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Impact of Patient Health Insurance Protocols on the Maryland Physician's Ability to Provide Care

A Survey of the Members MedChi, The Maryland State Medical Society

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Summary

Maryland physicians have been voicing concerns about the intrusion of patient health insurance plan requirements into the patient-physician relationship. Such requirements, intended to contain costs, stipulate how and what physicians can prescribe or order on behalf of their patients. Requirements include obtaining pre-approval for prescription medications, medical tests and procedures; step-therapy and fail-first protocols; and therapeutic switching and generic substitution. (See "Explanation of Terms" at end of document.)

In April 2010, the Maryland State Medical Society (MedChi) issued a survey to measure physician perceptions about patient health insurance plan requirements and protocols. The goals were: (a) to determine whether the concern was universal or isolated to pockets of the physician community; and (b) to understand how patient health plan requirements are impacting patient care, practice management and professional satisfaction.

Method

MedChi used a web-based survey tool to distribute a 15-question survey to its membership base. Questions were designed to measure physician perceptions about four specific areas potentially affected by the requirements of patient health insurance carriers: The ability to provide quality care; physician and staff time necessary to meet requirements; quality of communication between insurance carriers and providers; and impact on physician job satisfaction.

Findings

Physician frustration about the intrusion of patient health insurance requirements on the patient-physician relationship appears to be nearly universal. Almost 95 percent of survey respondents said that insurance carrier requirements that dictate how and what physicians can prescribe or order on behalf of their patients had a "somewhat" or "very negative" effect on physician ability to treat patients. Further, 88.5 percent went on to qualify their interactions with insurance carriers (regarding pre-approvals, step therapy, therapeutic switching and other protocols) as "burdensome," "very burdensome" or as a "major hassle." Finally, in an open-response portion of the survey, several respondents reported that in most cases, insurance carriers ultimately capitulate and agree to move forward

with the physicians' original orders, which calls into question the need for these protocols in the first place.

Especially alarming from the individual patient and public health perspective is that 59.5 percent of respondents said they believe insurance providers "*frequently delay or deny*" prescription medications or diagnostic testing for their patients; another 34.4 percent said care and testing were "*occasionally delayed or denied*." Possibly further contributing to delays in care is the quality of communication between insurance carriers and busy physician practices. For example, 58.3 percent of physicians said they are only "*sometimes*" or "*rarely*" aware of current pre-approval requirements for prescription medications and medical procedures.

Adding to physician frustration is the amount of physician and staff time required to comply with insurance requirements and protocols. Nearly 26 percent of respondents report that they and their staff spend between 21 and 60 hours per month just interacting with insurance carriers to obtain pre-approval on prescription medications and medical procedures and to determine requirements for other protocols such as step therapy. Almost 19 percent reported that they and their staff spend more than 150 hours per month interacting with insurance carriers. In an open-response section of the survey, several respondents reported hiring one or more staff persons just to manage insurance requirements associated with various patient health plans. Additionally, several respondents reported that it is necessary to hire skilled providers "*with extensive clinical knowledge*," such as registered nurses, to manage these tasks due to the complexity of information required.

Just over 70 percent of respondents believe that the hidden costs associated with completing and clarifying patient health insurance requirements have a "*significant to crippling*" impact on their practice. For example, one respondent reported hiring one FTE (full-time equivalent) to "handle pre-authorizations" for a group of seven surgeons, and a .5 FTE to review insurance requirements, update staff and develop procedures to comply with protocols and to appeal errant denials. The cost to the practice: \$75,000 annually.

Finally, nearly 77 percent of respondents said they had seriously considered one or more of the following measures to avoid or minimize administrative tasks associated with patient health insurance requirements: *Moving their practice to another state, retiring early, leaving the profession* or, the most common answer at 57.4 percent: *re-establishing practice as fee-for-service only*. In other words, these physicians would no longer accept insurance as a form of payment.

Conclusion

This survey indicates that insurer practices that interfere with the patient-physician relationship negatively impact the ability of Maryland residents to receive adequate medical care in a timely fashion. Intended to contain costs, practices such as pre-approval requirements, step therapy protocols and therapeutic switching require physicians and patients to complete, and sometimes repeat, one or more additional tasks before a prescription or medical procedure can be provided with coverage.

Inconvenient for everyone, these practices are particularly discriminatory toward individuals with limited resources and to those who, simply put, don't feel well. Each additional requirement can have indirect costs, e.g., transportation and childcare fees associated with multiple trips to doctors' offices and pharmacies, as well as opportunity costs such as missed wages. Those who are ill may be physically unable to undertake the extra steps necessary to obtain the health services ordered by their physicians. This could lead to an increasing number of non-compliant patients and a sicker patient population in Maryland.

In addition, there are other hidden costs associated with this system: physician and staff time necessary to comply with requirements, clarify protocols and appeal denials as well as insurance carrier personnel necessary to enforce requirements. Another way to look at hidden costs is missed opportunities: every hour a skilled provider spends on administrative tasks associated with insurance protocols is an hour not spent on patient care.

Explanation of Terms

Generic substitution occurs when the pharmacist replaces a prescribed medication with a drug that has the same active ingredient and mechanism-of-action but is produced by a different manufacturer.

Prior authorization is an extra step that some insurance companies require before they decide if they want to pay for a prescription medication. The physician, or other medical provider, is required to obtain approval from the insurance carrier before the carrier will agree to cover the cost of the medication.

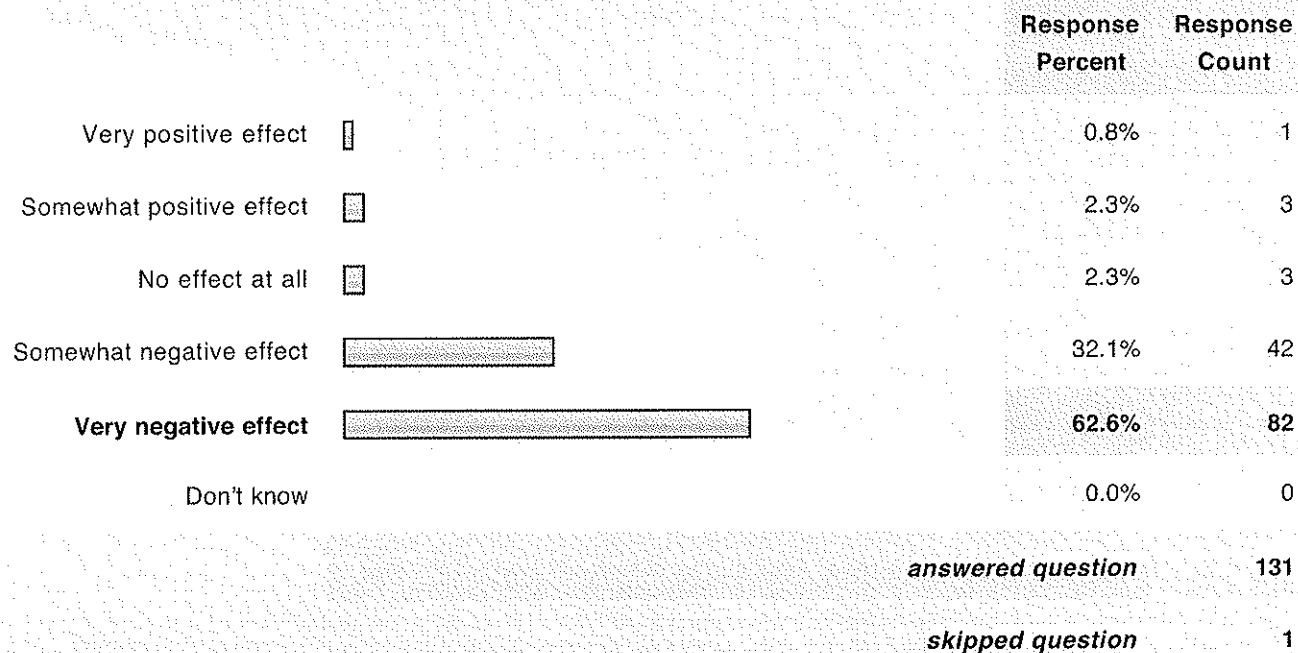
Pre-certification is similar to prior authorization, but applies to medical procedures as opposed to prescription medications.

Step therapy, also referred to as **fail-first**, requires patients to "fail" on a less costly medication before the health insurance carrier will agree to cover a more expensive medication, even if a physician thinks it is a better option for a particular patient.

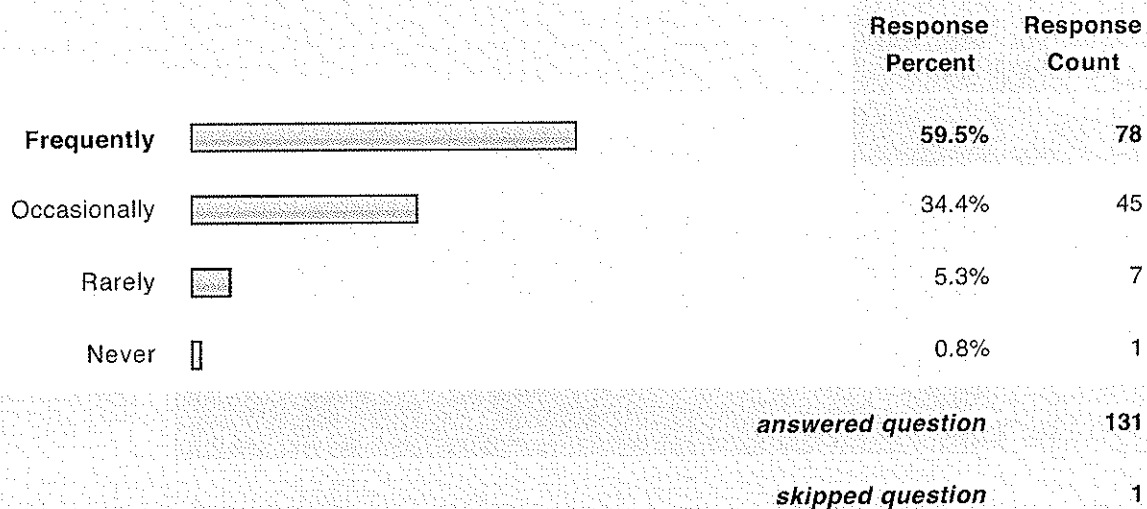
Therapeutic substitution or switching occurs when medicines that have been prescribed for a patient by his or her physician are switched with a less-expensive substitute. Because the substituted drug has different active ingredients and / or mechanisms-of-action, there are two risks: the medication could be less effective than what the physician prescribed and / or there could be negative side effects. Often the switch is made without the prescribing physician's permission, and the patient may or may not be alerted by the pharmacist.

Impact of Health Insurance Protocols on Ability to Provide Care






1. What effect do insurance company requirements such as prior authorization, pre-certification, therapeutic switching and step therapy (also called fail-first) protocols have on your ability to treat patients?






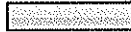


2. In your experience, how often do you feel that insurance companies DELAY or DENY prescription medications or diagnostic testing for your patients?



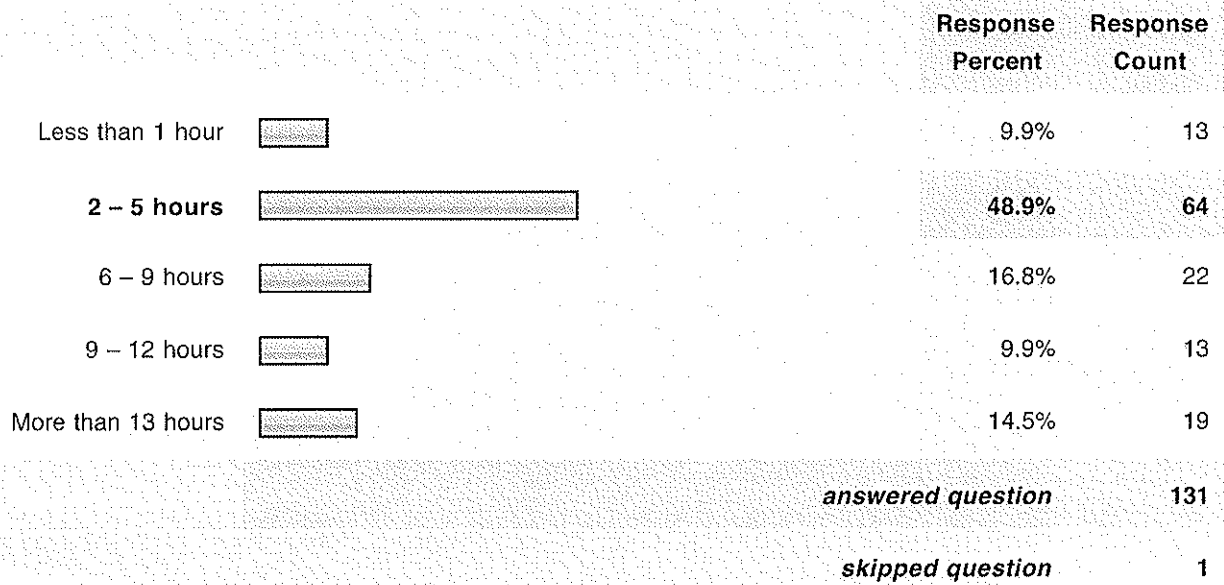
3. When writing a prescription or ordering a procedure, how often are you aware which drugs or procedures will require pre-approval?

	Response Percent	Response Count
Always 	1.5%	2
Often 	35.6%	47
Sometimes 	40.9%	54
Rarely 	17.4%	23
Never 	4.5%	6
<i>answered question</i>		132
<i>skipped question</i>		0

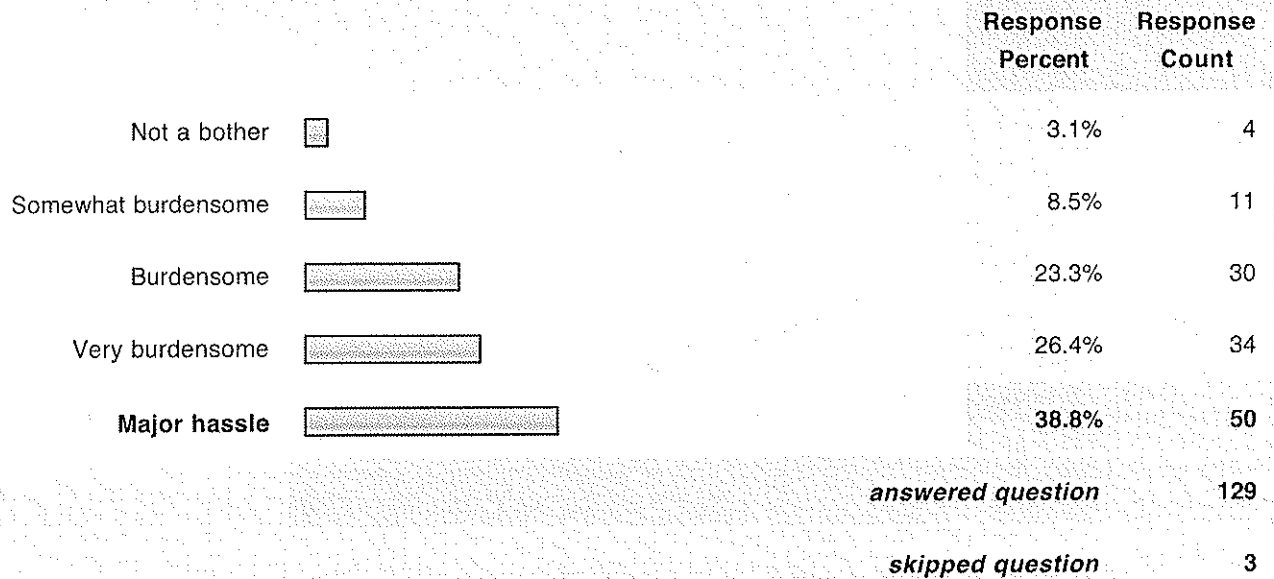
4. Approximately how many times per month are you or your staff required to interact with an insurance provider to obtain approval (of a prescription or procedure) or to determine protocols (such as step therapy or fail-first protocols)?

	Response Percent	Response Count
Less than 5 	6.8%	9
5 – 20 	20.5%	27
21 – 60 	25.8%	34
61 – 100 	19.7%	26
101 – 150 	8.3%	11
More than 150 	18.9%	25
<i>answered question</i>		132
<i>skipped question</i>		0





5. How many total hours per day do you estimate that you and your staff spend completing and clarifying insurance requirements, including paper work and phone calls?








6. Please rate your overall experience with insurance company interactions regarding pre-approvals (for prescriptions or procedures), therapeutic switching, step therapy and other protocols:








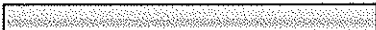

7. Are you ever concerned that insurance protocols such as prior authorization, pre-certification, step-therapy or therapeutic switching negatively impact your ability to provide the best possible patient care?

		Response Percent	Response Count
Frequently		63.8%	83
Occasionally		30.0%	39
Rarely		4.6%	6
Never		1.5%	2
<i>answered question</i>			130
<i>skipped question</i>			2

8. How much do you feel the "hidden" costs associated with completing and clarifying insurance requirements, including paper work and phone calls, impact your practice? (Hidden costs might include business expenses such as extra staff hours required to comply with or clarify various insurance protocols.)

		Response Percent	Response Count
No impact at all		2.3%	3
Mild impact		6.1%	8
Moderate impact		21.2%	28
Significant impact		56.1%	74
Crippling impact		14.4%	19
<i>answered question</i>			132
<i>skipped question</i>			0



9. Have you ever given serious consideration to taking any of the following actions to avoid or minimize the administrative work associated with insurance protocols such as pre-approval, step therapy (fail first), therapeutic switching or other insurance practices? Check all that apply.

		Response Percent	Response Count
No, I have never seriously considered changing my practice in response to my patients' health insurance requirements		23.1%	30
Yes, I have considered moving my practice to another state		16.9%	22
Yes, I have considered changing specialties		4.6%	6
Yes, I have considered leaving the profession all together		21.5%	28
Yes, I have considered retiring early		29.2%	38
Yes, I have considered re-establishing my practice as fee-for-service only (to no longer accept insurance as payment)		57.7%	75
Other (please specify)		16.9%	22
<i>answered question</i>			130
<i>skipped question</i>			2


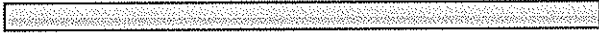


10. Is there anything you'd like to share about your experience with insurance requirements such as pre-approval, therapeutic switching or step-therapy / fail-first protocols?

	Response Count
	70
<i>answered question</i>	70
<i>skipped question</i>	62

11. Would you be willing to share your experiences with insurance protocols such as pre-approval and step therapy / fail first protocols with others, including the media?




		Response Percent	Response Count
Yes		33.6%	37
No		66.4%	73
<i>answered question</i>			110
<i>skipped question</i>			22

12. If you answered YES to the previous question, please provide your full contact information. (All contact information will be kept confidential. It will be used only to follow up as necessary for clarification, and/or if you expressed an interest in sharing your experiences with others, including the media.)







		Response Percent	Response Count
Name:		100.0%	39
Address:		92.3%	36
Tel:		94.9%	37
Email:		94.9%	37
<i>answered question</i>			39
<i>skipped question</i>			93

13. Please indicate the field that best describes your area of practice:

	Response Percent	Response Count
Allergy / Immunology	0.0%	0
Cardiology <input type="checkbox"/>	3.4%	4
Critical care medicine	0.0%	0
Dermatology <input type="checkbox"/>	3.4%	4
Emergency medicine <input type="checkbox"/>	0.9%	1
Endocrinology <input type="checkbox"/>	1.7%	2
Family medicine <input checked="" type="checkbox"/>	18.8%	22
Gastroenterology <input type="checkbox"/>	3.4%	4
General practice <input type="checkbox"/>	1.7%	2
General surgery <input type="checkbox"/>	2.6%	3
Gynecology <input type="checkbox"/>	1.7%	2
Hematology	0.0%	0
Immunology	0.0%	0
Infectious disease	0.0%	0
Internal medicine <input checked="" type="checkbox"/>	15.4%	18
Nephrology	0.0%	0
Neurology <input type="checkbox"/>	4.3%	5
Obstetrics	0.0%	0
Obstetrics, gynecology <input checked="" type="checkbox"/>	6.8%	8
Oncology <input type="checkbox"/>	3.4%	4
Orthopedic surgery <input checked="" type="checkbox"/>	6.0%	7
Orthopedic (foot & ankle)	0.0%	0
Pediatrics <input type="checkbox"/>	4.3%	5
Psychiatry <input type="checkbox"/>	3.4%	4

Pulmonary medicine		2.6%	3
Radiology		0.0%	0
Surgery		14.5%	17
Urology		1.7%	2
Vascular medicine		0.0%	0
<i>answered question</i>			117
<i>skipped question</i>			15

14. Approximately how many prescriptions do you write in a typical month?

		Response Percent	Response Count
Less than 5		2.5%	3
5 – 20		7.5%	9
21 – 60		9.2%	11
61 – 100		20.8%	25
101 – 150		20.0%	24
More than 150		40.0%	48
<i>answered question</i>			120
<i>skipped question</i>			12

15. How many years have you been in practice?

	Response Percent	Response Count
Less than 5 <input type="checkbox"/>	3.3%	4
5 to 10 <input type="checkbox"/>	4.2%	5
10 to 20 <input type="checkbox"/>	32.5%	39
More than 20 <input type="checkbox"/>	60.0%	72
	<i>answered question</i>	120
	<i>skipped question</i>	12