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How Health Insurance Denials Induce Administrative Burdens, and How to Fix It

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Key Findings

- 36% of Americans experience at least one, and often multiple, health insurance coverage denials, across a range of health services. Prior authorization is a key vehicle for denials.
- Less affluent patients are less likely to appeal denials, with those making $25,000 annually being 9 percentage points less likely than those making $100,000 to appeal.
- Approximately half of patients, especially those who are lower-income and Black or Hispanic, postpone medical care and other purchasing following a denial, and nearly half of those postponing medical care reported getting worse. Denials thus serve as a key vehicle for deepening existing inequities in U.S. health care.

When Jessica learned in her late 20s that she had a rare and severe immunodeficiency, she was prescribed subcutaneous immunoglobulin therapy (scIG), which required prior authorization that was promptly denied by her private health insurer. The reason for the denial was puzzling: she had not yet experienced a sufficiently life-threatening infection. While she pursued the appeal over the subsequent several months, she was forced to take approximately a dozen courses of antibiotics to fend off infections. Ultimately, it required that she not only endure the red tape of the administrative appeal process, but that she contact her United States Senator to obtain assistance in covering her required medication.

Though Jessica's condition is rare, her predicament is not. With the enactment of Medicare and Medicaid in 1965, congressional attention turned to cost containment and in turn the introduction of a limited degree of "utilization management" (UM) for select care such as certifying hospital stays. UM expanded with the growth of managed care beginning in the 1980s, with reliance on prior authorization, or pre-approval for health care, extending to surgeries, high tech imaging, high-cost drugs, and other forms of care to contain rising health care costs and guard against overprescribing.

The problem is that prior authorization erects barriers to health care access. My research found that 36% of respondents experienced at least one coverage denial, and 59% of those individuals experienced multiple

denials. Many people who received denials underestimated the odds with which people win insurance appeals, which contributed to a disinclination to appeal denials. Lower-income patients are less likely than their counterparts to appeal denials: every $25,000 decrease in annual household income is associated with a 3-percentage point decrease in propensity to appeal a coverage denial, such that a patient earning $25,000 per year is 9 percentage points less likely to appeal than someone earning $100,000 per year. What's more, while just over half of patients were successful in their appeals, Black or Hispanic Medicaid recipients are significantly less likely to prevail in this endeavor, highlighting the way that this insurance practice of coverage denials reinforces existing inequities along race and class lines.

Coverage denials hurt health outcomes even when a person successfully appeals the denial. Even among those who win their appeals, it leads to high levels of health care postponement—with 45% of those individuals reporting a worsening of their condition—and purchasing postponement. My research showed that the negative health outcomes from this postponement disproportionately affected patients who are less affluent and identify as Black or Hispanic.

The Proliferation of Utilization Management in Health Insurance

Utilization management proliferated as America witnessed the expanded reliance on managed care, which has extended to areas such as Medicare with Medicare Advantage and managed Medicaid. Indeed, the only health insurance program that is virtually free of it is traditional Medicare. UM has a few central goals: to contain the already very high costs of health care in the United States, and relatedly to guard against physician overprescribing, which contributes to both higher cost care as well as risk of patient harm.

The savings to health insurers can come at the cost of patients' health. Implementation of utilization management can often have the effect of delaying access to care due to protracted review processes, in some cases keeping prescribed care out of reach altogether through denials (which according to Change Healthcare have increased from 9% to 12% of claims between 2016 and 2022), in addition to imposing administrative burdens on patients and their physicians, who must maintain staffing for the processing of prior authorizations and be available for "peer-to-peer" reviews of prescribed care.

The issue of coverage denials is going to be even more significant as insurers increasingly turn to AI to process large volumes of prior authorizations, with potential for errors that have significant administrative burden and inequality implications for American patients and their physicians.

Ensuring Patients Receive Needed Care

In September 2022, the House of Representatives supported by a voice vote the Ensuring Seniors' Timely Access to Care Act, which would have streamlined the prior authorization process within the setting of Medicare Advantage, ensuring electronic prior authorizations processed within a shorter time span. While this would not eliminate the administrative burden of physicians' submission of prior authorizations, it would mitigate delays associated with their processing, allowing more timely access to treatments.

Increasing reliance on independent medical reviews (IMRs) of health insurer decisions regarding medical necessity is integral to promoting access to prescribed care. There is currently state variation in guaranteed access to IMRs, with California leading the way, and improving access to reviews external to health insurers

would also mitigate patient administrative burdens by allowing them to avoid multi-stage internal appeal processes.

Transitioning from prior authorization to audits of physician prescribing would guard against runaway health care costs and overprescribing. However, it would target the “bad actors” – that is, the overprescribers – without imposing front-end barriers to health care access.

A key impediment to health reform is the Employee Retirement Income Security Act (ERISA) of 1974, which governs self-insured health plans (covering approximately 65% of workers in employer-sponsored health plans) and limits legal recourse to those who have been denied, and additionally preempts state health policy action. Amending ERISA to allow wrongly denied patients to recover damages and attorney’s fees (as Congress tried to do with the proposed Patient’s Bill of Rights) would promote health insurer accountability in claim processing.

Policy Recommendations

- Pass the Ensuring Seniors’ Timely Access to Care Act
- Require states to provide for IMR without first exhausting administrative remedies
- Transition toward reliance on random audits of physician prescribing
- Amend ERISA to provide for damages and attorney’s fee recovery after wrongful denial