

These stories are just the tip of the iceberg. Most patients who are denied care are away from the spotlight, so their challenges don't make the headlines. At the American Hospital Association, we hear many of these stories from hospitals and health care providers fighting these battles on behalf of their patients—and it's only getting worse.

Hospitals and health systems are increasingly seeing commercial insurers limit patient access and issue more burdensome requirements for medically necessary care. Beyond prior authorization delays, for example, some insurers are expanding the use of so-called fail first policies, forcing patients to first try their insurer's preferred prescription drug treatment regardless of what a patient's doctors recommend. Others are restricting where patients can get covered care, such as by preventing some individuals from continuing to get their cancer infusion therapies from their long-standing providers and instead forcing them to go to new providers not connected to their care team.

New research conducted by Morning Consult on behalf of the AHA underscores the severity of the situation. Over the last two years, 62% of the 1,500-plus patients surveyed say treatment has been delayed because of their insurance provider, a trend that

caused many of these patients to reportedly become sicker.

While 54% of patients have had difficulty affording their insurance, commercial insurers are earning record-high profits. Perhaps that's because the barriers they put in place delay and deny care for their customers.

These policies don't just limit health care access for patients; they also interfere with doctors, nurses and other clinicians' ability to do their jobs. Prior authorization takes providers away from focusing on lifesaving patient care for potentially hours each day. Physicians and their staff report spending an average of 14 business hours—nearly two days—each week completing prior authorizations, according to a 2022 survey by the American Medical Association. About 95% of hospitals say staff time completing prior authorization requests and logging denial appeals is increasing. Much of this effort is spent challenging flawed insurer analysis, as most denials that are appealed are ultimately overturned. All these factors interfere with clinician time that they want to spend caring for patients and add to the challenges hospitals and health systems already face recruiting and retaining a sufficient workforce.

This is a major reason why over 80% of doctors tell us that insurance policies affect their ability to practice medicine, and more than half of nurses report a serious drop in job satisfaction due to the administrative burdens insurers too often erect. Most tellingly, patients overwhelmingly believe their clinicians should decide their care, not their insurance company.

Hospitals and health systems themselves also are facing increased denials and payment delays from some commercial health insurers. During a time of severe financial challenges for many hospitals, 50% say they have not been paid for claims totaling $100 million or more for more than six months. Meanwhile, an astonishing 7 in 10 hospitals say they are still dealing with outstanding claims from 2016 or before.

All of this exacerbates the intense financial pressures hospitals and health systems are facing. Severely disrupted by the COVID-19 pandemic, inflation and other increases in the costs of staffing and supplies, most hospitals have been operating at a financial loss for more than a year. How can hospitals care for an aging population, invest in newer facilities and technological upgrades (such as those to fight against growing cybersecurity threats) and ensure patients have access to cutting-edge scientific breakthroughs if insurers refuse to reimburse them for the care they provide to patients?

Patients deserve access to the care they need when they need it. Clinicians should be able to focus their time on providing that care instead of going through costly bureaucratic hurdles and spending too much time on unnecessary paperwork. And insurance should be a facilitator—not a detractor—to accessing necessary health care services. It is time to hold the commercial health insurers accountable and put patients first.

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