# How Insurer Interference Impacts Medical Care

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**Brittani Riddle:**

Hello and welcome to the latest edition of the College of American Pathologists' CAPcast. I'm Brittani Riddle, manager for advocacy communications and production at the CAP. Insurer interference is on the rise, creating barriers for patients to access medical care insurer. Interference often happens under the guise of cost cutting measures for patients, but pathologists report an increase in disruptions to providing timely diagnosis and medical care for their patients. On this edition of CAPcast, we will discuss how this issue disrupts medical care. Before we dive more into the topic, I'd like my guest, Dr. Theresa Emory, to introduce herself. Dr. Emory, thank you for joining me today.

**Dr. Theresa Emory:**

Hi there. Well, thank you for having me. My name is Theresa Emory. I'm a practicing pathologist in Virginia at a community health system, and I've been practicing for 30 years. I currently serve as vice chair for economic affairs at CAP and also I am the chair of the payment policy subcommittee for CAP.

**Brittani Riddle:**

So Dr. Emory, pathologists are seeing a rise in what is called insurer interference. Can you explain what insurer interference is for the listeners?

**Dr. Theresa Emory:**

Sure. So about two thirds of the American population has private insurance. And private insurance really is meant to have an insurer pay for medical care and not control it. But what we've been seeing over the last 10, 15 years is a rise of insurers interfering with the doctor patient relationship and the physician relationship, which is causing a disruption to patient care and is causing harm to patients by interfering with the appropriate care and the appropriate care teams. So examples of that would be when a patient is seen in their doctor's office and they have a biopsy and of some sort or another, it could be a breast biopsy, it could be a skin biopsy, it could be something, and the insurance company mandates that the specimen be sent to a specific laboratory rather than to, for example, the local laboratory where the clinical doctor would like the specimen to go because that is going to be part of the whole coordinated care model.

So an example of that would be a patient comes in, is seen at their ENT doctor because they are having a hard time swallowing. The doctor sees a tumor or something on the tonsil takes a biopsy and it has to be sent to another laboratory. But really the doctor did that rapidly in the office because they wanted a rapid diagnosis, because they're concerned that the patient might have cancer. Well, by sending it to the required laboratory, this may delay the diagnosis because it is perhaps a state or two away and it just takes time to get that diagnosis back. And so that is not in the best interest of the patient care. And we have seen a similar case to that where the patient then had to be taken to the hospital to get an urgent biopsy because of this several week delay in diagnosis, and this patient had an invasive squamous cell carcinoma. So that's one example of what can happen when a patient is not able to get the care in a timely manner because of an insurance interference with regard to where the specimen must go for this outpatient biopsy.

**Brittani Riddle:**

So you mentioned that the specimen may have to be sent off to a different laboratory. It may take instead of a couple of days, a rapid response. It may take longer. Do patients often know when an insurer might be interfering with their healthcare treatment and plans?

**Dr. Theresa Emory:**

So I would say the answer to that is generally no. I don't think patients really know the whole mechanism of how biopsies and things like that are done until there's a problem and they become very aware when there's a concern, for example, of cancer or of they're concerned, for example, in the case of having a breast biopsy that they have cancer and not getting a diagnosis back in a timely manner. And so this is a problem. It's not a problem just for the patient. It's also a problem for the laboratory who has to get the specimen because if the volume of material is so high that there is not the ability for enough pathologists to make a diagnosis, there will be a delay for them as well. According to CAP, diagnosis should be made within two business days. But what we're seeing and likely due to this interference is that it's taking longer for the laboratories to be able to get those diagnoses turned around.

**Brittani Riddle:**

Can you provide an example or examples of a time where insurer interference has really impacted a patient's care and could impact their lives?

**Dr. Theresa Emory:**

Well, yes, sure. That's a really great question and I'll give two examples that have happened that I'm aware of that have happened where I am the last six months. The first was a woman who went to see her gynecologist and she had a biopsy of her cervix because there was what looked like a tumor on her cervix. And the specimen was mandated to go to a particular laboratory and time went by a week and a half, then two weeks, and she came back to the doctor urgently because she was bleeding. They went and looked again and this tumor that they could see there had tripled in size. The doctor took her to the hospital so that she could get a biopsy so that we could get a diagnosis that day. And she had a high grade, a malignant tumor called small cell carcinoma. This is a very high grade, very aggressive, spreads throughout the body quite quickly.

And she had had this for two weeks without that original diagnosis having come back. That's one example. And that led to just really a lot of very rapid treatment, chemotherapy and a great concern by her treating physician. The second was just in the last two weeks, was a gentleman who was having difficulty breathing and had a sore throat was sent to the ENT doctor. They saw a large mass on his tonsil. They were concerned it was cancer, and so quickly took a biopsy in the office hoping to get a diagnosis back quickly because they assumed they were going to have to go to surgery. Two weeks again went by, the patient had to be rushed to the hospital because he came in having difficulty breathing because this tumor had gotten larger and it was obstructing his airway and he was operated on and had an invasive squamous cell carcinoma and his tonsil that was now obstructing. So those are just examples of when insurance mandates how the physician and the patient, where the specimen goes and what must happen because of an insurance interference.

**Brittani Riddle:**

So this really does create a domino effect, so to speak.

**Dr. Theresa Emory:**

Yes, and I don't think it's just limited to pathology. We're seeing this also with regard to clinical care. Patients are reporting because of interference by insurance that they can't get into the local doctor in a timely manner because there's not enough appointments, there's not enough providers within the network of the insurer, so the patients are not able to get in. So there's a bottleneck with regard to getting in network care or getting care in a timely manner.

**Brittani Riddle:**

So how can patients begin to work with their physicians and their pathologists to make sure that they have access to the care that they need?

**Dr. Theresa Emory:**

So that is a real challenge that we are facing and that is something that patients generally don't know until they find out they're having a problem. That would be the case where there's a delay in diagnosis and the doctor said, gee, I'm really concerned about what you've got, and you're waiting a long time for it. So it's difficult until the public becomes aware that there are these barriers to care. It's difficult for us to challenge them. And so both the physicians and the patients and the clinical practice need to be aware that this is happening because it is something that when you really need to know your diagnosis, waiting a long time and then having to wait even longer to get that specimen re-reviewed by the care team that will take care of you, can be very psychologically distressing.

**Brittani Riddle:**

Absolutely. And so the CAP recently released a new white paper on insurer interference. Can you talk to us a little bit more about the report?

**Dr. Theresa Emory:**

So this report, which is entitled "Examining the State of Healthcare's Private Payers, and the Adverse Impact of Insurance Interference" is meant to help bring together all of these issues that we are seeing that are being caused by insurance companies being focused on profits rather than patient care. And how this interference is impacting quality of care, doctor, patient relationship, physician to physician relationships, and ultimately is disrupting coordinated care for patients and also appropriate care. So one of the issues is what I talked about, which is the steering, but there are several other issues. There are issues with regard to limiting diagnostic ability. In other words, a limited number of biopsies can be taken from a patient, or for example, requiring prior authorization, which will delay care. There are issues with regard to a number of other things. And so we've tried to look at all of these and take a deep dive and then come up with solutions for those issues, recommendations, how they might be solved. Because it's one thing to say, Hey, here are all the problems. But it's also really important that we come up with ideas to improve them because ultimately we're trying to take care of patients and do what's in their best interest.

**Brittani Riddle:**

So could you talk and walk us through a little bit of the recommendations from the CAP report?

**Dr. Theresa Emory:**

So in the report, the CAP identified five recommendations to address insurance interference. First is to require an adequate networks that include hospital facility-based physicians like anesthesiologists, radiologists, and pathologists. Next is to restrict in-network steering and tiering that prohibit economic cost only network criteria. In other words, the requirement to send a specimen to a certain place cannot be just limited to economic profits for the health insurer. Third is to maintain a physician-LED team-based care system. If the physician is the center of the care team, the best interest of the patient should be realized. It should not be that the insurer is the head of the care team. Fourth is to include regular monitoring and audits and meaningful enforcement and come up with criteria that insurers must operate under in order to ensure that the patient's best interest is always the top priority. And then fifth is to address issues around antitrust and have some scrutiny around that. As we have seen over the last several years, insurers have consolidated and they really have a huge market share and therefore their interest is really not been based on patient care, but on profits.

**Brittani Riddle:**

Thank you for walking us through those. And again, to our listeners, if you have not read the report, we encourage you to do so cap.org and also shared with your colleagues as well. So in addition to releasing the white paper, what are some additional CAP advocacy efforts that we will engage in?

**Dr. Theresa Emory:**

CAP is working, with this white paper, to get it more well known to try to get some media coverage. Also to interact with our state and local legislators about issues that really are impacting patients hospital systems. We need to coordinate with them as well. And then as necessary, we will reach out to congressional leaders to try to start working on this to address this more fully. In addition, CAP is involved in so many other advocacy issues, and I direct you to cap.org, the advocacy page. We are working on a number of issues around the LDTs payment through Medicare. We work on issues that have a lot to do with how we are paid and the payment processes that we are always engaged in. So I strongly recommend that you go to c.org to the advocacy page and it's updated all the time. We also always ask for members to reach out to CAP. We have a great team that works in advocacy full time, and they are always happy to help address new issues that come up around this. Anything that has to do with pathology and advocacy nationally for all of us.

**Brittani Riddle:**

Dr. Emory, this has been such an insightful conversation. I want to thank you again for joining me today. I know you have a very busy schedule, so thank you again. Could you also let our listeners know how they can get connected to the CAP if they aren't already?

**Dr. Theresa Emory:**

Sure. So just the first thing I'd say is go to cap.org and you'll find ways to be connected and get involved. And ultimately, it'd be great to have more people involved around all these issues because they impact all of us.

**Brittani Riddle:**

Thank you for listening to this edition of the College of American Pathologists' podcast. I want to thank today's guest, Dr. Theresa Emory for joining me. Be sure to subscribe to CAPcast where podcasts are available. To learn more about the CAP, visit our website cap.org or download the MyCAP app.