LONG VIEW
THRIVE BY DESIGN

The Lifetime Blindspot

How Different Time Horizons for Payers, Providers and Persons Create Waste

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The Missing Link to Heal Prior Authorizations

Key Learnings

- **A clash of time horizons between payers and providers has created a lifetime blind spot about the member/person.** Payers operate on an annual cycle of premiums and claims, while providers manage within episodic services and payment. Neither matches the time horizon of the person whose care stretches across decades. The result is that decisions such as delaying cancer treatment may yield short-term savings for the payer or a revenue shift for the provider (ED admissions due to delayed care), but they can create delays or abandonment that create years of added expense and harm for the member and the system at large. For example, a delay of more than 60 days in initiating breast cancer surgery is linked to a 66% higher risk of overall mortality and an 85% higher risk of breast cancer–specific death, and each additional four weeks of delay increases mortality across common cancers.
- **Members are finding ways to push back.** As denials rise, people are responding in unanticipated ways. Some are using tools like ChatGPT to draft successful appeal letters, others are learning to escalate directly to state regulators, and more are shopping for health plans with an eye to restrictive prior authorization policies. These strategies show that members are no longer passive recipients of system rules but are instead becoming active agents in protecting their long-term health interests.
- **The failed promise of payer-provider collaboration leaves the member as the missing link.** Despite decades of pilot projects, joint ventures, and risk-sharing contracts, true alignment between payers and providers remains elusive. Payers still dictate utilization rules and providers still pursue volume-based gains. Until the system recognizes and activates the member as the central stakeholder and owner of lifetime value, the cycle of short-term incentives and long-term losses will continue.

The Tale of Two Time Horizons

The story of prior authorization is, at its core, a story of two clocks that never keep the same time. On one side are the payers, who live by the 12-month cycle of the medical loss ratio. Their horizon is shaped by budgets that must balance within a year without prohibitive premium rises in the next cycle. Payers are also influenced by the expectation that many of their members will not stay long enough to justify investments in long-term health. When the average commercial member churns every two to three years, and when Medicaid churn can be even higher, it is challenging not to focus on immediate cost containment rather than the possibility of distant returns.

On the other side there are providers, whose incentives are no less short-term, though they play out differently. A physician is reimbursed for an office visit, not for keeping a patient well over a decade. A hospital is reimbursed for a DRG episode, not for avoiding admissions in the first place across a lifetime. Incentives reset with each encounter. The care team may see the same patient again and again, but the payment system treats each event as a discrete transaction (unless readmissions occur), untethered from the broader arc of a person's health.

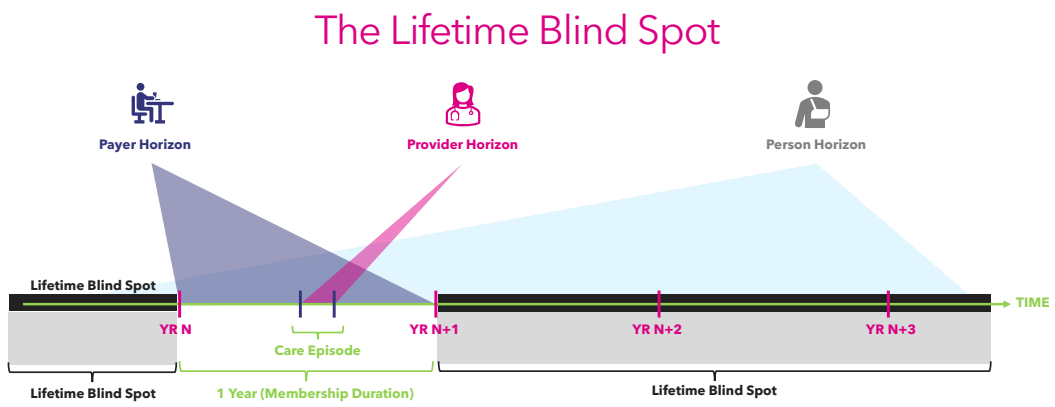
The result is a structural misalignment. Neither payer nor provider truly owns the long view of health, which is measured in decades, not months. Both are compelled by design to focus on the near term—payers to satisfy annual ratios, providers to submit episodic claims. Prior authorization has emerged as a referee in this tug-of-war, not because it was designed to promote lifetime value, but because it serves the immediate interests of short-term accountability.

The Lifetime Blind Spot

There is, in fact, a third clock that governs healthcare, and it is the one that matters the most. This is the clock of the individual person, whose horizon stretches not in fiscal years or billing episodes but across a lifetime of health, illness, and recovery. Unlike payers or providers, who measure success in twelve-month cycles or isolated encounters, a person experiences healthcare as a continuous journey. This journey is not reset when an insurance policy lapses or when a hospital discharge is recorded. It accumulates, in both its gains and its failures.

The problem is that no stakeholder today takes full responsibility for that third clock. Payers track medical-loss ratios and cost performance year by year. Providers deliver care and collect payments for one visit, one admission, or one DRG at a time. The consequence is a structural bias toward short-term targets that influence the design of utilization management. Policies are written to contain costs inside a fiscal boundary, not to nurture health across decades. Incentives are aligned to close today's charts or balance this year's budget, not to sustain the person through tomorrow's illness or next year's complications.

This is the lifetime blind spot. Three clocks, the payer, the provider and the person, none in synchronicity with one another, all making decisions according to their own time frames while the person whose body and mind carries the compounding results of those decisions, is the only one living out the human cost and burdening the overall system. The lifetime blind spot is illustrated in the diagram below.



For example, a step therapy restriction for psychotropic drugs that nominally smoothed formulary spend by about $208 per patient per year was offset by a 16% rise in total costs and a 23% increase in inpatient spending, underscoring how short-term savings can often increase long-run human and system burden.

Membership statistics make this further clear. In Medicaid, the typical enrollee has coverage for less than ten months in a year, and about ten percent lose and regain coverage within twelve months. In

Medicare Advantage, annual churn exceeds fifteen percent, while in exchange plans it can approach twenty-five percent. These churn levels mean that neither payers nor providers can assume long-term engagement, reinforcing short-term behavior by design.

Putting the Lifetime Blind Spot in Motion: Cancer, Three Clocks, Three Incentives

Below is an example of how the three clocks play out differently among the payer, provider and the person.

1. The Payer's Clock

- Payers operate on 12-month medical loss ratios (MLR). If a high-cost treatment like radiation or immunotherapy costs $50,000 today, and the patient likely churns next year (by 20–25 %), the plan may never recoup its investment, even if the treatment extends life by years.
- That makes paying today a financial risk, not an investment. A payer saved $50,000 this year, but if the member leaves tomorrow the "return" on that spend evaporates outside the reporting window.

2. The Provider's Clock

- Providers are paid by episodic revenue: a radiation course, imaging exam, or chemotherapy infusion. Many oncology practices report 70–80 % of their revenue from episodic services.
- Every delay from prior authorization not only delays care but directly impacts scheduling efficiency and revenue per linear accelerator or infusion chair. Their incentive is to keep throughput steady, not slow down for long-term outcomes.

3. The Person's Clock

- A growing body of evidence quantifies the human cost of delay. In one study, each week's delay in initiating radiation or systemic therapy increased mortality risk by up to 4 % in lung cancer, and 1–3 % across various cancers. That may seem incremental, but over time it multiplies as a five-week delay equates to a 5–20 % higher chance of cancer-related death.
- These stakes are life itself, not financial. They reflect true lifetime value yet are invisible to payers and providers measuring performance within years or episodes.

Summary Table: Incentive Misalignment in Action

Stakeholder	Time Horizon	Incentive Focus	Numeric Example
Payer	12-month MLR / churn	Cost avoidance in the short term	$50K saved today is a win if member does not churn
Provider	Episode/Reimbursement	Throughput and volume; avoid delays	70–80 % revenue tied to episodic oncology services
Person	Lifetime wellness	Survival, quality, years of life	Delays cause 1–3 % per week higher mortality, up to 4 % in some cancers

How Are People Responding?

Members and patients are not standing still. They are learning new paths through a complex system and, in some cases, finding leverage that did not exist even a year ago.

Example 1: DIY AI appeals. New consumer tools now draft personalized appeal letters in minutes. Services like Claimable and Fight Health Insurance guide patients through a short intake, cite clinical guidelines and policy language, and produce a structured appeal that a human can review and submit. General chatbots are also being used by patients to draft appeals quickly. ClearHealthCosts documented a step-by-step case using ChatGPT to generate a strong appeal letter in under five

minutes. This trend matters because consumers rarely appeal on their own. On HealthCare.gov plans in 2023, fewer than 1 percent of in-network denials were appealed. AI reduces that activation barrier.

Example 2: Going straight to the state for external review. Generally, patients can request a review of a prior authorization by the same specialty as an external review which the insurance company has to pay for. If after such an external review, the insurance company still does not reverse their denial, the case can be taken to State appeal. In California, members who escalate to an Independent Medical Review at the Department of Managed Health Care receive the requested service in about 72% of qualified cases, either because the plan reverses itself or an independent reviewer overturns the denial. The state also publishes plain-language guidance and real case summaries that show people how to file. New York's Department of Financial Services runs a similar process and maintains a searchable external-appeal portal for consumers and clinicians. These channels are more visible to members today than in the past, and the success rates give them a credible path outside the plan's internal loop.

Example 3: Switching or abandoning plans altogether when access breaks down. Sicker beneficiaries are increasingly willing to leave plans or leave insurance altogether that they perceive as blocking care. Several studies show that Medicare Advantage enrollees with poor health or high service needs are significantly more likely to switch to traditional Medicare, often driven by access and prior authorization barriers. A recent Health Affairs study summarized by Managed Healthcare Executive found that dissatisfaction with access and quality, more than out-of-pocket costs, predicts switching out of Medicare Advantage altogether. In other instances, members are taking on the burden of negotiating procedures directly with the health system without any insurance at all.

Taken together, these behaviors signal a quiet rebalancing. As of the timing of this paper, one can assume that members can and will appeal with better tools, escalate to the state with meaningful odds, and vote with their feet when access falters.

The Failed Promise

For more than two decades, health care leaders have looked to payer–provider collaboration as a cure for misaligned incentives. The promise has been that if insurers and physicians could find common cause, they might reduce friction, streamline prior authorization, and advance genuine patient-centered care. Unfortunately, reality has fallen short.

For example, Norton Healthcare and Humana, launched one of the country's most closely watched Accountable Care Organization pilots in 2012. With shared governance, joint performance goals, and a commitment to lowering costs, it seemed to offer a new template. Yet, despite early enthusiasm, the model failed to scale. Cost savings did not materialize at the levels promised, and providers chafed at the burden of managing multiple, often conflicting, payer rules.

This pattern has repeated itself across the industry. The California Health Care Foundation documented community care pilots designed to align incentives around palliative and chronic care. The pilots collapsed when administrative friction, inconsistent metrics, and unilateral program design by payers eroded provider trust. Even within Medicare, disease management demonstrations spent more than $360 million without reducing hospital admissions or overall spending. What was supposed to be a collaborative innovation became another layer of bureaucracy.

So why do these collaborations keep failing? There are several reasons shown below:

- **High administrative burden**: While the concept of collaboration is easily adopted, the reality of administrative burdens to both providers (for managing multiple payer contracts and data feeds for analysis) and payers (for managing multiple contracts with different terms with different provider) seems to outmaneuver the original idea. The American Medical Association surveys show that several administrative burdens exist such as 93 % delay in care, 89 % burnout, 78 % treatment abandonment managing PA denials and approvals. All of these types of burdens stretch administrative teams thin.

- **Erosion of trust**: 78 % of hospitals say their relationships with commercial insurers are worsening, undercutting collaborative goodwill. Many have decided to abandon certain payer contracts.
- **ACO failure to reduce cost**: All four major Medicare ACO experiments failed to reduce spending significantly, showing that structural alignment alone doesn't deliver savings.
- **Deep-seated distrust**: Physician distrust of payers remains pervasive and rooted in decades of adversarial interactions. This acts as a barrier to genuine partnership.

These failures matter for prior authorizations. Without true structural collaboration that aligns incentives across the lifetime of care, prior authorization remains a defensive mechanism. It remains fragmented, adversarial, and disconnected from the patient's continuum. Past efforts were not just insufficient; they illuminate why the lifetime blind spot remains unaddressed.

The Missing Link

For all the attention paid to payer–provider collaboration, the truth is that the missing link lies elsewhere. Until there is a stakeholder who owns lifetime value, prior authorization will remain a revolving barrier and can only improve incrementally. We contend that the missing stakeholder must be the end person who plays the role of a patient AND a member. Payers and providers will continue to measure success in annual budgets or episodic reimbursements, but the person lives with the consequences of each decision. If the system is ever to escape the cycle of short-term gamesmanship, the person must become the central actor in utilization management. Activated persons, supported by clear rules, transparent data, and proper navigation, can shift the balance of power and force both payers and providers to act with a longer horizon in mind.

In part 2 of this article series, we expound upon how such a person-centered payer-provider collaboration can work.

The Long View

In the long view, the winners will be those plans and health systems that design beyond the budget cycle and beyond the episode. Success will belong to those that engage, activate, and continually serve the person across the person's full journey. From that perspective, consumer service and clinical service must become synchronous and not at odds with each other. The key to lasting differentiation is not in short-term gains, but in creating trust and value that endure for a lifetime.

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