Denials of health insurance claims are rising, and getting weirder

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Millions of Americans in the past few years have run into this experience: filing a health care insurance claim that once might have been paid immediately but instead is just as quickly denied. If the

experience and the insurer's explanation often seem arbitrary and absurd, that might be because companies appear increasingly likely to employ computer algorithms or people with little relevant experience to issue rapid-fire denials of claims—sometimes bundles at a time—without reviewing the patient's medical chart. A job title at one company was "denial nurse."

It's a handy way for insurers to keep revenue high—and just the sort of thing that provisions of the Affordable Care Act were meant to prevent. Because the law prohibited insurers from deploying previously profit-protecting measures such as refusing to cover patients with pre-existing conditions, the authors worried that insurers would compensate by increasing the number of denials.

And so, the law tasked the Department of Health and Human Services with monitoring denials both by health plans on the Obamacare marketplace and those offered through employers and insurers. It hasn't fulfilled that assignment. Thus, denials have become another predictable, miserable part of the patient experience, with countless Americans unjustly being forced to pay out-of-pocket, or faced with that prospect, forgoing needed medical help.

A recent KFF study of ACA plans found that even when patients received care from in-network physicians—doctors and hospitals approved by these same insurers—the companies in 2021 nonetheless denied, on average, 17% of claims. One insurer denied 49% of claims in 2021; another's turndowns hit an astonishing 80% in 2020. Despite the potentially dire impact that denials have on patients' health or finances, data shows that people appeal only once in every 500 cases.

Sometimes, the insurers' denials defy not just medical standards of care but also plain old human logic. Here is a sampling collected for the KFF Health News-NPR "Bill of the Month" joint project.

- Dean Peterson of Los Angeles said he was "shocked" when payment was denied for a heart procedure to treat an arrhythmia, which had caused him to faint with a heart rate of 300 beats per minute. After all, he had the insurer's preapproval for the expensive ($143,206) intervention. More confusing still, the denial letter said the claim had been rejected because he had "asked for coverage for injections into nerves in your spine" (he hadn't) that were "not medically needed." Months later, after dozens of calls and a patient advocate's assistance, the situation is still not resolved.
- An insurer's letter was sent directly to a newborn child denying coverage for his fourth day in a neonatal intensive care unit. "You are drinking from a bottle," the denial notification said, and "you are breathing on your own." If only the baby could read.
- Deirdre O'Reilly's college-age son, suffering a life-threatening anaphylactic allergic reaction, was saved by epinephrine shots and steroids administered intravenously in a hospital emergency room. His mother, utterly relieved by that news, was less pleased to be informed by the family's insurer that the treatment was "not medically necessary."

As it happens, O'Reilly is an intensive-care physician at the University of Vermont. "The worst part was not the money we owed," she said of the $4,792 bill. "The worst part was that the denial letters made no sense—mostly pages of gobbledygook." She has filed two appeals, so far without success.

Some denials are, of course, well considered, and some insurers deny only 2% of claims, the KFF study found. But the increase in denials, and the often strange rationales offered, might be explained, in part, by a ProPublica investigation of Cigna—an insurance giant, with 170 million customers worldwide.

ProPublica's investigation, published in March, found that an automated system, called PXDX, allowed Cigna medical reviewers to sign off on 50 charts in 10 seconds, presumably without examining the patients' records.

Decades ago, insurers' reviews were reserved for a tiny fraction of expensive treatments to make sure providers were not ordering with an eye on profit instead of patient needs.

These reviews—and the denials—have now trickled down to the most mundane medical interventions and needs, including things such as asthma inhalers or the heart medicine that a patient has been on for months or years. What's approved or denied can be based on an insurer's shifting contracts with drug and device manufacturers rather than optimal patient treatment.

Automation makes reviews cheap and easy. A 2020 study estimated that the automated processing of claims saves U.S. insurers more than $11 billion annually.

But challenging a denial can take hours of patients' and doctors' time. Many people don't have the knowledge or stamina to take on the task, unless the bill is especially large or the treatment obviously lifesaving. And the process for larger claims is often fabulously complicated.

The Affordable Care Act clearly stated that HHS "shall" collect the data on denials from private health insurers and group health plans and is supposed to make that information publicly available. (Who would choose a plan that denied half of patients' claims?) The data is also supposed to be available to state insurance commissioners, who share with HHS the duties of oversight and trying to curb abuse.

To date, such information-gathering has been haphazard and limited to a

small subset of plans, and the data isn't audited to ensure it is complete, according to Karen Pollitz, a senior fellow at KFF and one of the authors of the KFF study. Federal oversight and enforcement based on the data are, therefore, more or less non-existent.

HHS did not respond to requests for comment for this article.

The government has the power and duty to end the fire hose of reckless denials harming patients financially and medically. Thirteen years after the passage of the ACA, perhaps it is time for the mandated investigation and enforcement to begin.

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