

Commercial Health Plans' Policies Compromise Patient Safety and Raise Costs



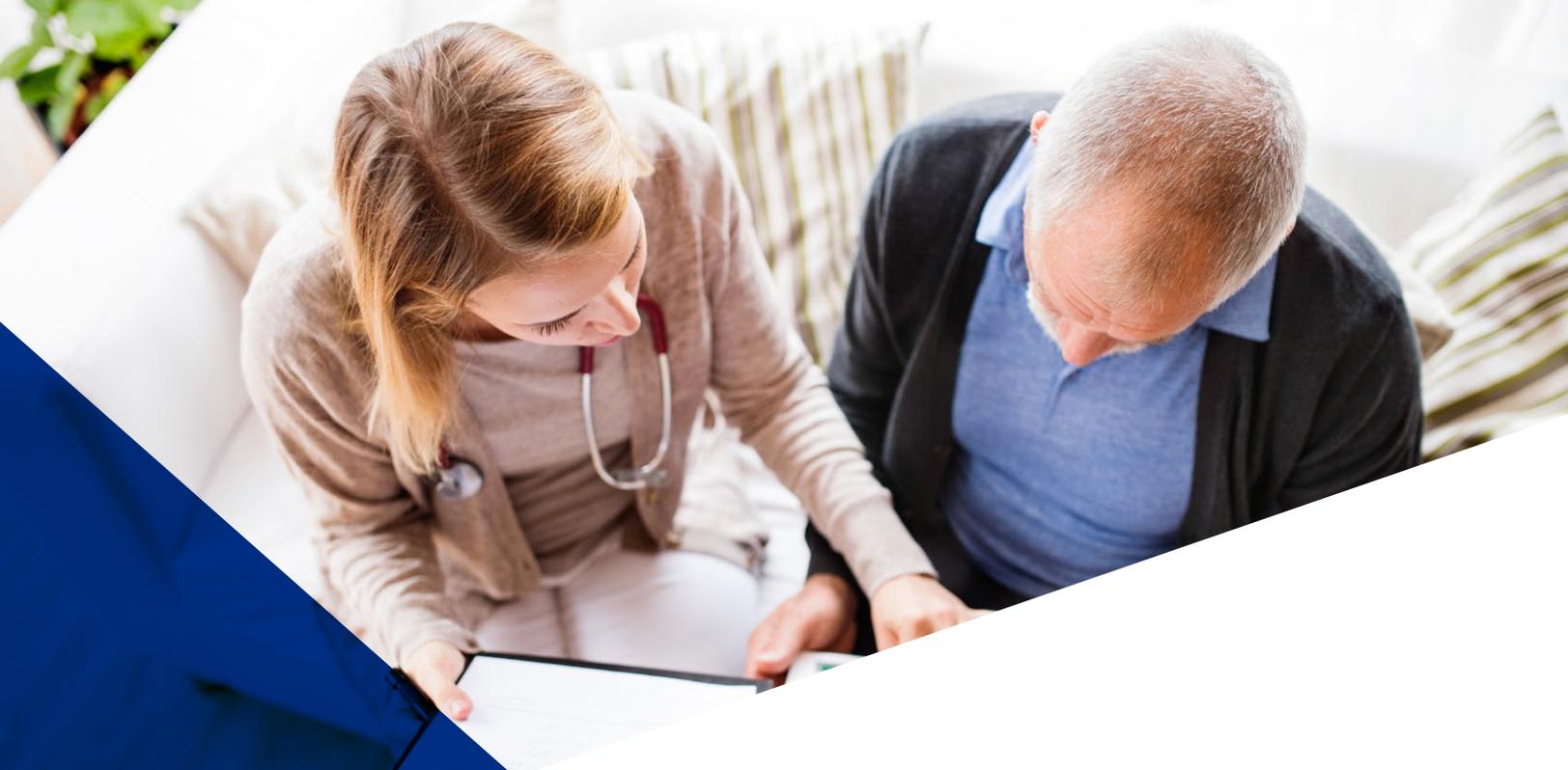


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Private commercial health insurance coverage has long served as the central pillar of our national health insurance system. Not only are commercial health insurance plans the dominant source of health coverage for most Americans and employers but Medicare and Medicaid programs often rely on private health insurance plans to administer their health benefits.



The cost of commercial insurance is increasing at an unsustainable rate — squeezing individuals and families, employers, and public programs. The average family insurance premium has increased 47% over the past 11 years — faster than general inflation and more than any other part of the health care system.ⁱ This contrasts with hospital prices, which have grown an average of 2.1% per year over the last decade, about half the average annual increase in health insurance premiums. And, more recently, hospital prices have grown much more slowly than the overall rate of inflation.ⁱⁱ

Key Takeaways



Many health plans apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and significantly drive up administrative costs for the health care system.



Insurers often force patients to suffer through periods of ineffective treatment before permitting access to the most appropriate therapy. Use of step therapy or fail-first policies is increasing, and its inappropriate application often results in short-term savings for insurers while increasing provider administrative burden and adding downstream costs due to patient delays and complications.



Insurers frequently establish flawed or overly stringent medical necessity policies that prevent patients from obtaining the necessary care recommended by their physician.



Many commercial insurers leverage their market power and position to steer providers to purchase their auxiliary products that drive up administrative costs and line insurers' pockets.



White bagging is an insurer practice that effectively bans a provider from using their own medication inventory to supply drugs used to treat patients in their facility and prohibits providers from having oversight of the procurement, storage and handling processes, which has important implications for safety and efficacy.



Many insurers use electronic payment methods that require providers to pay money to receive their contractual reimbursements from commercial insurers. The insurers often receive incentives from credit card companies or payment vendors for issuing these payments. Providers should not have to pay to get paid.

Need for Action

Some commercial health insurers have implemented policies that add billions of dollars in added unnecessary administrative costs to the health care system while compromising patient care. Commercial health plan abuses must be addressed to protect patients' health and ensure that medical professionals, not the insurance industry, are making the key decisions in patient care.

Commercial Insurer Policies That Hurt Patients, Increase Costs

Several under-examined features of commercial health insurance contribute to unsustainable cost growth — many of which are unnecessary at best and harmful to patient health and workforce wellbeing at worst. **Insurers' use of policies that deny or delay medically necessary care — often applauded by insurers as ways to control cost — have become extraordinarily burdensome on hospitals, providers and patients.**

Massive administrative costs are due in large part to the complex payment and reporting requirements of various commercial health insurers.ⁱⁱⁱ More frequently they include excessive and unjustified application of utilization management tools and prior authorization requirements. These practices add costs by slowing down the provision of care, requiring providers to purchase additional information technology tools, and requiring them to hire additional staff to manage the requirements.

Ironically, many commercial health insurers point to these processes and requirements as part of their efforts to manage health care spending. What is often ignored are the complicated business and financial relationships between many health insurers and intermediary service providers.

For example, the three largest pharmacy benefit managers (PBMs) are owned by commercial health insurers. The administrative services-heavy data and analytics company Optum **drives more revenue for UnitedHealth Group than its commercial health insurance arm**, UnitedHealthcare (UHC), despite UHC being the largest commercial health insurer in the country. These complex relationships create potential conflicts of interest. Specifically, the insurer may put in place an administrative requirement on providers that drives the provider's need to procure the intermediary's tool or service.

As the nation works to improve the affordability of the U.S. health care system, holding health plans accountable will help to reduce unnecessary spending on administrative processes and services while simultaneously improving patient access to care and reducing undue burden on our health care workforce.

1. First, we recommend identifying and measuring unnecessary administrative costs because of health plan abuses and excessive requirements. Currently, much of this information is reflected in national datasets as spending on hospitals, health systems and physicians because they are the ones who must absorb the cost of paying staff and acquiring the expensive products needed to comply with these commercial health insurer policies.
2. Second, we must adopt policies to streamline, standardize and reform these burdensome processes to reduce administrative inefficiencies.

This report provides information on the areas with the most opportunity for improvement.

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A 2019 AHA survey of hospitals revealed that one large, **national hospital system spends \$15 million per month on administrative costs** associated with insurer prior authorization changes. The system employs two to three full-time staff just to monitor insurer bulletins for changes to their prior authorization rules.

Delaying Authorizations for Patient Care

Prior authorization is a process whereby a provider, on behalf of a patient, must seek approval from the patient's insurer before delivering a treatment or service. Although initially designed to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, many health plans apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and significantly drive up administrative costs for the health care system.

The prior authorization process is often inefficient, with excessive response times, lack of transparency in coverage criteria and inconsistent submission requirements across insurers. It generally requires the following steps:

According to a 2021 American Medical Association (AMA) survey of more than 1,000 physicians, physicians and their staff reportedly spend about two days per week completing prior authorizations, and **88% of physicians describe the burden associated with prior authorization as high or extremely high.**^{iv} This burden not only adds cost to the system through inefficient staff time and information technology investment to comply with insurer policies, but also contributes to workforce burnout.

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- After assessing a patient, the clinician determines the appropriate course of medical care.
 - The clinician or office staff must then consult the insurer's website to determine whether any part of the proposed care plan requires prior authorization. This is a manual process of staff culling through lists of "provider bulletins," which insurers generally issue monthly. The process is specific to a patient's health plan; some insurers may offer plans that feature different prior authorization rules for the same service.
 - The provider or office staff must collect relevant documentation that they believe establishes the patient's medical need for the service. **However, commercial health insurers often do not publicly share which documentation is required nor the criteria used to determine patient eligibility.** Therefore, the initial document submission is the provider's best guess at what the insurer requires.
 - This information is then submitted according to the insurer's unique submission requirements, which may include using its proprietary online portal, fax machines, or even sending via the U.S. Postal Service.
- The provider must then await a response, which can often take multiple days and result in an inconclusive answer through a request for additional documentation or a call with the insurer's clinical team, often referred to as a "peer-to-peer."
 - If the authorization is approved, the provider generally proceeds with the care regimen.
 - Prior authorization does not ensure that the service will be covered. Once the provider submits the claim for reimbursement, insurers may require providers to undergo a similar process of submitting documentation to determine whether the insurer will cover the care. This process of determining medical necessity is described in additional detail in a following section.

- If the authorization is denied, the provider often initiates an appeal on behalf of the patient, which requires further documentation or peer-to-peer calls.

The National Academies of Medicine identified compliance with such administrative processes as one of the primary contributors to clinician burnout.^v Burnout can lead to a number of negative consequences for individual clinicians and the health care system, including loss of staff. Hospitals and health systems often then must turn to staffing agencies or other costly recruitment methods to fill gaps. In some cases, they may need to delay or cancel care altogether.

With the added administrative burden comes unnecessary patient frustration and suffering. Patients are left in a position of uncertainty as to their prospective care plan, facing unnecessary delays in care while their physician navigates the complex prior authorization process. **According to the 2021 AMA survey, 93% of physicians reported care delays associated with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment.**

Fail-first Policies

Step therapy policies, sometimes referred to as “fail first,” is another insurer practice that adds unnecessary costs to the health care system and undermines patient access to care. Step therapy protocols require patients to try and fail certain treatments — generally less expensive treatments — before the insurer will authorize more costly treatments, even if it is against expert medical opinion.

When prescribing a drug or treatment that is subject to step therapy, providers need to first submit to the insurer documentation that the patient is unable to achieve therapeutic benefit from the insurer’s preferred treatment. Generally, the evidence must come in the form of the patient trying the insurer’s preferred therapy first, even if that does not align with the physician’s recommendation. Such an approach comes with a number of risks, not least of which is delayed start of effective therapies. Furthermore, health plan step therapy protocols vary significantly, and approvals are not transferrable for patients who change insurers. This often requires patients and providers with established treatments to repeat step therapy processes, thus intensifying administrative costs and interrupting ongoing therapies.

The added costs associated with step therapy are not just administrative. A recent study found that more than half of step therapy protocols were more stringent and required more steps than recommended clinical guidelines, often resulting in unnecessary care.^{vi}

A recent Department of Health and Human Services (HHS) Office of Inspector General (OIG) report found that many Medicare Advantage plans inappropriately implemented such requirements for imaging services, including by requiring patients to first obtain X-rays even though the patient’s clinicians and clinical best practices recommended another type of imaging for the patient’s condition.^{vii} In addition to subjecting the patient to unnecessary care (adding unnecessary costs in the process), the delays that occur as a result of patients needing to first try and then fail various care regimens can result in advancing disease acuity and irreversible damage, something also noted by the OIG.

Insurers forcing patients to suffer through periods of ineffective treatment before permitting access to the most appropriate therapy is a critical patient care concern. Use of step therapy by health plans is increasing, and its inappropriate application often results in short-term savings for insurers while increasing provider administrative burden and adding downstream costs due to patient delays and complications.

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Recently, one hospital system cared for a patient with a rheumatic disease who could not continue with his medication regimen because of a change in coverage. **His new insurer required him to fail other therapies before receiving his longstanding drug treatment.** Despite his clinician providing clear evidence that he had been successfully using the particular biologic for the three prior years, the new insurer’s policies forced the patient to try and fail several other treatments before finally granting approval for the original biologic. Unfortunately, the patient’s condition regressed, causing him to unnecessarily experience adverse events with the two failed therapies. Once back on his original course of treatment, it took six months before his condition improved to that experienced before his therapy disruption.

Denying Medically Necessary Care

Claiming an inability to demonstrate medical necessity is the most common rationale commercial health insurers use to deny prior authorization requests and payments. **Insurers frequently establish flawed or overly rigorous medical necessity policies that prevent patients from obtaining the necessary care recommended by their physician.**

These policies, which are often inconsistent with widely accepted clinical guidelines, frequently are not shared with providers that may wish to proactively apply them to care planning. In fact, commercial insurers consider their changes to established clinical guidelines as proprietary and block clinician access to them. Therefore, providers must establish care plans for patients without knowing how or whether the patient's health plan will cover the care. **This intentional lack of transparency creates a significant administrative burden for physicians and troubling obstacles that hamper patient access to needed services.**

The inappropriate and widespread practice of denying necessary medical care was highlighted in two notable reports by the HHS OIG. The first, from 2018, found that, when beneficiaries and providers appealed prior authorization and payment denials, Medicare Advantage plans overturned 75% of their own denials at the first level of appeal.^{viii} The high turnover rate demonstrates that the care plan was necessary and appropriate, and highlights that the inappropriate commercial insurer policies serve little purpose other than to delay or limit access to services and payment. The second report, from 2022,

found that 13% of Medicare Advantage care denials should have been covered under Medicare. Additionally, about 18% of legitimate Medicare Advantage claims were denied despite meeting Medicare coverage rules. The OIG specifically found that the cause for many of the inappropriate denials were insurers' unique clinical guidelines.

A hospital reports that recently a patient with a history of breast cancer surgery and partial mastectomy was referred for a follow-up visit with a radiation oncologist. A physician panel determined that the visit was medically necessary and reasonable as there may be cardiac, pulmonary and other complications from breast radiation. **The patient's insurer denied the visit by citing internal clinical criteria but would not indicate the specific criteria that were not met.**

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This dangerous trend is highlighted in a [video](#) from Atrium Health depicting that, in a one-year period, the system experienced a 95% success rate in overturning Medicare Advantage denials. Once again, the success rate of overturned denials illustrates that the denials were inappropriate in the first place.

Appeals processes can be arduous and vary by plan. As a result, they delay patient care and require significant provider resources to conduct. In particular, inappropriate denials and inefficient appeals processes require providers to hire additional staff to manage the administrative tasks thus adding excess costs to the health care system.

Insurer Business Conflicts of Interest

Many commercial insurers leverage their market power and position to steer providers to purchase their auxiliary products. This practice drives up administrative costs for providers and lines insurer pockets, often with negative implications for patient coverage.

One example is UnitedHealthcare (UHC) — part of UnitedHealth Group — a \$223 billion health insurance company with over 45 million covered lives. UHC imposes rules and policies on providers based on its Optum tools and services. Optum, owned by UnitedHealth Group, markets services to providers who feel compelled to purchase them in order to get paid by UHC. Take, for example, coverage of emergency services. UHC determines in part whether and how it will pay for emergency services based on the algorithm used in Optum’s proprietary Emergency Department Claim Analyzer tool. Optum then sells this tool to providers, which are under substantial financial incentive to purchase it for fear that not doing so will result in excessive denials for emergency claims.

When the insurer that sets the coverage rules is aligned or owned by the company that sells products providers need to comply with the coverage rules, a substantial conflict of interest exists. Furthermore, these products are often designed to benefit the insurer by resulting in even more claims denials, such as by reducing reimbursement for emergency services claims as noted above.

These types of conflicts are typified by UnitedHealth Group’s planned acquisition of Change Healthcare, which manages the InterQual clinical standards that UHC health plans use to decide prior authorization and coverage decisions. This potential relationship raises serious concerns about conflicts of interest given the ability of one part of the company — Optum — to insert undue influence on the clinical standards to financially benefit another part of the company — UHC.

Furthermore, it exploits UnitedHealth Group’s market power by forcing hospitals and other providers to purchase expensive technology licenses just to try and understand the health plan’s rules for approval or denials of medically necessary care. **Providers should have free and open access to the rules that insurers will apply when adjudicating coverage determinations.**

UnitedHealth Group is not alone in this strategy. As discussed in the next section, this disturbing trend of entangled financial and business interests at the expense of patients and providers is growing rapidly, especially in the area of specialty pharmacy. Indeed, the three largest pharmacy benefit managers (PBMs) are all owned by insurers or their parent companies.

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Recently, one health system reported that its annual InterQual license — owned by Change Healthcare who serves the majority of U.S. health plans — cost over \$800,000 for 2020. Put another way, **the system had to spend over \$800,000 to obtain access to information on how the payer may decide its prior authorization and payment requests.**

Pharmaceutical White Bagging Compromises Safety

White bagging is an insurer practice that requires in-network facilities and providers to obtain and administer specialty drugs from an insurer-affiliated specialty pharmacy. **The practice effectively bans a provider from using their own medication inventory to supply drugs used to treat patients in their facility and prohibits them from having oversight of the procurement, storage and handling processes, which have important implications for safety and efficacy.**

An oncology patient was scheduled to receive a chemotherapy drug infusion, but their health plan practiced white bagging.

The hospital staff tried for two weeks to receive approval from the health plan for the needed chemotherapy drug. The health plan, using white bagging policies, required the drug to be sent by overnight freight from their owned specialty pharmacy, even though the drug was readily available through the hospital pharmacy. The drug was left in the truck overnight, rendering it unusable. The service had to be cancelled and subsequently delayed several additional weeks following further problems in obtaining the drug from the third party specialty pharmacy.

Concerned for the patient's health, the hospital team continued to pressure the health plan to approve use of the hospital's stock to prevent harm to the patient. The health plan finally approved one dose from the hospital stock, but no more.

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White bagging typically applies to infused or injected medications that require a clinician to administer in a hospital or clinic setting for medication management and safe patient monitoring. In cases of white bagging, the insurer requires a third-party pharmacy to dispense the drug and ship it to a hospital or physician office on a one-off basis for administration. **White bagging compromises patient safety and adds significant complexity to the health care system and tremendous administrative burden to providers who are trying to manage these policies on behalf of their patients.**

Specific safety issues and administrative burdens that result from white bagging mandates include:

- Circumventing established safety systems designed to ensure safe ordering and management of patient medications in a health care facility;
- Causing delays in time-sensitive patient care when medications are not delivered or are shipped late by the external pharmacy, or if changes in a patient's treatment plan or dosing requires more medication than was provided by the third-party pharmacy;
- Inhibiting health care providers from validating that specialty medications, which often have specific temperature and handling requirements, were managed appropriately throughout the supply chain and delivery processes and are safe to administer to patients; and

- Creating opportunities for error by requiring hospitals to develop and maintain a separate inventory of drugs for individual patients subject to white bagging policies.

Additionally, white bagging transfers costs from insurers to hospitals and health systems.

This occurs when hospitals prioritize the quality and safety of patient care and proceed with using their own drug supply in instances when the third party vendor is delayed or their supply is unsafe to use.

In these cases, the insurer typically denies the claim, and the hospital receives no payment as a result. This results in significant lost revenue for hospitals, who must either receive no payment for the procedure or expend significant resources attempting to recoup payment from health plans.

The prevalence of insurer white bagging mandates is forcing hospitals and health systems to navigate substantial supply chain and logistical challenges to continue providing safe and effective care to their patients. These challenges have been exacerbated by recent global supply chain disruptions across industries, including health care.^{ix}

Each of the steps required to accept white bagged medications - or to push back on insurer-mandated white bagging-adds cost to the system. These include additional labor expenses to manage increased workload associated with drug supply chain coordination; extensive staff time and resources dedicated to negotiating patient-specific waivers or amendments where insurer policies put patients at risk; and discarded drugs in cases where the dosing or treatment plan changes and the medication cannot be re-dispensed. White bagging penalizes hospitals for prioritizing the safety of their patients and adds significant cost and unnecessary complexity to the health care system.

Transaction Fees

Many insurers utilize electronic payment methods that charge providers transaction fees to receive payments. Often, health insurers pay providers using virtual credit cards (VCCs). Insurers may receive “cash back rewards” for the revenue generated by VCC fees, which amount to the insurer receiving a kickback from credit card companies while leaving providers with a 2-5% credit card fee to process a claim payment. Similarly, when insurers pay providers electronically through standardized electronic fund transfer transactions, many insurers (or their vendors) charge providers up to 2% of the total to receive payment, a process that is offered free of charge by government payers.

By passing these costs onto providers, insurers can reduce their administrative expenses and increase their profit opportunity. Specifically, by forcing providers to pay for the electronic transaction out of their reimbursement, the insurer gets to pass the cost onto the provider, which is then reflected as part of the medical spending for purposes of the medical loss ratio requirements. In that way, insurers avoid counting these administrative costs toward the 15%-20% of premium available for administrative expenses and profit.

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Following a health insurer’s sudden switch to virtual credit card payments, **one large radiology practice in North Carolina indicated that they were charged almost \$10,000 in credit card fees over a 4.5-month period.**



Need for Reform



Some commercial health insurers have implemented policies that add billions of dollars in unnecessary administrative costs to the health care system while compromising patient care. The need for reform is now.

- Commercial health plan abuses must be addressed to protect patients' health and ensure that medical professionals, not the insurance industry, are making the key decisions in patient care.
- The health care system should take action to eliminate, streamline or standardize a number of these commercial health insurer administrative practices. Doing so would reduce unnecessary and low-value services, improve patient care and outcomes, and reduce health system costs.

The AHA will continue to do its part by working to hold commercial health insurers accountable while advancing a responsible regulatory and legislative agenda in these areas.

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