MESSAGE FROM AMERICA'S HOSPITALS & HEALTH SYSTEMS

Commercial Insurer Policies That Can Compromise Patient Safety and Raise Costs Must End

Hospitals and health systems recognize the importance of commercial health insurance, which millions of Americans rely on to receive coverage. Unfortunately, some commercial insurer policies may hurt patients, contribute to clinician burnout and drive up the cost of care. Here are four examples:

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#1: Delaying Authorizations for Patient Care

Doctors often have to get permission from insurance companies before delivering a treatment or service to a patient. This process can be time- and labor-intensive, and delays can lead to the patient's condition worsening. A government watchdog recently uncovered examples of patient harm from such practices, such as elderly Medicare beneficiaries who waited needlessly in hospital beds for their Medicare Advantage plan to approve their rehab or home health care. Prior authorization used to be applied only to new, costly or high-risk services. Now, many insurers require authorizations for even routine care like insulin for diabetic patients. If the scale and scope weren't bad enough, many of these requests are wrongfully denied only to be later overturned after arduous appeals processes.

#2: Forcing Patients to First Try Potentially Ineffective Treatments and Therapies

Under step therapy, or "fail first" policies, patients have to first try the commercial insurance company's preferred treatments and therapies, even when they are not recommended by the patient's doctor. Only when the insurer's preferred treatment is shown not to work will the doctor's recommendation be approved for coverage. These policies lead to unnecessary and wasteful utilization of tests and prescription drugs, and can directly harm patients by delaying the start of effective therapy.

#3: Denying Coverage of Medically Necessary Care

Commercial insurers increasingly deny coverage for care by claiming that it is not medically necessary. In other words, the insurer questions the doctor's judgement – and, repeatedly, the insurer gets it wrong. These practices lead to foregone or delayed care, as well as unnecessary stress and financial burden for patients. Providers also spend significant time and effort appealing these decisions – time they should be spending at the bedside. Recently, a government watchdog found that 18% of denials by Medicare Advantage plans should have been covered.

#4: Placing Limits on Where Patients Can Access Care

Some commercial insurers limit where patients can get care even when this practice disrupts a patient's access to their longstanding, in-network providers. This is increasingly happening for certain surgeries, diagnostics and specialty pharmacy medications administered by clinicians. The insurer requires the patient to go to another provider, often without appropriate quality and safety controls in place. The insurer may benefit financially from referring patients to the new provider, such as specialty pharmacies and ambulatory surgical centers that the insurer owns or is affiliated with.

<u>Here's the bottom line:</u> Patients deserve access to the care they need *when* they need it. Clinicians should be able to focus their time on providing care instead of going through costly bureaucratic hurdles. Hospitals and health systems will continue to fight to change commercial insurer policies that harm patients, burden our workforce and add unnecessary costs to the system.

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