



CNS

Health Care Reform Survey of Neurosurgical Leaders

On March 19, 2017, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) surveyed a cross-section of approximately 300 leaders in organized neurosurgery. The survey asked a series of questions related to their experience since the Affordable Care Act (ACA) was enacted in 2010. As of March 21, nearly one-third (100) of those surveyed had responded. The following report summarizes the findings.

Most Neurosurgeons Accept ACA Exchange and Medicaid Plans, but Cracks in the System Exist

Eighty-two percent of respondents accept patients insured through an ACA exchange plan. However, 12 percent limit the number of ACA-exchange covered patients that they see in their practices. Slightly fewer (66%) accept patients who are insured through Medicaid, and a higher percentage (21%) restrict the number of Medicaid patients that their practice sees. Nevertheless, less than half (46%) of neurosurgeons participate as a preferred provider in an exchange or Medicaid plan.



This relatively robust participation rate generally correlates with the number of neurosurgeons that are now employed by hospitals. For these individuals, they take care of patients based on their hospital agreements and policies. However, there are cracks in the system, as neurosurgeons in private practice cease participating in exchange health insurance plans.

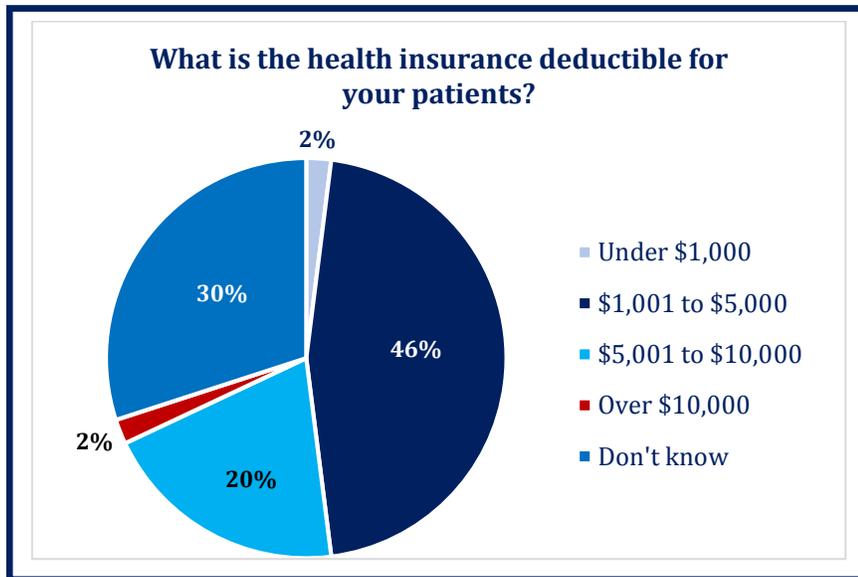
For example, a neurosurgeon in Texas writes, “We accepted PPO marketplace plans until the insurance carriers moved the PPO plans out of the marketplace. HMO plans are labor intensive anyway, but the marketplace plans were particularly burdensome because of the subsidy and gathering information whether premium payments were up to date.” Another neurosurgeon in private practice from Mississippi pointed out, “We have accepted United and Humana exchange patients as they both paid commercial rates for services provided. Once both of these carriers pull out of the exchanges (United already has), we will quit seeing any exchange patients as the only carrier left (with whom we’ve never participated) reimburses at 125% of Medicare.”

When it comes to Medicaid, many neurosurgeons only treat patients who have emergency medical conditions. For example, a neurosurgeon in California notes, “We only accept Medicaid patients through the emergency department. We don’t accept new Medicaid patients in the clinic.” A neurosurgeon in North Carolina likewise informed us that, “I only see emergencies from trauma call or patients that were established some time ago. The payments from my state are prohibitively low.”

Skyrocketing Deductibles Leave Patients Financially on the Hook for Large Medical Bills

Unfortunately, more and more patients in need of neurosurgical care are experiencing high deductibles and other out-of-pocket expenses. Eighty percent of respondents verified that an increased number of their patients have high-deductible health plans. Slightly less than half (46%) are treating patients whose health plan

deductibles range from \$1,001 to \$5,000 and an addition 20 percent have plans with deductibles from \$5,001 to \$10,000. Although rare (2%), some neurosurgical patients have deductibles in excess of \$10,000.



Despite improved health care coverage, these skyrocketing deductibles are nevertheless leaving patients financially on the hook for large medical bills. To keep their practices open and functioning, forty-five percent of neurosurgeons require their patients to pay all or part of any deductible or other cost-sharing fees at the point of service or before performing any test or procedure. As a neurosurgeon from Georgia noted, their practice must collect these fees in advance “because if we don't, we won't get paid after the fact.” However, this neurosurgeon goes on to tell us, “If it's a brain tumor or life threatening issue we don't [collect the fees in advance].”

Fortunately for patients, as a neurosurgeon from Tennessee points out, they will “work out a payment schedule and have their patients meet with our financial counselors before seeing us.” A little more than a third (38%) do not require their patients to pay these costs up front.

To cope with these high deductibles, nearly one-third (29%) of neurosurgical practices have adopted new administrative or other accounts payable strategies. For example, many will hold their claims until after the hospital first files, so the hospital is responsible for managing health plan deductibles.

Administrative Burdens

Health insurers and Medicaid programs are increasingly using prior authorization as a cost-control process that requires providers to obtain approval before rendering medical services. Three-quarters (77%) of neurosurgeons now regularly must comply with onerous prior authorization procedures. More important than the administrative burdens these processes impose, prior authorization is resulting in unnecessary delays in patient care. Prior authorization is a source of extreme frustration among neurosurgeons. Consider the following comments:

The insurance company will authorize the surgery up front after we provide needed medical records to support the need for the surgery, then they will deny the claim after the surgery is performed saying it was not needed. Their disclaimer "authorization is not a guarantee of payment." They drive up the cost of health care delivery with all the burdens put in place to obtain an authorization only to deny it after.

Neurosurgeon from Florida

Medicaid has 14 days to approve; they look at the authorization request on the 13th day then want additional information. This means we have to cancel the surgery because of no authorization and reschedule. This makes the patient have to reschedule their plans for child care, work schedule, who is going to get off work to take them and pick them up and taking that surgical slot means someone else will have to wait, we can't fill it at the last minute. Even after the medical records are sent, they request a peer to peer review. It's hard to get our doctors on the phone when they are in surgery 4 out of 5 days a week.

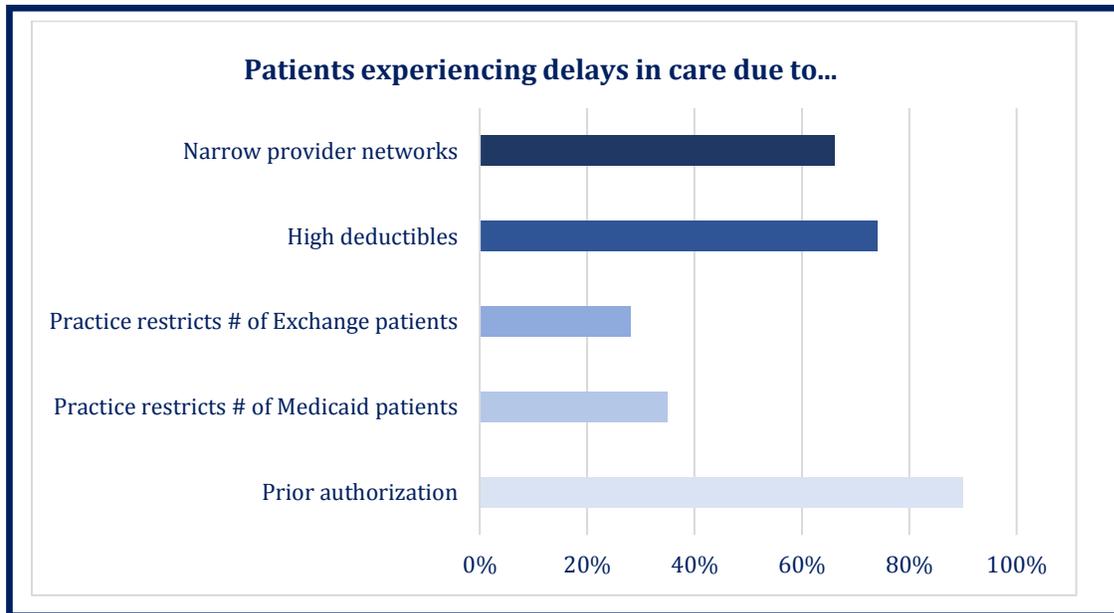
Neurosurgical Practice Administrator from Georgia

We have had to jump through many hoops for patients who are on ACA plans, the worst being that after-the-fact, insurance companies refuse to abide by the authorizations they required us to get upfront.

Neurosurgical Practice Administrator from North Carolina

Delays in Access to Care

There is no question that millions of Americans have health insurance as a result of the Affordable Care Act and as a neurosurgeon in Maryland wrote, “A lot more patients have access to care because they now have insurance. Before the ACA they had none.” Nevertheless, having a medical insurance card does not always translate into timely access to quality neurosurgical care at an affordable price. Indeed, our findings demonstrate that barriers to access remain. Narrow provider networks, high deductibles and prior authorization processes are all contributing to access to care problems for neurosurgical patients. To wit:



Prior authorization or other administrative barriers to care	90%
Physician practice restrictions on the number of Medicaid patients treated	35%
Physician practice restrictions on the number of ACA-exchange plan patients treated	28%
High deductibles or other out-of-pocket costs	74%
Narrow provider networks	66%

Many survey respondents added a variety of comments related to their ACA-related experience. Some examples include:

We are having to limit the number of Medicaid slots in clinic, as no one in the state will see the spine Medicaid patients, and they are filling our group's clinic as a result. There is now a long wait list for Medicaid patients.

Neurosurgeon from Indiana

Now patients being followed for tumors with repeat imaging have to see us before the imaging can be approved. This results in patients having to make two trips to see us and get yearly imaging, instead of one trip. Given the long distances and limited means of many of our patients, this is a huge burden.

Neurosurgeon from West Virginia

We have a brain tumor patient for whom we have been caring. Now that he had to switch plans to Blue Cross-Blue Shield, we can no longer see him, and he has to travel 2 hours away to get care.

Neurosurgeon from Georgia

Because patients' insurance plans now change so frequently, and the networks also change often, we have had many patients whom we have taken care of for many years, but now we have to jettison. This is especially difficult on the more disabled patients on Medicaid who have such issues as intrathecal pumps that need surgical care and intractable epilepsy or pain that need chronic specialist management.

Neurosurgeon from Illinois

Patient signed up for Covered California and then discover there are virtually no specialists in the networks.

Neurosurgeon from California

I had a cancer survivor patient who waited one year for surgical approval to get her active spondylolisthesis treated. Approval waiting times are getting longer. Narrow networks have markedly increased the complexity to finding services our patients need.

Neurosurgeon from Illinois

Since the ACA and Medicaid expansion, we have seen a dramatic increase in the number of patients coming to the emergency department for care. The promise that the increased number of patients with insurance would allow them to substitute low-cost primary care for high-cost emergency department care has not occurred.

Neurosurgeon from Pennsylvania

Concluding Thoughts

America's neurosurgeons strongly support improving our nation's health care system, including expanding access to affordable health insurance coverage for every American, as well as reforms to redress a number of inexcusable insurance practices. While the Affordable Care Act's (ACA) insurance market reforms — such as coverage for pre-existing conditions and guaranteed issue — provide critical consumer protections, rather than lowering costs and expanding choice, premiums have skyrocketed, high deductibles leave patients financially on the hook for their medical bills and narrow networks restrict patient access to the physician of their choice. To address these ongoing shortcomings, policymakers must take additional steps to require plans to offer a sufficient number and type of specialists and subspecialists in their provider networks; maintain patient choice through out-of-network options; improve access to trauma and emergency care; reduce preauthorization requirements; and expand competition and the choice of health plans — including health savings accounts. Additionally, to ensure that our nation's children have uninterrupted health insurance coverage, Congress should reauthorize the Children's Health Insurance Program (CHIP) — for two to five years — before it expires later this year.

For More Information Contact:

Katie O. Orrico, Director
AANS/CNS Washington Office
725 15th Street, NW, Suite 500
Washington, DC 20005
202-446-2024
korrigo@neurosurgery.org