Opinion

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Blurring the Lines: Are You an Insurance Company?

I found the leather-bound 1946 appointment book for our practice. It seems quaint from the vantage of the 21st century. Each entry is handwritten—in cursive—sometimes in blue ink, sometimes in pencil, and the charge to each patient is meticulously recorded. This relic illustrates that ophthalmic practice was simpler when the physician provided care and the patients paid for the service (on the same day). Ophthalmologists concentrated on delivering the best possible medical care and needed only basic accounting and scheduling assistance. Today, not only are scheduling and billing crushingly complex, but we also function as insurance companies.

How so? As financial risk shifts to ophthalmology practices, the lines blur between payer and provider.

The most obvious example is the high deductible, which places the burden of collecting payment for medical services on the ophthalmology practice. In just 5 years, the percentage of employees with a deductible of $1,000 or more (for single coverage) has increased from 34% to over 50%.[1] On average, the deductible for the popular "Silver Plan" in the insurance marketplace is more than $3,000. When the ophthalmologist is responsible for collecting payment from the deductible, the practice must devote resources to this extra work, and it risks not getting paid. Furthermore, when a patient needs urgent care or surgery, there are medical-legal and ethical requirements to provide or arrange care even when payment is not assured.

Co-pays are another example. While high co-pays are usually framed as an issue of access, they also pose a financial risk because the ophthalmologist must collect payment. These collections become more difficult when a patient experiences financial hardship from co-pays, especially during episodes that require frequent office visits.

Practices assume risk in more subtle ways, too. After considerable staff time is spent obtaining a preauthorization for a procedure, occasionally an insurance company will retroactively deny payment or even request repayment. The process of rectifying these situations can be so complex and frustrating that a practice might give up or lose track of a particular claim. In fact, the ophthalmology practice must monitor the entire revenue cycle, including eligibility, authorization, predetermination, denial, claims resubmission, eventual payment, and postpayment audits.

And there's more. Practices also assume risk when giving anti-VEGF injections. Expensive medications must be purchased and properly stored, and expiration dates must be monitored. Even with meticulous inventory tracking, one bad claim can have a significant negative impact. The physician assumes the risk, not the insurance company, the patient, or the pharmaceutical company. Moreover, new and innovative medications and devices are increasingly being offered using the "buy and bill" model, in which the practice purchases the product and bills insurance for reimbursement.

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Most significantly, the health care marketplace is further blurring the lines between provider and payer. Large integrated health systems are offering insurance products that only include providers from their own health system. CVS Health announced plans to buy the insurance giant Aetna for $69 billion. Many CVS pharmacies include retail clinics that provide health care. Under this model, the health care provider, the pharmacy, and the insurance company are the same.

The roles in health care delivery are exceedingly complex and comingled—and the lines will increasingly blur as providers, health systems, pharmacies, and insurance companies consolidate and integrate. As systems become more complex, responsibility for revenue cycle management and risk analysis may shift to a centralized business office. Interestingly, this just might return ophthalmologists to our real expertise—being superb clinicians, counselors, and surgeons.

1 www.kff.org/report-section/ehbs-2017-summary-of-findings/. Accessed Jan. 5, 2018.