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News Release

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IMS COMMENTARY:
Getting Needed Care

Many patients see physicians or have procedures and then feel like they are being cheated or are extremely disappointed because they get a bill that they expected their insurance company to cover. Why does this happen?

Patients receiving health care services need to be aware of what is occurring behind the scenes as physicians and others work to give patients care that is needed and the best available.

There is no question every patient office visit, procedure, or test is scrutinized for necessity and price. This leads to confusion, unpaid health care claims, and frustration on the part of patients, health care providers and insurers, not to mention delay in delivery of care while these differences are ironed out.

"Transparency," which would help patients, physicians and health care facilities, is nothing more than a buzz word. There are so many layers of rules and regulations that those providing care, can never be assured they will be paid for the services being provided. Also, those receiving the service, have no idea how much it will eventually cost them. Think about it; this system of buying something and not knowing how much you will have to pay is crazy! It is even worse because this system requires someone to order or provide the service ordered and they too have no idea if they will ever be paid. This lack of transparency results in billions of dollars of excess administrative costs every year.

As an example:

> Employers buy an insurance product which reassures the employer, if there is an employee that needs back surgery then the insurance will cover back surgery.

Here is where the case gets very complicated and confusing. Each employer buys a specific plan from an insurance company. But each insurance company has multiple plans which cover various options differently. Most employers add another layer and hire a company called a third party administrator (TPA) to oversee the plan, which allows this intermediary company to interpret the plan in their own way in an effort to save the employer money and the employee unnecessary procedures. So a physician or a health care facility does not know the details of each plan or how the particular TPA is going to interpret the plan. This varies from one TPA to another.

The physician office and hospital get approval for back surgery and the patient has back surgery. Let's suppose the physician chooses to do the surgery with a new piece of equipment or supply because they feel their patients heal faster and get back to work quicker when they use this process. But the particular health plan doesn't cover the cost of the equipment or supply because the TPA doesn't think it is necessary, even though they said they covered back surgery. Approvals are given by the health plan for the surgical procedure – not the various components of the surgery, so hospitals and physicians proceed to provide the best care using their best judgment and optimal techniques as defined by various specialty societies. Then later, denials of payment occur for certain portions of the care that each insurance plan individually considers "unnecessary, experimental, or

investigational." Since these rules and policies differ by plan it is nearly impossible for physicians or hospitals to know ahead of time what is going to be paid for by the plan/employer - and more importantly what is not covered, thus making those costs patient responsibility.

It is important for physicians to perform at the top of their licensure and expertise. The special relationship between physician and patient determining the best treatment options should ideally include the costs to the patient. We physicians tend to discuss the costs we know – how long before the patient feels better and what are the risks and benefits of the treatment options. But the added and unknown variable costs hurt all of us.

This also places you as a patient in a situation where you and your physician have agreed on a treatment plan, and now your insurance is failing to pay for the care you agreed upon with your doctor as the best care for you. Financial responsibilities may fall to *you* in this circumstance.

We physicians of The Indianapolis Medical Society want to begin a dialog highlighting some of the difficulties we face as we work to improve health care delivery, communication, and the doctor patient relationship.

Unfortunately, there may be some physicians who provide unnecessary services to try to increase their bill. However, almost all physicians are honest and want what is best for their patient. There is simply some disagreement as to what is "best." There is no way that a physician could afford to hire enough employees to check to see if every single piece of equipment or product that they want to use in a procedure is covered by the hundreds of different insurance plans that their patients have. It would be doable if there was just one Anthem or one United Health Care plan – or even one set of rules that all plans had to follow. But there are multiple insurance companies and those companies have many different health plan options, as well as a wide variation in rules for each plan. Employers can also dictate what gets covered as long as they are paying the bill.

Frequently, there may be various opinions on the best way to care for a given patient (This is why we as doctors or you as patients sometimes ask for second opinions). But once the treatment plan is chosen and agreed upon by patient and physician and "approved" by the insurance company, the physicians, health care facilities and patients should all know how much they will receive as payment and how much they will owe out of pocket.

Inconsistent payment policies have a very significant effect of driving up health care costs. Having a single set of agreed upon guidelines makes all the sense in the world and would move health care costs in the right direction – down.

Unless and until there is real transparency, you, as a patient, are always at risk of having higher than necessary out-of-pocket costs. It is no wonder that few are really happy with the current health care system. Costs are high; administrative costs climb every year; and patients are continuously put in the position of "caught in the middle." You and your physician have agreed upon a plan of care that offers you the best chance of feeling better and improving your quality of life.

Then, some third party, based on rules that are inconsistent from payer to payer decides *for you* what gets paid. ... **Patients should demand better.** And we all will be patients at some time.

Respectfully submitted:

Doctors Bernard J. Emkes, John C. Ellis, Linda Feiwell Abels, Susan K. Maisel, Paula A. Hall, and Mary Ian McAteer

Dr. Mark M. Hamilton, IMS President, is available for interviews; please contact Beverly Hurt, EVP, Indianapolis Medical Society to schedule an interview.

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