

PUTTING PROFITS BEFORE PATIENTS:

PROVIDER PERSPECTIVES ON HEALTH INSURANCE BARRIERS THAT HARM PATIENTS

Findings of a National Survey of Primary Care Physicians
Conducted for the Alliance for the Adoption of Innovations
in Medicine (Aimed Alliance)

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INTRODUCTION

Primary care physicians, including general practitioners, family physicians, internists, pediatricians, and geriatricians, collectively represent slightly less than one third of the physician workforce in the United States.¹ Spending the majority of their time delivering direct patient care, these doctors examine and treat people of all ages and with a wide range of medical conditions. Of the nearly 990 million ambulatory care visits that Americans made to physician offices in 2015, 51 percent were to primary care physicians.²

In addition to providing treatment, primary care physicians also routinely confront health insurers' restrictive cost-containment practices, known as benefit utilization management policies (and referred to in this report as "access barriers"). These policies impose undue barriers for patients seeking access to preventive and diagnostic tests, medical services, and treatments prescribed by their doctors.

The Role of Primary Care Physicians

Primary care physicians deliver direct patient care to the majority of American families.

As such, the experiences of primary care physicians offer a real-world view of the heavy toll that insurers place on patients, doctors, and the health system by requiring patients to try potentially ineffective treatments, delaying prescribed treatment regimens, and imposing burdensome paperwork requirements on physicians to control costs. Among the consequences are poorer patient outcomes, avoidable medical costs for emergency room visits and hospitalizations,³ and increased administrative time and costs for physician practices.⁴ Additionally, physicians have reported greater stress, emotional strain, and depression, which can result in increases in medical errors.⁵

METHODOLOGY

Aimed Alliance commissioned focus group research and a comprehensive survey on insurance practices to determine what health care practitioners are witnessing across the country and to document their concerns for the future of patient care. Conducted by David Binder Research, the survey entailed both qualitative and quantitative research.

Laying the foundation for the research, physician assistants, nurse practitioners, and primary care physicians participated in two focus groups, which took place in San Diego, California and Bethesda, Maryland in January 2018. The goal of the focus groups was to guide the development of the national survey questionnaire and determine the composition of the online survey participants.

Based on the insights gained from the focus groups, Aimed Alliance commissioned an online survey between February 25, 2018 and March 2, 2018 of 600 primary care physicians currently practicing family medicine, internal medicine, pediatrics, or obstetrics/gynecology in the United States (“the Survey”).¹ The Survey examined primary care physicians’ attitudes and beliefs on the role that health insurers play in determining patient access to treatments.

Based on the Survey’s findings, Aimed Alliance identified several areas in which current benefit utilization management practices place significant burdens on primary care physicians and patients, and areas in which stakeholders should endeavor to work towards more efficient and effective health care delivery.

i The margin of sampling error is ± 4.0 percent at the 95 percent confidence level.

SETTING THE STAGE: INSIGHTS FROM THE FOCUS GROUP PANELS

Although advances in science and medicine make it possible to treat diseases more effectively and save lives, the reality is that many patients do not gain access to new treatments prescribed by their physicians.

Benefit utilization management policies, including step therapy, prior authorization, and nonmedical switching, can override physicians' treatment decisions and prevent patients from accessing treatment.ⁱⁱ Insured Americans also face high out-of-pocket costs, such as copays and deductibles, which increase the financial burden of health care and can further limit access to care. According to the U.S. Bureau of Labor Statistics, the average U.S. household spent \$4,928 on health care in 2017. Of this amount, 70 percent – or \$3,414 – went toward health insurance-related expenses.⁶

Utilization Management Defined

Utilization management (UM) is the use of techniques that allow health plans to manage health costs. However, when cost cutting is the main goal, UM can lead to overzealous denial of care and unexpected financial risks to patients.

To assess the impact of insurers' benefit utilization management policies on patient care, the first phase of the Aimed Alliance research entailed conducting two focus groups, made up of 33 primary care doctors, physician assistants, and nurse practitioners practicing in Southern California (San Diego) and the Washington, DC area (Bethesda, MD). Participants examined the role that health insurers play in contributing to the costs of health care for patients and provided an assessment of the challenges providers and patients face today.

ii Step therapy is a practice that requires a patient to try and fail on one or a series of less expensive treatments, sometimes with adverse effects, before the insurer will cover a prescribed treatment. Prior authorization is the requirement that a health care provider or plan enrollee obtain advance approval from a health plan before the cost of certain treatments and medications will be covered by the insurer. Nonmedical switching occurs when an insurer forces a patient to switch from his or her current medication to a different (but not generic) medication by either refusing to cover the medication any longer or increasing the medication's out-of-pocket cost.

Major observations are as follows:

1. **Health insurance access barriers are a serious and growing problem affecting patient care.**

Focus group participants said they have seen patients' health deteriorate due to insurers' access barriers, such as step therapy and nonmedical switching, especially when patients are living with chronic medical conditions. Health professionals cited two reasons for this deterioration—having to prescribe older, less effective drugs because insurers would not cover newer medications, and not being able to refer patients to needed specialists.

2. **High copays and deductibles force patients to go without care or to seek treatment at facilities where care is incomplete.**

Providers said that high copays for doctor visits and deductibles cause some patients to forgo care, go to urgent care facilities where there is no coordination of care, or wait until the situation becomes serious and then seek care at a hospital emergency room. However, such actions may be misguided, as urgent care can be costly as well. For example, health plans have begun enacting “avoidable emergency room programs” in which insurers can retroactively restrict or deny coverage if they determine that the patient's condition did not warrant emergency care.⁷

3. **Providers confront health insurer denials and delays on a daily basis.**

Focus group participants cited numerous examples where insurers make it difficult for patients to get prescribed treatments, diagnostic tests, and medical services, or deny coverage outright. Many said these issues are, at minimum, a daily occurrence and not limited to just one aspect of health care. Some physicians said they face insurance-related obstacles multiple times each day.

4. **Restrictive insurance practices, such as prior authorization and step therapy, are harmful to patients and increase the costs for insurers in the long run.**

Health care providers noted that some of their patients suffer unnecessary pain and delayed access to more effective medications as a result of step therapy. Another common complaint was that insurers often delay access to or do not cover appropriate tests, such as MRIs to detect breast cancer. This grievance was consistent with a 2017 American Medical Association survey in which physicians reported that prior authorization requirements delayed access to necessary care and significantly impacted patient clinical outcomes.⁸

5. **Providers want insurers to reduce or eliminate prior authorization requirements and to lower out-of-pocket costs for patients.**

Believing that the costs borne by patients are too high, providers want health insurers to reduce patients' copays and deductibles. Providers reported that high out-of-pocket costs have created financial disincentives for patients to make routine office visits. Providers also say prior authorization undermines clinical decision-making. Therefore, they believe health insurers should be more “patient-centric” and should trust the professional judgement of treating physicians when making coverage decisions.

6. Health insurers' cost-containment policies and low reimbursement rates place a financial burden on primary care physicians.

Physicians said insurers' burdensome administrative requirements are costly and time-consuming, reduce the amount of time they have to spend with patients, and necessitate hiring administrative staff to deal with paperwork responsibilities. Some physicians also noted that insurers often delay making payments to them, leading some clinicians to stop accepting certain types of insurance, such as Health Maintenance Organization (HMO) plans.

Elsewhere, it is reported that due to year-over-year reductions in reimbursement rates, physicians must see more patients per day to maintain income and pay for the significant office overhead, affecting quality of care.⁹ The current payment systems discourage and disincentivize primary care physicians from spending more than 20 minutes with any patient, so physicians frequently triage patients out of the office if patients present with complicated or time-consuming conditions.

7. Physicians generally do not charge patients yearly administrative fees but have considered it.

Some physicians reported being intrigued with the idea of charging patients yearly administrative fees to defray costs associated with managing insurers' administrative burdens, but they ultimately feel that patients are simply unwilling to pay this cost. A small number of physicians noted that they provide concierge medical servicesⁱⁱⁱ rather than accepting insurance and acknowledged requiring annual fees. This reinforces a trend documented in an August 2018 survey reporting that a growing number of primary care physicians are converting to concierge medical practice so they can ensure good patient care.¹⁰

8. Health insurers' access barriers can take an emotional toll on primary care physicians, causing some physicians to consider changing their career plans.

Due to the daily challenges resulting from insurers' cost-containment strategies, many physicians said they are often frustrated, angry, and overwhelmed, and some admitted to taking out their emotions on staff or family members. As a result, some have considered leaving medical practice or retiring early.

9. Physicians want patients to know that they are on the same side as patients and are sometimes powerless to help them.

Some physicians mentioned that some of their patients do not trust them fully. The reason, according to physicians, is the misperception among many patients that doctors and insurance companies conspire to delay or deny their care. Despite believing that patients need more education about insurance coverage, physicians nonetheless reported that patients often have negative reactions when doctors attempt to discuss insurance issues with patients. Moreover, some physicians admitted being frustrated when trying

iii "Concierge" medical practices do not typically take insurance and instead offer personalized medical services to patients by charging a yearly or retainer fee.

to talk to patients about coverage, stating that their patients do not understand their responsibilities under their health plans or insurers' requirements of physicians. In fact, some physicians said some of their patients assert it is the physician's responsibility to call the insurance company to resolve coverage issues, while others believe that their doctors made the decision to deny coverage for their care.

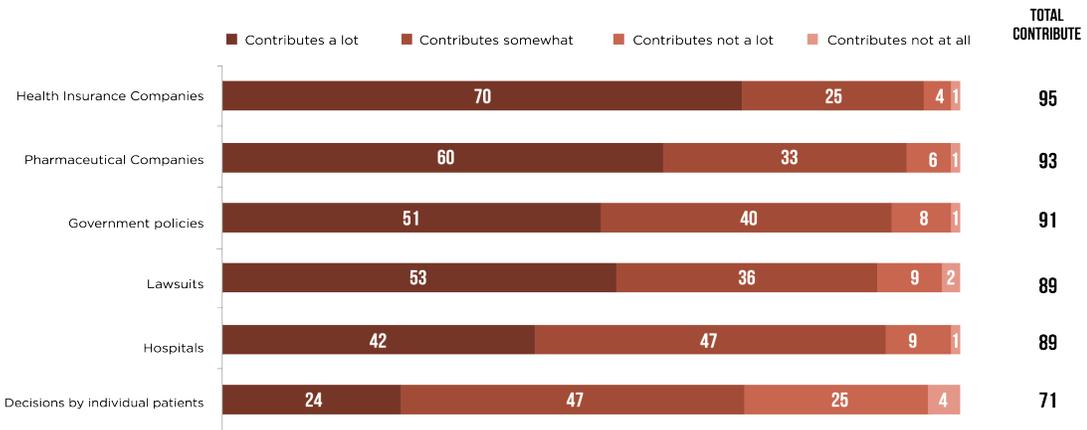
FINDINGS FROM THE COMPREHENSIVE SURVEY

Based on the insights from the focus group research, Aimed Alliance surveyed 600 physicians in the U.S. currently practicing in the areas of family practice, obstetrics/gynecology, pediatrics, and internal medicine to examine their experiences, attitudes and beliefs regarding the negative effects of insurance access barriers on patient care and medical practice. The following findings document the challenges facing primary care physicians today and underscore that physicians’ loss of clinical autonomy to health insurers yields poorer health outcomes and takes an emotional and financial toll on physicians.

1. Physicians believe health insurance companies are most responsible for increasing costs of health care.

When asked who is most responsible for increasing health care costs in the U.S., 95 percent of the physicians surveyed place blame on insurance companies. Physicians point out that insurance companies affect every aspect of the health care delivery system and, therefore, are most responsible for rising costs. Health care providers also cite pharmaceutical companies and government policies as leading to rising health care expenditures.

How much do the following contribute to rising health care costs?



2. Few primary care physicians have positive attitudes about health insurers and health plans’ effect on patient care.

Almost three times as many physicians in the survey hold negative opinions of health insurers than positive perceptions, and 79 percent of respondents said health insurers have a negative effect on physicians’ abilities to provide proper care to patients. These opinions come at a time when physicians face onerous administrative burdens in their interactions with health insurers; increasingly struggle to get prescribed treatments and

medications approved for coverage; must push to receive proper payment from insurers for their services; and spend more time, effort, and expense navigating complex administrative insurance processes.

OPINION: EFFECT OF HEALTH INSURANCE COMPANIES ON CARE

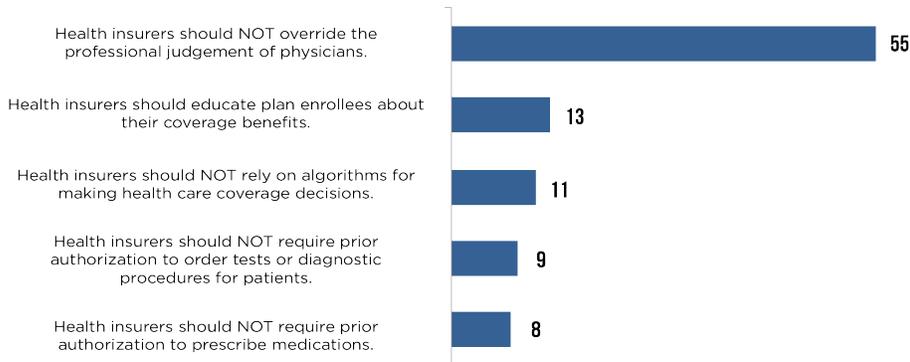
What effect do health insurance companies have on your ability to properly care for your patients?



3. Physicians’ overriding concern is insurer interference with their professional judgment.

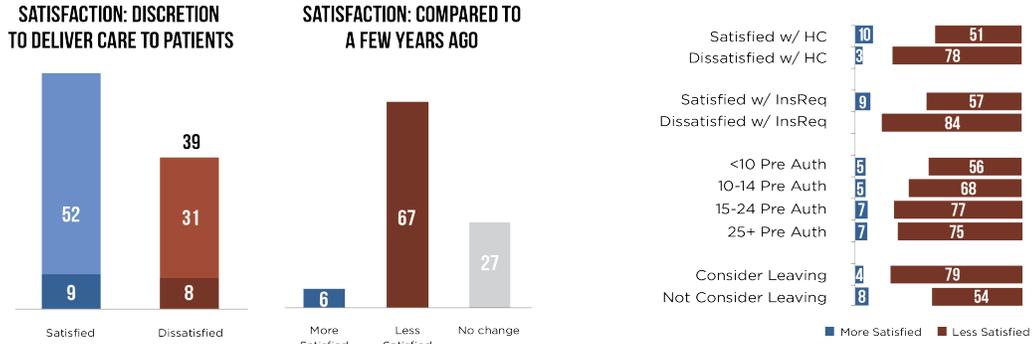
In the focus group research, one Bethesda-based physician said, “[insurers] tell you they are not in the business of practicing medicine, but they tell us what we can and cannot do.” This frustration is widespread among primary care physicians, according to the physician survey. When asked what aspect of insurers’ policies providers would most like to change, the majority (55 percent) of primary care physicians singled out insurers’ ability to override the professional judgment of physicians, garnering more responses than the four next choices combined.

If you could change one thing about health insurance plans, what would you change?



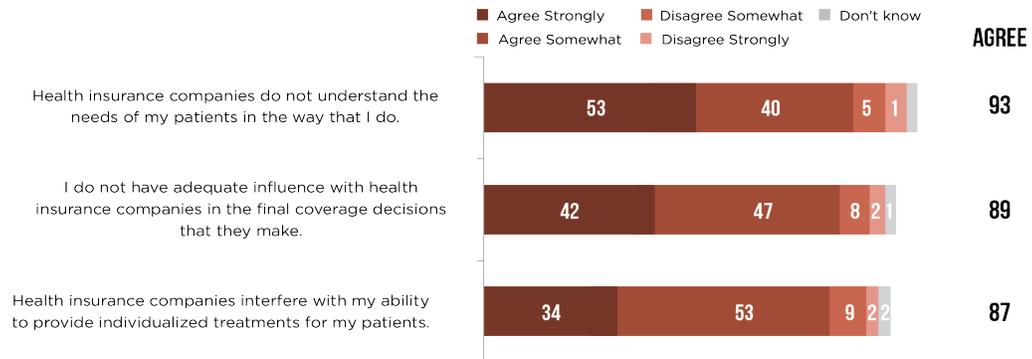
Physicians also say interference by health insurers is getting worse, with 67 percent of survey respondents indicating they are less satisfied with the amount of discretion insurers permit them to exercise compared to a few years ago.

Thinking about the requirements of insurance companies, how satisfied are you with the discretion you currently have to deliver quality health care to your patients? Compared to a few years ago, are you more satisfied or less satisfied with the discretion you have to deliver quality health care to your patients?



Most physicians surveyed (93 percent) also said insurers do not understand the needs of patients or physicians. Yet, they overwhelmingly agree that physicians do not have adequate control over treatment decisions and that insurers interfere with physicians’ ability to provide patients with individualized treatment.

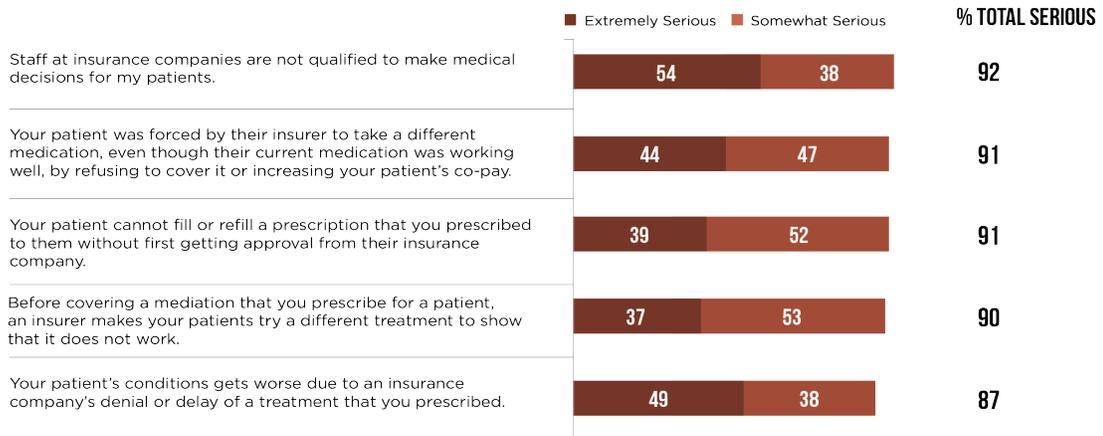
Please indicate if you agree or disagree with the following statements.



The survey further identified the most serious concerns of primary care physicians regarding the negative influence of health insurers on quality patient care. Most troubling for doctors is that unqualified insurance personnel are overriding physicians’ treatment decisions to the detriment of patients.

Other major concerns are insurance practices that force patients to take different medications than prescribed, require patients to try one or more less expensive treatments first and “fail” on them before the health insurer will cover the one the doctor prescribed, or deny or delay patients’ treatment coverage, leading to worsening health conditions. Respondents said these practices cause patients to use ineffective drugs or medications with additional side effects.

How serious are the following issues with respects to your ability to deliver quality care to your patients?



4. Physicians believe insurance company policies are compromising patient health.

Today, primary care physicians are increasingly worried that onerous insurance company policies are limiting their ability to deliver quality care to their patients. Describing the challenge for clinicians, a physician who participated in one of the focus groups highlighted the struggle to obtain coverage for an obesity medication, stating, “90 percent of the time, it requires a pre-authorization and 60 percent of the time those [requests] are denied.”

What Doctors Are Saying

“90 percent of the time [getting a treatment covered] requires a pre-authorization and 60 percent of the time those [requests] are denied.”

This frustration is shared by more than eight in ten (84 percent) of the physicians surveyed, who believe health insurers do not trust their medical expertise. Additionally, 84 percent of the physicians surveyed say having to obtain prior authorization for a prescribed test or treatment is a serious problem while 83 percent report that their patients experience difficulties getting referrals to specialists covered by insurance.

The vast majority of physicians surveyed (83 percent) also report that insurers’ delays or denials of prescribed tests and treatments can lead to disability, prolonged pain, and deteriorations in the health of patients with chronic conditions. Situations cited by focus group participants include patients not getting needed medications and being readmitted to the hospital and patients experiencing more asthma attacks because the insurer would not cover the prescribed type of inhaler.

How serious are the following issues with respect to your ability to deliver quality care to your patients?



5. Health insurers' restrictive cost-containment policies erode patients' trust in their doctors and can lead physicians to recommend purchasing medications from other countries.

Without access to needed medications, patients are more prone to order medications online from pharmacies in other countries with less stringent safety rules than in the U.S.¹¹ Due to these lower standards, drugs purchased online from other countries are more likely to be counterfeit, adulterated, or otherwise substandard to those meeting American regulatory requirements, which exposes patients to greater risk.¹² The U.S. Food and Drug Administration warns consumers against purchasing drugs from foreign countries because the agency cannot assure that the drugs are the same as prescribed by their physicians.¹³ The importation of unapproved foreign drugs is also a violation of U.S. law.¹⁴

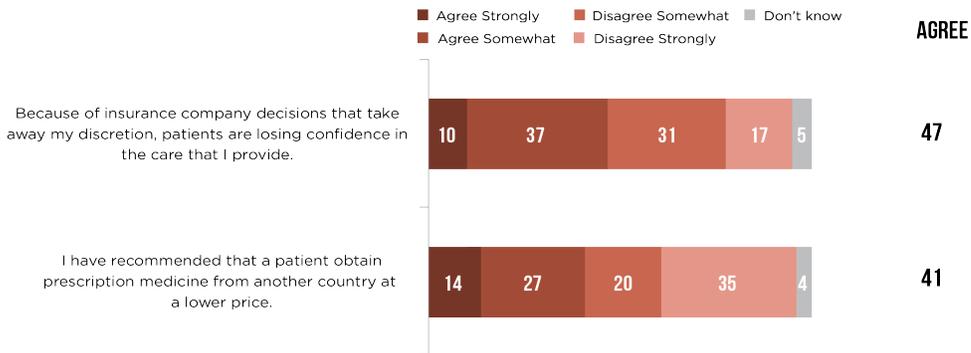
Despite these concerns, the Aimed Alliance research shows there are times when primary care providers will recommend that patients order a needed drug through a foreign online pharmacy at a lower price. In the physician survey, four in 10 of the practitioners polled (41 percent) said they sometimes recommend this option to their patients. Similarly, nurse practitioners participating in the focus groups confirmed this practice. One nurse practitioner in the Bethesda, MD focus group said she recommends that patients visit an online Canadian pharmacy; another nurse practitioner reported explaining to patients the cost savings derived from using online foreign pharmacies to fill prescriptions.

Another consequence of insurers' restrictive cost-containment practices is the erosion of patient trust in physician decision-making. In the survey, almost half (47 percent) of respondents said their patients are losing confidence in the care they provide. As one San Diego physician taking part in the focus groups explained it, "Big insurance companies have eroded trust in doctors."

What Doctors Are Saying

"Big insurance companies have eroded trust in doctors."

Please indicate if you agree or disagree with the following statements.



6. Physicians point to benefit utilization practices and insurance denials as examples of how insurers’ cost-containment policies impede the delivery of individualized care and increase health costs in the long term.

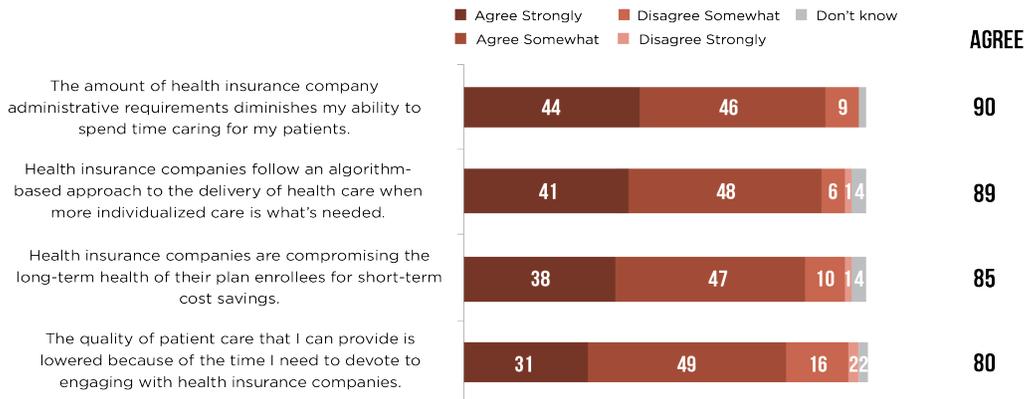
Besides documenting the harm to patients when health plans override doctors’ professional judgement, the vast majority of primary care physicians (85 percent) said that restrictive insurance company practices compromise the long-term health of patients for short-term cost savings. Underscoring this opinion, one of the physicians taking part in the focus group research said, “Insurance companies are governed by costs ... they attempt to control what we do and are motivated by their bottom line.”

What Doctors Are Saying

“Algorithm-based rules prevent patients from receiving more individualized care.”

Explaining some of the consequences for patients, 90 percent of physicians reported that health insurers’ administrative requirements diminish time for patient care, and 89 percent said insurers’ algorithm-based rules prevent patients from receiving more individualized care.

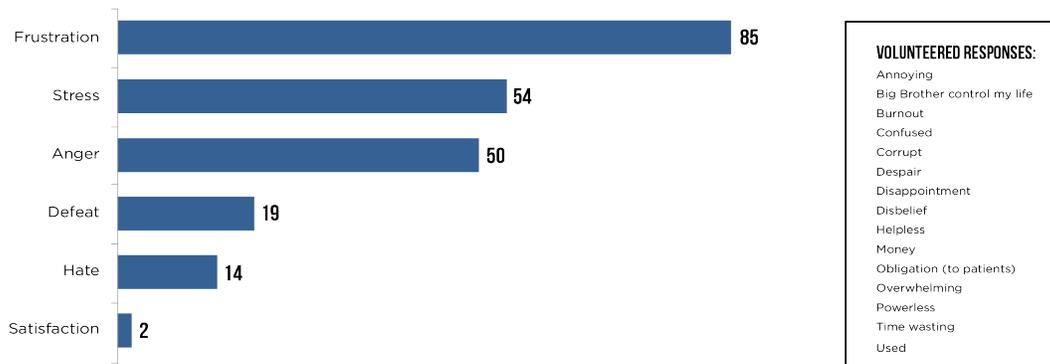
Please indicate if you agree or disagree with the following statements.



7. Navigating insurance access barriers is a financial and logistical burden on medical practices and a significant source of physician stress.

Navigating health insurers’ obstacles also takes a heavy financial and emotional toll on physicians and their practices. When asked to describe how they feel when encountering insurance access issues, physicians said they experience frustration, powerlessness, anger, and defeat. Physicians also described bringing their frustration home and venting to friends and family about their encounters with health insurers.

Please think for a second about what you feel when you encounter health insurance coverage issues. Which of the following words describe what you feel when insurance coverage issues occur? Please choose all that apply.



Among the insurance hurdles physicians said are most burdensome, physicians are especially exasperated with prior authorization requirements, under which health plans put clinicians through a time-consuming process to get approval from the insurance company before the plan will pay for the test, treatment, or procedure they ordered. Of the 600 primary care physicians surveyed, almost two-thirds (63 percent) reported needing to obtain 10 or more prior authorizations per week from insurers. Moreover, due to the time and costs required for physician practices to complete the paperwork, doctors’ negative opinions of insurers and their impact on patient care increases with the number of prior authorizations physicians must obtain.

The Burden of Prior Authorization

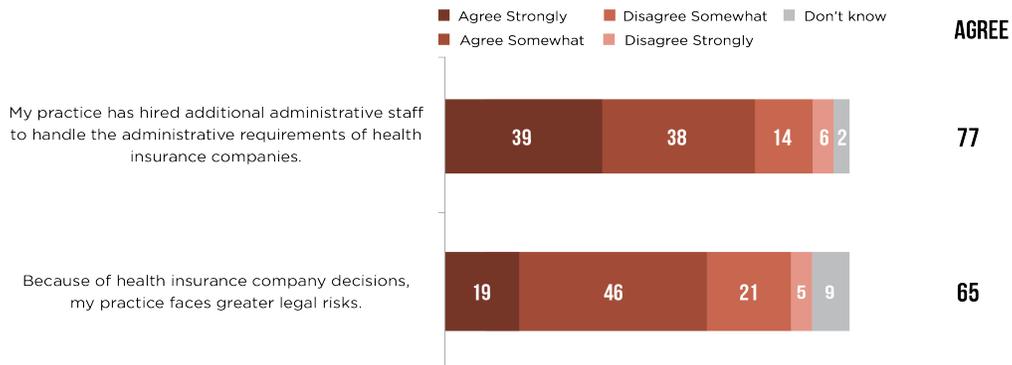
63 percent of primary care physicians surveyed must obtain 10 or more prior authorizations a week from insurers so patients can get the test, treatment, or procedure ordered.

Please indicate if you agree or disagree with the following statements.

	Percent Strongly Agree	Total Prior Authorizations per Week				Year in Healthcare			Patients per Week				Consider Leaving	
		<10	10-14	15-24	25+	<20	20-29	30+	<50	50-74	75-89	90+	Yes	No
Q25. Do not understand the needs of my patients	53	36	51	64	66	52	52	57	53	53	57	49	61	45
Q22. Diminishes my ability to spend time with patients	44	29	40	47	62	46	42	43	45	41	52	35	54	32
Q29. Do not have adequate influence with health insurance	42	35	40	44	51	39	41	49	46	42	46	34	51	33
Q26. Algorithm-based approach to the delivery of health care	41	29	41	38	54	41	36	46	38	39	50	31	46	34
Q23. Hired additional administrative staff	39	28	40	43	53	36	37	47	45	40	39	34	46	32
Q27. Insurance companies are compromising the long-term health	38	27	39	39	50	41	35	37	37	36	43	34	45	32
Q24. Health insurance companies interfere	34	18	39	35	54	38	28	37	37	31	40	29	41	27
Q21. Patient care that I can provide is lowered	31	18	26	33	52	33	30	32	31	27	40	26	41	20
Q28. My practice faces greater legal risks	19	9	20	14	41	20	18	18	27	15	21	15	26	11

In terms of added costs for primary care physician practices, more than three in four of the doctors surveyed (77 percent) said they had to hire extra staff to handle the paperwork submitted to insurance companies and 65 percent worry they are facing greater legal risks due to policies of insurers. Many physicians also reported having to write off fees for services the health insurer did not cover so the patient would not be harmed and to avoid any potential legal liability associated with turning an established patient away in need of medical attention. Generally, physicians are ethically bound to treat established patients even if the patients cannot pay for services.¹⁵ As one physician taking part in the focus group research put it: “malpractice is the shadow that looms behind.”

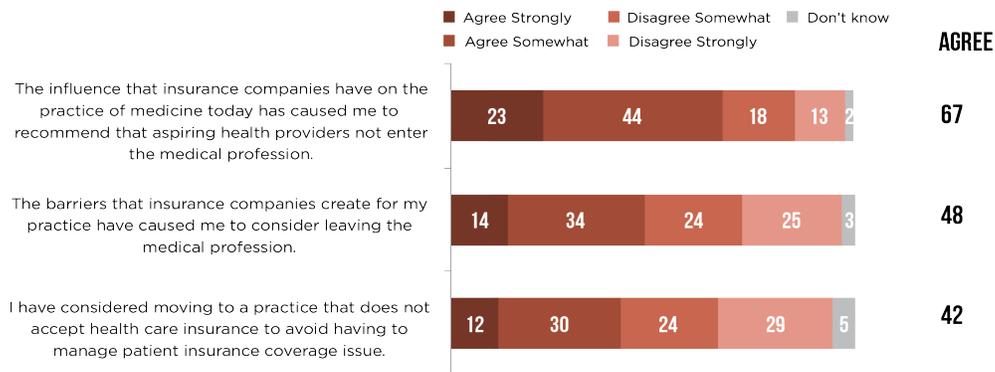
Please indicate if you agree or disagree with the following statements.



8. Many physicians are considering leaving the medical profession due to insurers' practices that compromise the health of patients and impede doctors' ability to deliver quality care.

As documented by the new physician survey, the barriers that insurers create for medical practices has caused almost half of primary care physicians (48 percent) to consider getting out of medicine, and 67 percent said they would not recommend a career in medicine to aspiring medical professionals. Moreover, four in ten survey respondents (42 percent) are considering moving to a practice that does not accept health insurance as a strategy to control their daily stress.

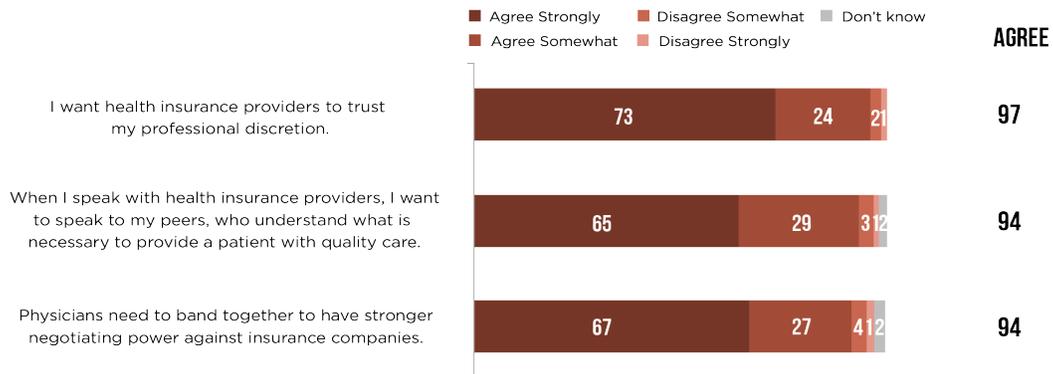
Please indicate if you agree or disagree with the following statements.



9. Physicians proposed several solutions.

In terms of ways to improve interactions between medical practices and insurance companies, the physicians surveyed offered several solutions. The vast majority called on insurers to respect physicians' professional judgment on patient care, allow physicians to speak with peer physicians staffed by insurance companies who understand patients' individualized needs, and reduce access barriers (particularly prior authorization).

Please indicate if you agree or disagree with the following statements.



While physicians recognize the positive contributions that health insurers can make to patient health, particularly in providing care in catastrophic cases, there is widespread agreement that treatment decisions should be left to physicians based on their training and professional judgement and not to insurers. As one physician in the focus group panels stated, “I know right away what works. The quicker I get the patient healthy, the less treatment they need.”

According to the physician survey, doctors strongly agreed (95 percent) that health insurers need greater transparency in their plans so enrollees will know which treatments and medications are covered, and 94 percent said the quality of patient care could improve if insurers would listen more to physicians.

What Doctors Are Saying

“I know right away what works. The quicker I can get the patient healthy, the less treatment they need.”

RECOMMENDATIONS

An insurance plan is a contract between the patient and the health plan.¹⁶ However, most patients have great difficulty understanding their health insurance plans and thus are ill equipped to challenge an insurer’s decision once a treatment is denied. Thus, physicians often take an active role in addressing insurance barriers on their patients’ behalf so patients can receive appropriate treatments and services. Physicians undertake these responsibilities even though they are not able to recoup their administrative expenses. In doing so, physicians are forced to sacrifice time that could otherwise be devoted to patient care to resolving access issues for their patients.

To lessen the burden on patients and physicians, Aired Alliance makes the following recommendations:

1. States should pass legislation to reduce unnecessarily burdensome processes and procedures that interfere with the physician-patient relationship.

States should enact laws to streamline benefit utilization management policies, including plans’ prior authorization and step therapy processes, which will reduce administrative waste and burden on both providers and patients. For example, enacting state laws that require health insurers to provide and use uniform prior authorization claims forms produces shorter claim response windows. Laws requiring easier appeals and exemption processes also promote greater physician autonomy.

2. Federal action is needed to increase protections for patients and reduce the waste associated with benefit utilization management.

State law is not applicable to all health plans. Therefore, federal responses should include enacting laws to reduce administrative waste and burden on providers and patients, require greater plan transparency, and make the appeals and exemption processes less burdensome to patients in health plans covered by the federal Employee Retirement Income Security Act (ERISA) and federal health care programs, such as Medicare.

At the same time, the Centers for Medicare and Medicaid Services (CMS) can reduce administrative waste associated with benefit utilization management through its “Patients over Paperwork” initiative. As part of this initiative, CMS is evaluating regulations to reduce unnecessary burden, increase efficiencies, and remove regulatory obstacles that prevent physicians from spending more time with patients.¹⁷ In particular, under Patients over Paperwork, CMS should streamline the prior authorization process for Medicare Advantage Organizations (MAOs).

Such efforts will reduce administrative waste not only for physicians, but also for insurers. Just as primary care providers must hire additional staff to request prior authorization and appeals, payers' increased use of benefit utilization management programs requires insurers to spend more for staffing and technology to respond to the influx of requests and appeals from patients and providers. Therefore, efforts to streamline benefit utilization management policies will reduce some of this administrative waste for insurers.

3. Physicians should be empowered to work with patients and patient advocates to take action against insurers employing bad practices.

In addition to passing laws and creating regulations to reduce administrative waste for practitioners and provide greater patient protections, practitioners should be empowered to identify patterns and practices of insurers' bad behavior, and work with patients and patient advocates to file complaints with state attorneys general, insurance commissioners, and with the U.S. Department of Labor. As a last line of defense, physicians can file suit against insurers that interfere with their practice of medicine or impede their ability to receive payment.

4. Medical associations and patient advocacy organizations should work closely together to provide a unified voice for improving patient access to individualized care and greater physician autonomy.

Through collaborative efforts, patient advocacy organizations and medical associations can draw on each other's unique experiences and expertise to develop reform recommendations that will both optimize patient care and promote greater physician autonomy. Working together also will provide patient advocacy organizations and medical associations with a more powerful, unified voice, and greater leverage when working with legislators and regulators.

CONCLUSION

With each passing year, Americans are paying more for health care coverage.¹⁸ Compounding the problem, those with insurance face higher out-of-pocket costs due to rising deductibles and copayments.¹⁹

Yet, even so, health insurers are increasingly utilizing benefit utilization management practices to delay needed care for patients and to delay or deny patients access to the most effective diagnostics and treatments. Because these common benefit utilization management practices negatively affect patients and health care providers alike, now is the time for much needed health insurance reform at both the state and federal levels.

ABOUT AIMED ALLIANCE

Aimed Alliance is a tax-exempt, not-for-profit organization that works to improve access to quality health care by educating, implementing, and enforcing consumer protections. To achieve its mission, Aimed Alliance conducts legal research and analysis; develops sound, patient-centered recommendations; and disseminates its findings to inform policy makers and increase public awareness. To learn more about Aimed Alliance, go to www.aimedalliance.org. For a list of our funders, see www.aimedalliance.org/collaborators.

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