

Guest Column: Will health insurers keep promises to cut patient denials?

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The nation's top health insurers — UnitedHealthcare, Cigna and Aetna — announced recently that they would cut their use of prior authorizations for treatment.

It would be great news, if true.

They constantly strong-arm us, our staff and our patients. We devote hours — hours that should be spent with patients — appealing their refusal to pay for treatments or services they deem “experimental.”

So, it's a tough sell when insurance companies suddenly decide to make our lives easier. Especially when the announcement happened so soon after an investigative publication revealed that Cigna saved millions by rejecting patient claims without reading them.

The largest insurers need congressional oversight after repeatedly betraying our trust.

The consequences are affecting our health. When was the last time you saw a doctor instead of a physician's assistant?

The Association of American Medical Colleges projects a shortfall of up to 124,000 physicians — including specialists — by 2034. The average wait time to see one is 26 days, up from 24 days in 2017.

Commercial payors accelerate physician burnout and subsequent early retirement through secret negotiation tactics, unsustainable reimbursement models and ever-changing authorization rules.

Patients don't often know that most commercial payors require surgeons to sign contracts with strict gag clauses. The clauses prohibit your doctor from discussing their reimbursement rates with anyone other than the insurance company.

They keep patients and government watchdogs in the dark about reimbursements for office visits and procedures. Why the secrecy? The insurance company does not want the average citizen to know how much they make off the transaction between you and your doctor.

Commercial insurance doubled its profits from \$103 billion in 2012 to \$191 billion in 2021. Americans faced 200 percent increases in out-of-pocket expenses while UnitedHealth, for example, reported \$24 billion in profits. No insurer has ever made that kind of money in history.

The healthcare syndicate fixes physician reimbursement by tying it to ever-dropping, unsustainable Medicare rates. This reimbursement represents less than 10 percent of the total cost for the procedure, many times even less.

Doctors risk making payroll, filing for bankruptcy or, worse, refusing the low fees and terms of the contract. They can't refuse the terms because their competitor may continue accepting the low rates and cover their loss by taking patients from physicians who opt out.

Therefore, both doctors sign on for another year of rate cuts.

Commercial insurers and the federal government put doctors in an impossible situation. They don't consider that the falling payment rate means physicians spend less time with patients and cannot hire more staff to deliver better service. Reduced wages with long hours and high liability risk also dissuade young people from entering medicine.

Meanwhile, medical practice costs increased 39 percent from 2001 to 2021 for surgeons while payments from health insurers shrank 20 percent.

Doctors want to deliver top-quality service to their patients without bankrupting their practices. How can elected officials fix the problem?

Democratize health insurance. Allow employers to provide patients with pre-tax health dollars and permit employees to choose the insurer that offers the most value to them. Requiring the insurance syndicate to compete for individual employees will increase value, decrease costs and provide patients with better service and more benefits.

Pay for value. Does your commercial payor provide any value to you? Or are they responsible for absurd co-pays, deductibles and extreme medication mark-ups? Insurers praise surgeons for cutting costs while maintaining a high level of care, yet they keep the savings. If the patient or provider reduces costs, the savings should be split by the parties who produced it, not the insurer.

Last, reset the Medicare physician fee schedule and allow doctors the same inflation adjustment that hospitals and laboratories enjoyed over the last 20 years. Or, expect doctors to significantly reduce access in 2023.

Congress can bust the cartel by exposing its anti-competitive practices, protecting whistleblowers from financial retribution and banning gag orders on phony negotiations.

Americans must hold Congress accountable for fixing the rigged healthcare market with mandatory transparency, portable health insurance and fair provider reimbursement.

We'll believe the insurers when they act. Not when they make promises.

ABOUT THE WRITER

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