

NOT WHAT THE DOCTOR ORDERED

Barriers to Healthcare Access for Patients

August 2017

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I. INTRODUCTION

For nearly a decade, the central concern of U.S. healthcare policy has been how to increase the number of Americans with meaningful health insurance coverage. Even now, the Congressional Budget Office (CBO) scores various options for overhauling the healthcare system by the number of people who would be covered or lose coverage as a result.

Meanwhile, Americans with health insurance are experiencing a growing crisis over access to the treatments and services their insurance coverage is intended to provide. With the rise of managed care in the 1990's, health insurance providers developed several practices to manage costs that have progressively restricted the treatments and services they will cover.

Insurers began requiring prior authorization before they would pay for certain medications and procedures, and many started denying authorization based on their own determination that a treatment was not medically necessary. Insurance providers started placing pharmaceutical medications into different tiers, with varying levels of



coverage, and issuing lists of drugs they would not cover except in rare, dire circumstances.

Insurers instituted step therapy, only paying for pricier medications once a patient had tried a series of less expensive alternatives and found them to be ineffective. They adopted non-medical switching policies, alerting pharmacists that they would only pay for a less expensive substitute medication in the same therapeutic class, but with an entirely different chemical structure versus the drug prescribed by a patient's doctor.

In adopting these restrictions, insurers found new ways to use their position as payers to influence treatment decisions. While no insurer has the authority to bar a patient from receiving care, they can refuse coverage, which, for most Americans, effectively blocks access to treatment and turns the insurance provider into the final authority on treatment decisions.

Until 2011, there was no comprehensive, national information on the extent of these practices to deny coverage of prescribed treatments. That year, for the first time since managed care became the dominant model of American healthcare, the Government Accountability Office (GAO) made a systematic analysis of the prevalence of application and claims denials by U.S. insurance providers. The GAO reviewed data on claims denials by insurers in California, Connecticut, Florida, Maryland, New York and Ohio—the six states industry experts identified as regularly collecting such data. The GAO's analysis found that the aggregate rate of claim denials varied from 11 to 24 percent across the six states, and also varied significantly among the insurance providers, from 6 to 40 percent.¹

Since 2011, the GAO (and others) have reported on rates of insurance company denials of applications for coverage, but there has been little official research on the rate of coverage denials for patients who have already purchased health insurance.

To help address the lack of research on coverage denials, the Doctor-Patient Rights Project commissioned a survey of insured Americans to understand how many people are being impacted by data on coverage denials for treatments of chronic or persistent illnesses or conditions and the impact this interference may be having on their health.

1 GAO (2011). *Private Health Insurance -- Data on Application and Coverage Denials*, Report to the Secretary of Health and Human Services and the Secretary of Labor, United States Government Accountability Office, GAO-11-268, March 2011. Available at: <http://www.gao.gov/new.items/d11268.pdf>

II. EXECUTIVE SUMMARY

Insurance providers are denying coverage for prescribed treatments.

- Insurance providers denied treatment coverage to one-in-four (24%) patients with a chronic or persistent illness or condition; 41% of the patients denied coverage were denied once, while 59% were denied multiple times.
- 55% of the those denied treatment said they were denied a prescription medication; 41% of those denied treatment said they were denied a diagnostic or screening test; 24% of those denied treatment said they were denied a medical procedure.
- More than half (53%) of those denied coverage for a treatment of a chronic or persistent illness appealed the denial, but less than half (49%) of those appeals were ultimately successful.

Coverage denials impact patients, healthcare providers, and insurance companies.

- The most vulnerable patients were more likely to experience a coverage denial and those patients denied coverage saw their health adversely impacted.
 - More than one-third (34%) of patients whose insurance provider denied treatment for a chronic or persistent illness had to put off or forego the treatment.
 - 43% of patients who were denied treatment for a chronic or persistent illness described themselves as “in poor health.”
 - 70% of the treatments for a chronic or persistent illness denied coverage by insurers were treatments for conditions described as “serious.”
 - Nearly a third (29%) of patients whose insurance providers denied treatment for a chronic or persistent illness reported that their condition worsened.



- Patients trust doctors the most when making treatment decisions and, by a wide majority, want insurers to play a secondary role (or no role at all) in decisions.
- Patients (57%) said they trust their doctors above all others (even themselves) when making treatment decisions; patients (1%) reported that they trust insurance providers as much as they would trust treatment advice from a third-party website.
- The majority of patients identified the treatment experience as the primary factor determining their trust in their doctor.
- A wide majority (88%) of patients said they believe that doctors should be empowered to control the treatment experience, without interference from insurance providers.
- The greatest consensus discovered among the patients polled (91%) agreed that insurance providers should not have the final say in treatment decisions.
- Insurance providers are seen—even by those satisfied with their insurance—as only caring about profits, but patients denied coverage have even worse perceptions.
 - While 36% of patients report that they are very satisfied with their health insurance provider, more than two-thirds (65%) say their perception of their provider has not changed (27%) or has gotten less favorable (38%) over the past 5 years.
 - Nearly nine in ten (87%) patients believe that insurance providers should have a secondary role to doctors (51%), or no role at all (36%), in deciding medical treatments.
 - Almost two-thirds (64%) of patients feel that insurance providers are currently failing their customers, but the number rises to more than four-fifths (85%) among patients who have been denied coverage of a treatment for a chronic or persistent condition.





Methodology

In March 2017, Schoen Consulting (a globally respected research and polling firm) conducted a comprehensive survey of a representative, nationwide sample of 1,500 Americans concerning:

- The role of insurance providers in the healthcare marketplace
- The role of doctors and trust in their judgment when making treatment decisions
- Patients' access to medications, screening and diagnostic tests, and medical procedures
- The impact of insurance providers intruding in treatment decisions, including coverage denials

All respondents either were insured through an employer-sponsored health insurance provider, or had healthcare coverage through Medicare or Medicaid. Any potential respondents who did not have insurance were excluded from the survey.

III. COVERAGE DENIALS FOR CHRONIC OR PERSISTENT ILLNESSES ARE COMMON AND WIDESPREAD

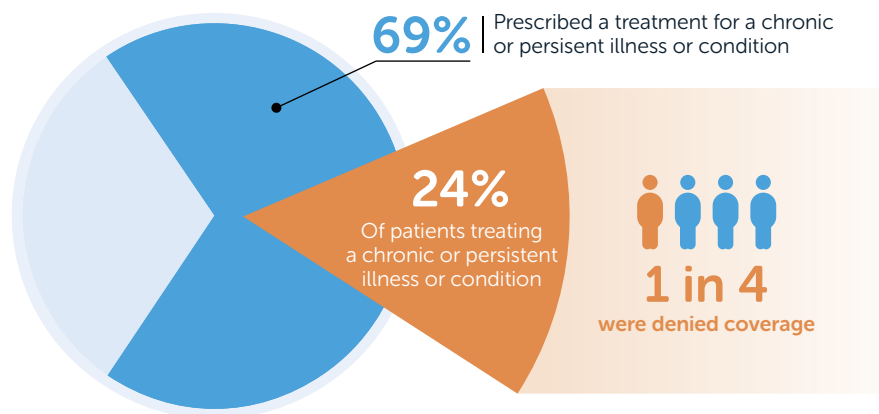
Coverage denials by insurance providers are real.

Health insurance providers have denied coverage for nearly one-quarter of the claims for treatment of a chronic or persistent illness or condition.

Of the 1,500 Americans surveyed, 69% say that they had been prescribed a medication, undergone a diagnostic or screening test, or had undergone a medical procedure to address a chronic or persistent medical illness or condition. 24% of those respondents reported that their health insurance provider denied coverage for the medication, test, or procedure.

Of those denied coverage, 59% were denied multiple times.

Denial of Coverage for Chronic Illness



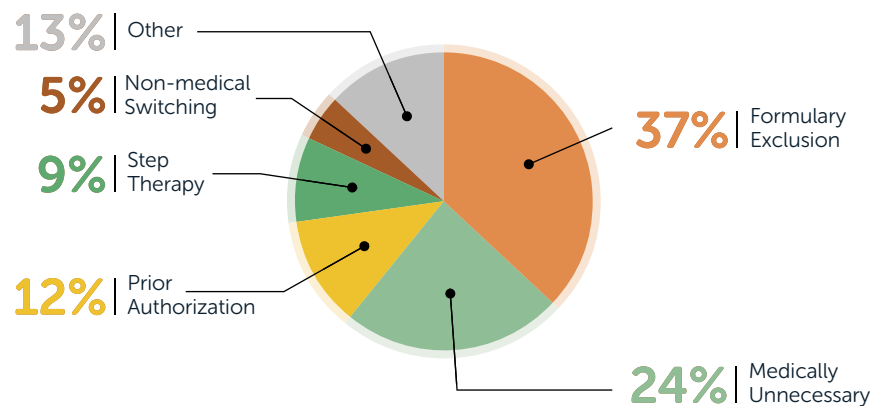
More than half (55%) of denials for treatment of the chronic or persistent illness were for coverage of a prescribed medication; 41% of denials were for a requested diagnostic or screening test; and 24% of denials were for a prescribed medical procedure.

Of the 24% of patients denied coverage for treatment of a chronic or persistent illness, more than half (53%) appealed their insurance provider’s initial denial. Of those who appealed, more than half (51%) were unsuccessful at changing their provider’s decision. Of those who lost their initial appeal, 6% appealed a second time, and 1% responded that they appealed 3 or more times.

Though only 42% of patients aged 18-29 were denied coverage of a prescribed medication, 70% of those aged 65 or older were denied.

Insurers employ many avenues and multiple justifications to deny coverage

Among the patients denied coverage for a prescription medication to address a chronic or persistent illness, 37% reported that their insurer denied coverage because of a **formulary exclusion**; 24% reported that their insurer deemed their treatment “medically unnecessary”; 12% said their insurance provider denied coverage because the prescription lacked **prior authorization**; 9% report that their insurance provider denied coverage because it required **step therapy**; 24% report that their insurance provider denied coverage because the requested prescription was **not medically necessary**; and 5% report that their insurance provider denied coverage because it had adopted a **therapeutic substitution** policy.







Of those patients whose insurance provider denied coverage for a screening or diagnostic test, or for a medical procedure to address a chronic or persistent illness, patients reported most often that the justification for the denial was, “lack of medical necessity.”

Gaining access to prescribed treatments is as challenging to patients as high treatment costs. Almost half (47%) of patients polled said they do not know what they can do if they cannot afford a prescribed treatment. More than half (54%), however, were uncertain what they can do if they are denied access to a treatment because their insurer refused to cover it.

Glossary of Insurer Terms

Health insurance providers have adopted several tactics to limit patient access to potentially life-saving treatments:

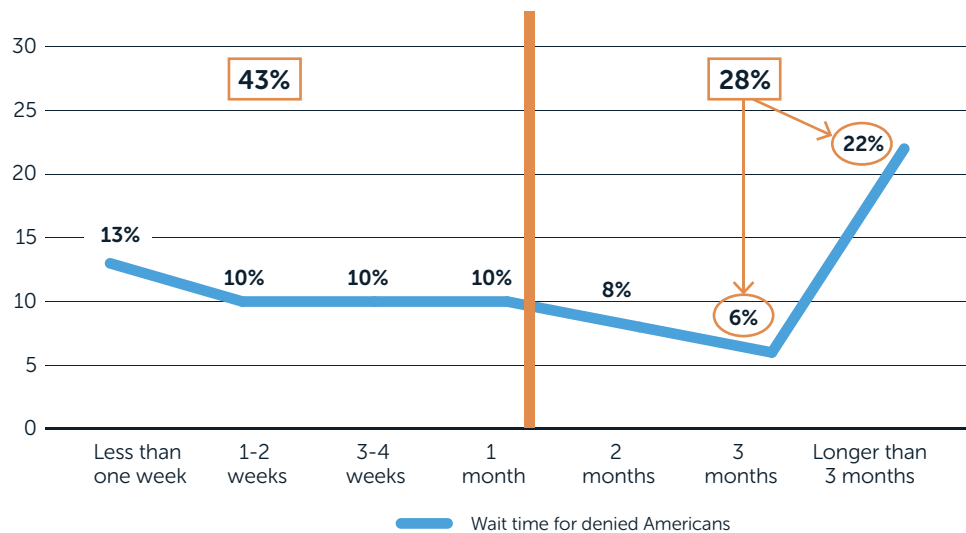
-  **Prior Authorization**
Requiring doctors to obtain the insurer's authorization before agreeing to cover a specific medication or procedure.
-  **Step Therapy (aka "Fail First" policy)**
Only paying for pricier medications once a patientt has tried a series of less expensive, alternative drugs and documented their ineffectiveness.
-  **Non-Medical Switching**
Directing pharmacists to dispense a cheaper drug in the same therapeutic class, but which may have a different chemical structure, instead of the medication the doctor prescribed.
-  **Adverse Tiering**
Placing all or most medications used to treat a particular condition (e.g. HIV/AIDS or hepatitis C) on formulary tiers with higher co-payments or cost-sharing requirements.
-  **Formulary Exclusion**
Adding more treatments to formulary exclusion lists announcing the medications the insurer will not cover.

IV. COVERAGE DENIALS IMPAIR PATIENT HEALTH

The process for approving coverage delays treatment, regardless of whether the treatment is ultimately approved or denied.

Among the patients whose insurance provider denied coverage of a prescribed treatment, the median time it took them to seek approval and be denied was greater than one month. However, 28% reported that their insurance provider's approval process took 3 months or longer.

Length of the Denial Process



Of the patients whose insurance provider delayed treatment while considering their authorization request, 29% report that their condition worsened.

Insurance providers effectively block treatments for more than one-third of patients denied coverage of a treatment for a chronic or persistent illness.

Of the patients whose insurance provider denied coverage of a treatment for a chronic or persistent illness, more than one-third (34%) said they did not undergo the recommended treatment because their insurer would not cover the cost.

A substantial number of blocked treatments were for patients in poor health.

Of the patients that did not undergo a prescribed treatment because their insurance provider would not cover the cost, up to 43% described themselves as being “in poor health.”

The large majority of blocked treatments were for serious conditions.

Of the treatments for chronic or persistent illnesses that patients did not undergo because their insurance provider would not cover the cost, 70% were for conditions characterized as “serious.”



V. COVERAGE DENIALS WEAKEN THE DOCTOR-PATIENT RELATIONSHIP

Patients trust their doctors to control treatment decisions.

When making treatment decisions, most patients trust their doctor's judgment over all others, even their own. 57% of respondents ranked their doctor's judgment as the most trusted when making healthcare decisions, even higher than the 32% of patients who said they trust their own judgment the most.

Trusted Judgment in Making Healthcare Decisions

INDIVIDUAL/ORGANIZATIONS	INSURED AMERICANS
Doctor's judgment	57%
Personal judgment	32%
Family's judgment	6%
Health insurance provider's judgment	1%
Third party websites, like WebMD	1%

Patients identified the treatment experience as the primary factor in determining trust in their doctor.

Half of patients identified the treatment experience as the most important factor in building trust between themselves and their doctor, even more than their personal relationship with the doctor, which 32% of patients identified as the most important factor.

Seven percent of patients reported that the reputation of a doctor's hospital or provider network was the top factor in building trust, followed by the doctor's reputation in the community (6%) and the recommendation of a friend or family member (3%).

Building Trust Between Doctors and Patients

FACTOR	% OF INSURED AMERICANS
Treatment experience with doctor	50%
Personal relationship with doctor	32%
Reputation of doctor's hospital/provider network	7%
Doctor's reputation	6%
Recommendation from a family member or friend	3%

Only 1% of patients reported they trust their insurance provider's judgment in making healthcare decisions. Patients said that they trust their insurance provider's judgment about as much as they trust a third-party website (1%).

Nearly 9 out of 10 patients (87%) believe that insurance providers should not have a primary role in deciding medical treatments.

When making treatment decisions, more than half (51%) of patients believe that insurance providers should play a secondary role to doctors and patients, while nearly 4 out of 10 (36%) believe that payers should have *no role at all* in making healthcare decisions.

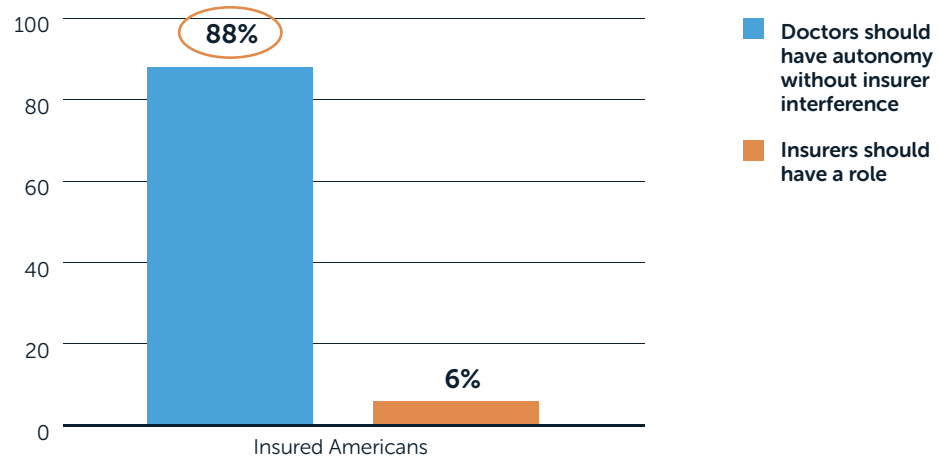
Role of Insurers in Patients Receiving Treatment

ROLE	INSURED AMERICANS
They should have the primary role in this decision	9%
They should have a role that is secondary to myself and/or my doctor	51%
They should have no role in this decision process	36%

Patients overwhelmingly want their doctor to be the primary authority in their treatment decisions and believe insurance providers should play a secondary role or no role at all.

88% of patients believe doctors should have the power to make treatment decisions without interference from insurance providers. Only 9% of patients feel that health insurance providers should have a primary role in the decision-making process.

Doctors' Autonomy in Decision Making, without Interference



Moreover, more than 9 in 10 patients (91%) do not want insurance providers to have the final say in treatment decisions.

Nearly 9 in 10 patients believe that the proper role of health insurance providers is to facilitate healthcare, not to impose treatment decisions. 86% of respondents agreed with the statement: *"Health insurance providers should facilitate healthcare, not impose healthcare decisions on doctors or patients."*

VI. COVERAGE DENIALS ERODE PATIENTS' PERCEPTION OF ALL INSURANCE PROVIDERS

The reputation of insurance providers among patients has stagnated or degraded.

40% of patients surveyed reported they were “somewhat satisfied” with their health insurance provider, while only 36% reported that they were “very satisfied” with their insurance provider.

However, more than two-thirds (65%) of patients said their perception towards their insurance provider had not changed (27%) or had gotten less favorable (38%) over the past 5 years. A majority (52%) felt insurance providers were playing a less constructive role in healthcare than they had previously.

Patients denied coverage for treatments by their insurance provider had a worse perception of health insurance providers generally.

Only 12% of patients thought their insurance provider was very transparent about its process for approving treatments, and only 10% thought their insurance provider was very transparent about its process for denying treatments.

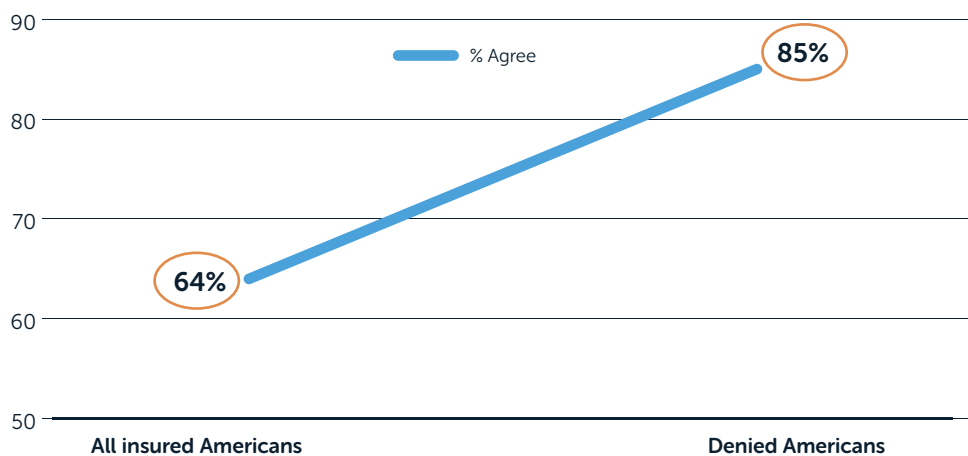
Almost half (46%) of the patients whose insurance provider denied coverage of a prescribed medication for a chronic or persistent illness or condition said they were denied because the provider thought the treatment cost too much. 20% of patients denied coverage for a prescribed medication said they were denied because the medication either was not listed on the provider’s formulary or was listed on the provider’s formulary exclusion list. 17% of patients denied coverage of a prescribed medication said they were denied because their provider did not cover the medication, and 9% of patients denied coverage for a prescribed medication reported simply that they were denied because of “cost.”

A majority of patients felt insurance providers deny coverage of certain treatments because they only care about profits.

A majority (56%) of patients whose insurance providers denied coverage of a prescribed treatment for a chronic or persistent condition indicated that they do not understand the process for appealing the denial. Moreover, a majority (53%) of patients denied coverage said insurance providers intentionally make the appeals process difficult because they want patients to give up and pay for treatments themselves.

Almost two out of every three (64%) patients polled said they thought health insurance providers were failing their patients. However, the number who believed that insurers were failing patients rose to four out of every five (85%) among those patients who had been denied coverage of a treatment by their insurance provider.

Health Insurance Providers are Failing their Customers



The Doctor-Patient Rights Project is a non-profit coalition of doctors, patients, caregivers, companies and advocates fighting to restore the fundamental practice of medicine and to ensure doctors, in partnership with their patients, drive patient care decisions.



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