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DISCLOSURES

No funding supported the writing of this article. The author has nothing to disclose.

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Insurance Denials of Care Amount to Unlicensed Medical Practice

William E. Bennett, MD, MS

Bennett's Viewpoint

As a specialist who often orders expensive medications, I find a significant portion of my week is spent addressing denials from insurance companies. Our team has extensive experience caring for complex, severely ill patients. We make recommendations after careful

consideration of the risks and benefits, examining the patient, reviewing the chart in detail, and meeting with the family to understand their preferences. Then, our recommendation is countered by some sort of denial—either an outright denial or a request for prior authorization, which usually amounts to a denial with the opportunity to appeal. This practice by payers is directly harmful to patients, and the health care system, because it (a) amounts to an unqualified entity practicing medicine with limited information

about the patient, (b) does not actually contain costs, and (c) is not an effective method to improve care quality.

J Manag Care Spec Pharm. 2020;26(7):822-24

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Insurance Denials Are Unqualified Medical Practice

Most of the denials we deal with in my office—a pediatric gastroenterology practice at a large, tertiary children's hospital—are related to medications and testing for inflammatory bowel disease (IBD). In a typical case, a child has been on multiple medications for months or years and continues to have active disease. Usually, this means switching to a biologic such as a TNF- α inhibitor. Only infliximab and adalimumab are approved by the U.S. Food and Drug Administration for IBD in children, and only recently at that. Any dose escalation or switch to a newer biologic (ustekinumab or certolizumab, for instance) not approved for children results in a denial the majority of the time. While I can often eventually get the medication approved, the patient waits months to receive a treatment with a chance of improving the disease, develops worsening IBD symptoms, misses more school and work, and has higher chances of surgery and risks for mental health disorders.¹ This is particularly difficult in rare disorders or situations without a clear evidence base, which occurs in children at an even higher frequency than in adults, since far fewer high-quality randomized controlled trials exist.

Another example from my own practice is the use of expensive imaging. In IBD, the standard of care for assessment of intestinal disease not amenable to endoscopic assessment is the magnetic resonance enterogram (MRE). This test is superior to an abdominal computed tomography (CT) scan, since it has equivalent sensitivity to detect mucosal inflammation but also does not expose a younger patient to ionizing radiation. Payers will deny MREs but not CTs (cheaper but more radiation), despite guidelines indicating preference for the MRE in younger patients.²

All of this is to point out that denials are clearly a usurpation of my role as the expert clinician with deep, intimate knowledge of the patient. It is patently ridiculous, even to the layperson, to think that an entity that has never met the patient and does not have sufficient training or experience to make a medical decision is more qualified than the patient's doctor.³ It is doubly curious that insurance companies rarely respond with a suggestion for what to do instead, only what we should not do. If the process were really directed at quality and appropriateness, would not there often be denials suggesting a more expensive treatment, if it were more effective or appropriate in that case?

I have reviewed the patient's history in person and confirmed the chain of events that lead to their present state. The payer has not. I have reviewed all the tests ordered, often for their entire life, usually personally viewing radiology tests and pathology results with the radiologist or pathologist. The insurance company has not. I have learned all about the patient's life and how their illness affects it, their fears about modern medicine, their financial situation, and their beliefs, often over the course of many years. The payer has not.

Denials Do Not Contain Costs (and Create More)

In order for denials to actually contain costs, they must prevent unnecessary care. If the denial simply delays necessary care, then it will only drive costs up, as the patient requires more treatment for their disorder. When denials are subject to external review (a federally mandated option), around half of them are overturned.⁴ This phenomenon is even more pronounced in some clinical venues, as in a study of emergency department visits, which found that when 1 payor denied visits as non-emergent, they were still clearly emergencies more than 85% of the time by the prudent layperson standard.⁵

Another problem is the unnecessary cost created by the delays themselves, most of which is born by hospitals and passed on to health care consumers. For instance, American hospitals are denied billions in inpatient claims—about \$260 billion per year—which hospital systems are forced to write off as debt.⁶ In most cases, patients still receive care in some way, but this delay, even if it eventually results in recovery of claims (which happens about half the time and usually months down the road), costs an additional \$118 per claim, above and beyond the provision of care.

High quality invariably results in lower costs,⁷ so ensuring that the highest quality care occurs should be top priority. And, we certainly need efforts to reduce health care costs, but we cannot have these efforts rely solely (or perhaps at all) on those paying for it. In even the best of situations, payers will always err towards denying care to improve their economic position. This is most alarming in for-profit companies, where duties to the stockholders will always trump their duty to pay for timely and effective care to patients. But, we should not be fooled into thinking that public payers such as Medicaid or Medicare behave any differently, albeit in a more attenuated fashion and with oversight by taxpayers.

Denials Are Not the Right Way to Improve Quality

Quality improvement needs to be a multidisciplinary exercise, and to place this at the feet of payers is, of course, ridiculous. Only those embedded in the practice of medicine with deep knowledge of how individual systems work should be involved in determining, tracking, or improving quality. The most successful approaches tend to be systematic, such as those imbedded within electronic medical records.⁸ Little research has focused on how payer behavior improves quality; meanwhile, numerous other firsthand interventions show improved quality and reduced cost: putting pharmacists at the center of medication management, optimizing sepsis recognition algorithms, using business techniques in hospitals to systematize quality improvement, improving accounting practices, active length-of-stay monitoring, and increasing interactions between decision support and accounting to reduce the rate of denials.⁹ While it may be helpful to have payers involved in all of these

processes, the current system simply attempts to react to payer behavior, not build comprehensive systems that include them.

Even if we can prove conclusively that payers are purposefully letting patients languish or die to save money, suing health insurance companies remains difficult. For instance, one component of the Affordable Care Act sets aside billions in public dollars to help offset lawsuit-related losses for payers, which is likely to be reaffirmed by the Supreme Court later this year.¹⁰

Proponents of the current system make the argument that it is all about saving money, and to a degree, that is exactly what happens. Erecting barriers (of any kind) to the receipt of prescription drugs clearly reduces costs, but this must be carefully weighed against the effect that this policy has on clinical outcomes. For instance, Dr. Caroline Forrester, in the previous viewpoint article, makes the argument that managed care reduces inappropriate medication use. This is certainly true in some situations, where a cheaper medication in the same class can be substituted with no change in clinical effectiveness. In many cases, however, it is very difficult to ascertain what appropriate care actually is, and as I have previously mentioned, the person most qualified to make this decision is clearly the patient's physician, not the payer.

Finally, Forrester argues that managed care helps support the use of formularies. This is specious reasoning—formularies were not, and are not, created for patient benefit alone. We make no efforts to limit what qualified physicians prescribe (with the exception of controlled substances), so why then place this limit on the payer? Because, patently, the goal is not to just improve patient care, but to reduce expenditure by any means. Overall, Forrester describes a system that *sounds* like it is doing the right thing, but in actual practice, it simply is not.

In the end, the argument that denials are based on anything other than cost savings does not appear true to anyone who has firsthand experience navigating denials. I do not blame payers for trying to contain costs; obviously, we live in a time of massive overuse and expense in medicine. I also do think that many who participate in this system believe they are working diligently towards improving the efficiency of our complex health care system. But, when the payer is in the position to make these decisions, often unilaterally, their inherent bias to lower cost will always dominate. So, to pretend that this is being done for the benefit of patients clearly rings false. Just ask them.

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DISCLOSURES

No funding supported the writing of this article. The author has nothing to disclose.

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