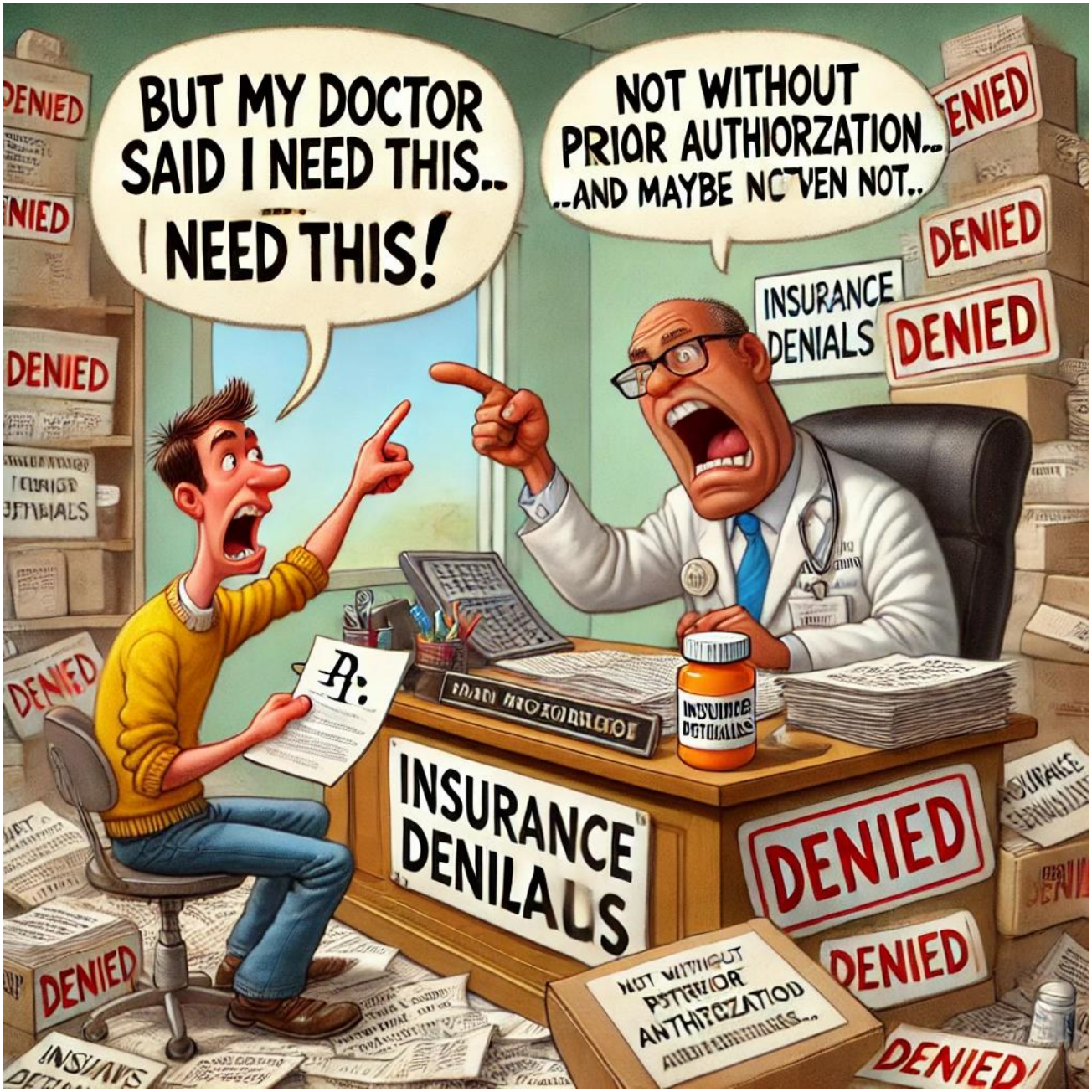
Consumer Perspectives on Insurer Denials, Prior Authorization & Appeals

CARL SCHMID

HIV + HEPATITIS POLICY INSTITUTE

MARCH 25, 2025


BUT MY DOCTOR SAID I NEED THIS..
I NEED THIS!
NOT WITHOUT PRIOR AUTHIORZATION..
..AND MAYBE NOT EVEN NOT..
INSURANCE DENIALS
DENIED
INSURANCE DENILAUS
DENIED
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DENIED


THE WALL STREET JOURNAL.
Health Insurers Deny 850 Million Claims a Year. The Few Who Appeal Often Win.
Patients who contest denials face a daunting process, but many are successful. 'This appeal saved my life.'

KFF

NEWS ALERT

Claims Denials and Appeals in ACA Marketplace Plans in 2023

Justin Lo, Michelle Long, Rayna Wallace, Meghan Salaga, and Kaye Pestaina

Published: Jan 27, 2025

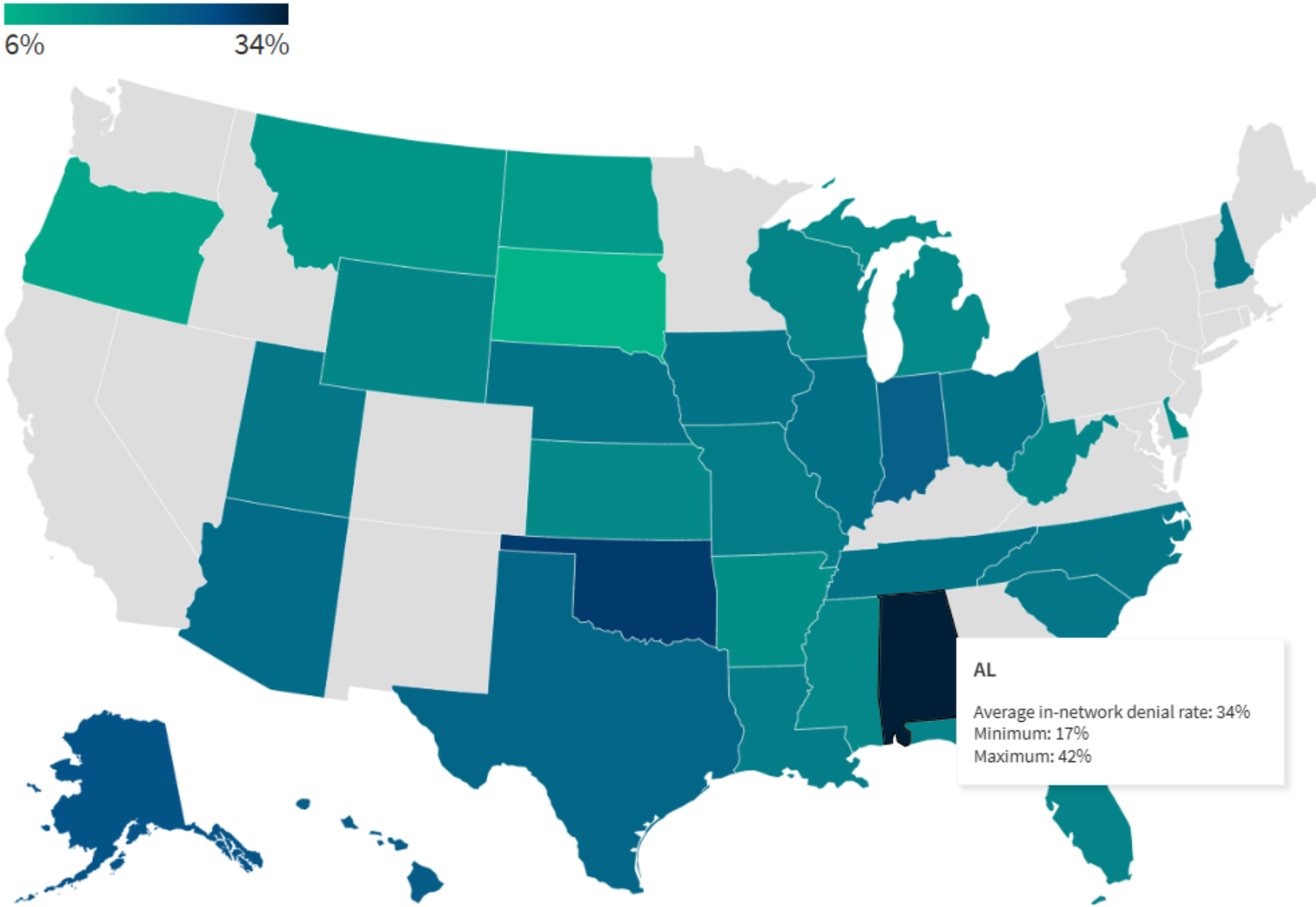
HealthCare.gov Insurers Denied Nearly 1 in 5 In-Network Claims in 2023, but Information About Reasons is Limited in Public Data

Enrollees Rarely Appeal Claims Denials; When They Do, Insurers Often Uphold the Original Denial

- Consumers rarely appeal denied claims (fewer than 1% of denied claims were appealed) and when they do, insurers usually uphold their original decision (56% of appeals were upheld).

Source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/

Average Denial Rates For In-Network Claims By HealthCare.gov Issuers, By State, 2023



Source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/

Reasons For In-Network Claims Denials Among HealthCare.gov Plans, 2023

Denial reason	Total	Share
Other reason not listed	24,274,807	34%
Administrative reason	12,591,104	18%
Service excluded	10,988,868	16%
Enrollee benefit limit reached	8,444,754	12%
Lack of referral or prior authorization	6,460,181	9%
Not medically necessary *(excluding behavioral health)*	3,878,165	5%
Member not covered	3,723,250	5%
Not medically necessary *(behavioral health only)*	467,516	1%
Investigational experimental cosmetic procedure	123,173	0%

Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year • Get the data • Download PNG

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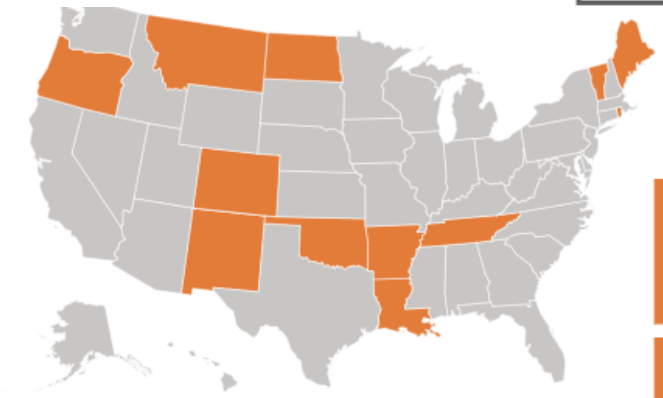
State PA Laws (2022-24)

Bills
3
States
3
Clear Filters

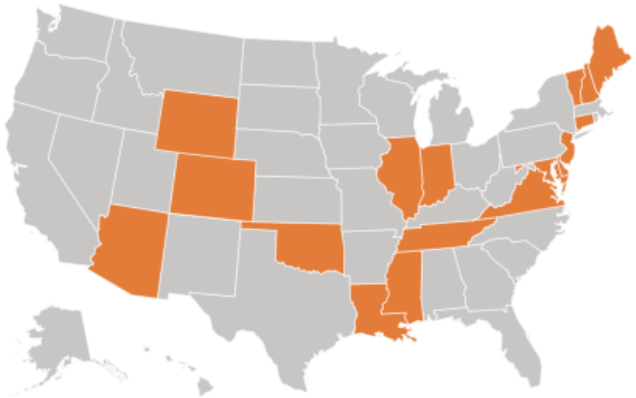
2022

Bills
22
States
12
Clear Filters



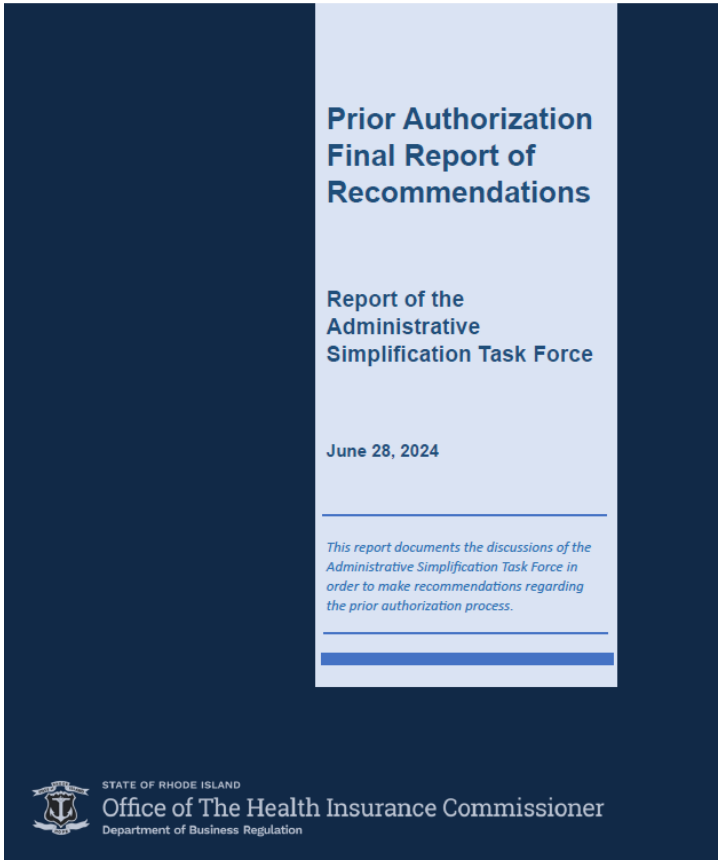
2023

Bills
20
States
17
Clear Filters



2024

States Implementing PA Laws



COLORADO
Department of Regulatory Agencies
Division of Insurance

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE ACCIDENT AND HEALTH

Amended Regulation 4-2-49

CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS AND THE REQUIRED DRUG APPEALS PROCESS

States Considering New Laws

Montana Looks To Regulate Prior Authorization as Patients, Providers Decry Obstacles to Care

By Mike DennisonFebruary 13, 2025

Deny and Delay? California Seeks Penalties for Insurers That Repeatedly Get It Wrong

Christine Mai-Duc:February 18, 2025

Insurers Reducing PA

September 08, 2023 11:35 AM

Michigan Blue Cross to axe 20% of prior authorization requirements

NONA TEPPER

January 30, 2025 11:49 AM

Cigna to spend $150M to improve prior auth, patient advocacy: CEO

NONA TEPPER

March 03, 2025 10:37 AM

UnitedHealthcare to cut 10% of prior authorizations

LAUREN BERRYMAN

Federal Changes that Impact State Efforts

- Prior Authorization and Interoperability final rule
  - Impacts MA, Medicaid, CHIP, and QHPs on the federal marketplace
  - Requirements include: specific reason for denial, shortened response times, public reporting, and automation
  - No changes for prescription drugs, but a proposed rule is anticipated
- 2024 Medicare Advantage final rule
  - Numerous meaningful changes that states can borrow from
  - New limits on use of PA, bans retroactive denials, PA approvals as long as medically necessary, grace period with new plans, expert reviewers, and more!
  - Also includes limits on AI for PA determinations

Suggested Increased Transparency of NAIC MCAS Health Data

National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC), via the Market Conduct Annual Statement (MCAS), collects uniform data annually on claims denials, prior authorization requests, appeals, and more from many insurers in the individual and group markets in nearly every U.S. state. MCAS data are intended to help state insurance regulators monitor the market conduct of insurance companies, and insurers can use this information to identify areas to improve performance. However, full MCAS health insurance data are shared with state regulators only, not the general public or CMS. A limited national summary published by the NAIC shows that the average claims denial rate for both in- and out-of-network claims (excluding pharmacy) in 2023 was about 16%.

MCAS State Ratio Distribution Report for Data Year 2023

Health Ratios - National Level

		2023
Ratio 1	The number of claim denials to the total number of claims received (Excluding Pharmacy)	15.786%
Ratio 2	Percentage of in-network claims (Excluding Pharmacy)	92.964%
Ratio 3	Percentage of out-of-network claims (Excluding Pharmacy)	7.036%
Ratio 4	Percentage of in-network claims paid within 30 days (Excluding Pharmacy)	95.929%
Ratio 5	Percentage of in-network claims denied within 30 days (Excluding Pharmacy)	91.832%
Ratio 6	Percentage of out-of-network claims paid within 30 days (Excluding Pharmacy)	90.284%
Ratio 7	Percentage of out-of-network claims denied within 30 days (Excluding Pharmacy)	85.516%
Ratio 8	Percentage of claims paid (Pharmacy Only)	75.378%
Ratio 9	Insured co payment responsibility to covered lives (Excluding Pharmacy)	$171.04
Ratio 10	Insured coinsurance responsibility to covered lives (Excluding Pharmacy)	$195.42
Ratio 11	Insured deductible responsibility to covered lives (Excluding Pharmacy)	$519.33
Ratio 12	Cost sharing responsibility to covered lives (Pharmacy Only)	$231.17
Ratio 13	Adverse determination grievances per 1,000 member months	1.016
Ratio 14	Adverse determinations overturned to total grievances involving adverse determinations	36.348%
Ratio 15	Adverse determinations upheld to total grievances involving adverse determinations	63.154%
Ratio 16	Grievances not involving adverse determinations per 1,000 member months	0.443
Ratio 17	Customer requested appeals on final adverse determinations to an external review organization (ERO) per 1,000 member months	0.029
Ratio 18	Final adverse determinations upheld upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.592
Ratio 19	Final adverse determinations overturned upon request for external review to number of requested appeals on final adverse determinations to an external review organization (ERO)	0.354

Data on Denied Claims

Qualified Health and Dental Plan Issuers have provided annual data fo

Claims received are defined as the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital, doctor, or dentist) that is contracted to be part of the network for an issuer.

- A claim means any individual line of service within a bill for services (medical, oral and pharmacy).
- Do not include claims that were pended for additional information and subsequently paid.
- Do not include out-of-network claims.

Claims denied are a received claim that the issuer subsequently denied.

- Include all denials in the total number of claims denied in the calendar year. This includes, but is not limited to:
  - Medical claim pediatric vision and pediatric dental denials;
  - Partial denials;
  - Denials due to ineligibility;
  - Denials due to incorrect submission;
  - Denials for incorrect billing; and
  - Duplicate claims.
- Plan level claim denials are reported beginning Plan Year 2018.

Click the links below to see the information the issuers have provided.

Aetna CVSHealth:

Individual Market

2023 Issuer Level Claims

2023 Plan Level Claims

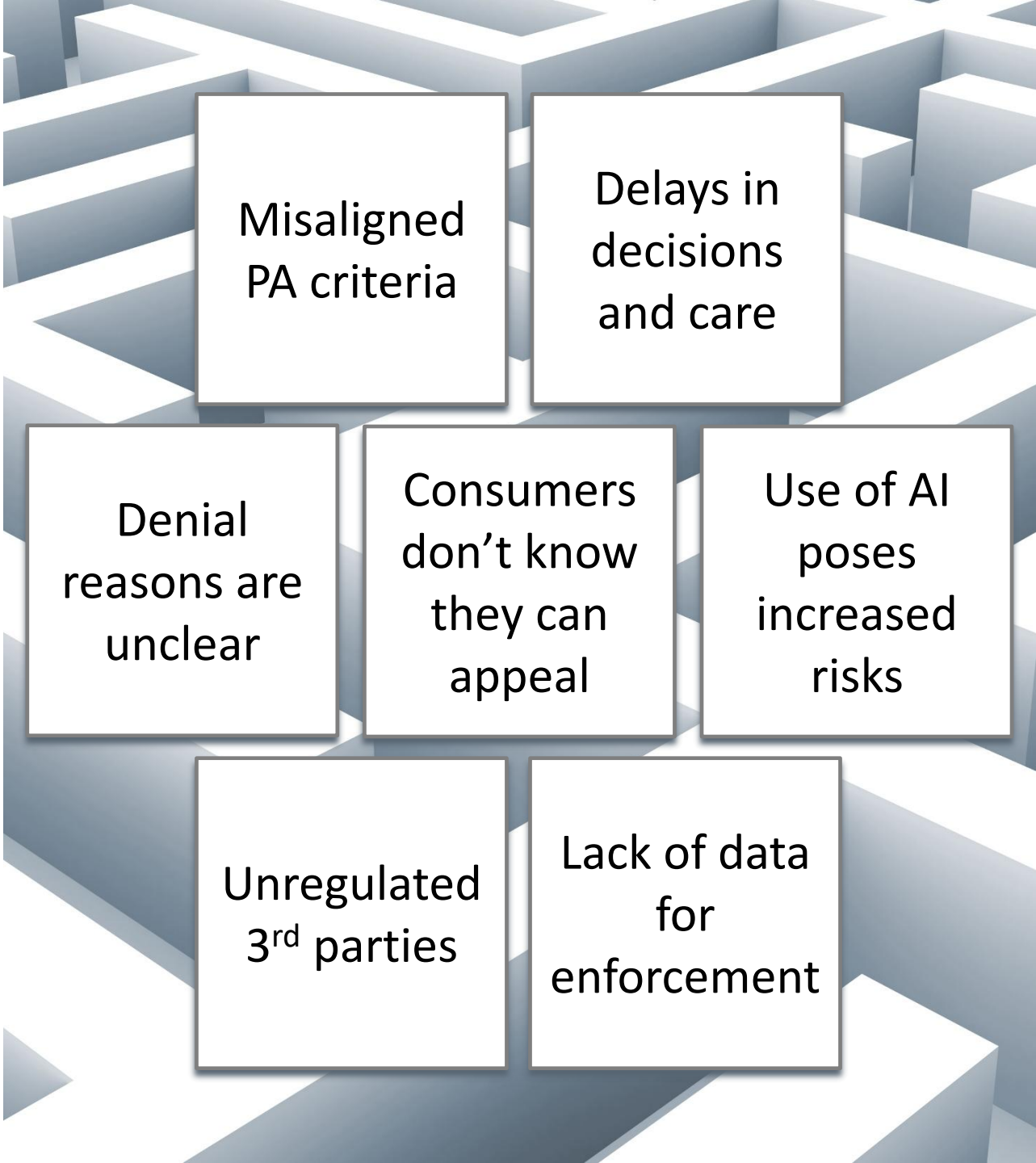
Consumer Recommendations for NAIC Regulatory Framework Task Force:

Prior Authorization White Paper

LUCY CULP

THE LEUKEMIA & LYMPHOMA SOCIETY

Consumers face challenges at many different turns



Explore the implementation and effectiveness of potential policy solutions

PA criteria often misaligned with clinical standards of care

- Transparency in plan documents and on plan websites
- Continuity of care
- Length of approval
- Limitations on PA for certain services
  - Including related protections to avoid new UM being put into place
- Data collection by state agencies
- Reference to clinical standards

Continued: Implementation and effectiveness of potential policy solutions

Delays in decisions and care

- Response time limits
- Interoperability standards

Reason for denial is not clear to consumers or providers

- Reference to clinical standards
- Disclosure of clinical reason for decision to patients and their doctors
- Detailed rationale for additional requests or denials, including admin or medical necessity
- Medical expertise of 3rd party reviewers

Continued: Implementation and effectiveness of potential policy solutions

Consumers don't know they can appeal

- Consumer outreach and education
- Opportunities for 3rd party review of appeals
- "No wrong door" for insurance complaints
- Consumer assistance, navigation programs, and SHIPs

Artificial intelligence and automated decision-making pose risks

- Ensure AI does not perpetuate systemic bias and discrimination against protected classes
- Prohibitions of adverse decisions by AI and other automated decision-making systems
- Meaningful transparency to consumers and regulators
- Monitoring governance and oversight
- Additional work at the NAIC
  - Big Data AI WG health plan survey
  - Model bulletin

Continued: Implementation and effectiveness of potential policy solutions

3rd parties involved in PA lack regulation

- Regulations applied to 3rd parties, including alignment with clinical standards
- Transparency standards
- Audit tools to ensure AI platforms are accurate and do not enshrine bias

Lack of data for enforcement and corrective action

- Robust data collection including service type by plan and category
- Corrective actions for improper denials
- Actuarial assessment framework
- MCAS capabilities and limitations

Thank you!

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