‘Rationing by inconvenience’: Health insurers count on customers not appealing denials

For many patients, the appeal process is just too much

Adobe

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When Jessica (not her real name) learned in her 20s that she had severe immunodeficiency, she was prescribed subcutaneous immunoglobulin therapy (SCIg), a very expensive type of injection treatment that can protect against infection and prevent long-term damage from infections. She had no idea the challenges that would lie ahead when her physician submitted the request for prior authorization, or pre-approval from her private insurer.

The prior authorization was denied. What’s more, in an unusual move, the insurer declined to allow a “peer-to-peer” review of her case between her physician and one working for her insurer.

As she told me when I interviewed her for my research, the denial was puzzling because the treatment was not experimental or investigational for her condition. Indeed, it was for on-label use. Then she read the fine print: She was denied because her infections were not yet life-threatening. *Did they also wait for diabetics to have life-threatening glucose levels before approving treatments?* she pondered.

While she appealed and coordinated with her physician’s and specialty pharmacy’s offices, she continued to acquire infections that necessitated several courses of antibiotics, exposing her to the possibility of antibiotic resistance. She was worn down. She considered it a matter of luck that she was not hospitalized. In an act of desperation, she reached out to the

office of Sen. Bill Cassidy (R-La.), a physician and one of her state's senators, not expecting much to come of it.

But she was in luck. Soon after contacting them, the office contacted her insurer, which approved the drug.

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Most Americans can relate to Jessica's experience of going to the pharmacy expecting to pick up a prescribed medication, only to learn that it was delayed because the insurer had not yet approved it. Or perhaps trying to get a scan to identify the cause of pain. Or a non-emergent surgery.

Largely an artifact of managed care plans guarding against overutilization of health care and excessive health care costs, most plans utilize prior authorization, especially for higher-cost tests and treatments. In fact, there are 182 million prior authorization requests per year in the medical commercial market alone. And in stark contrast with traditional Medicare, 99% of Medicare Advantage enrollees are in plans that have prior authorization requirements, with Medicare Advantage plans alone submitting over 46 million prior authorization requests in 2022.

Though most prior authorizations are approved, 36% of the 1,340 people who responded to my nationwide survey experienced at least one initial denial (usually multiple denials). As Jessica's story highlights, the effects can be devastating both medically and psychologically. In fact, a 2023 Department of Health and Human Services Office of the Inspector General report found high rates of wrongful denial by Medicaid managed care plans, which serve primarily low-income patients. These denials are disruptive not only because of delays, but because of the ensuing confusion and frustration of learning how to be an effective self-advocate.

What's more, that confusion and frustration might be intentional.

A physician employed by the health insurance company Elevance once told me, "We have productivity metrics. We probably have 10 or 15 minutes or so to do reviews and depending on the case, that may not be adequate. And we're told denying things is OK because people can appeal." The problem is that these appeals impose substantial costs on patients, many of whom don't ultimately get their prescribed treatments. While Jessica persisted in her appeal, others do not.

I characterize this dynamic as "rationing by inconvenience." The appeal process's administrative burdens — to draw on the language of Pamela Herd and Donald Moynihan's seminal work on this subject — lead far too many Americans to go without prescribed care not due to *final* denial, but rather because of accumulations of inconveniences and psychological toll leading people to abandon the appeal process. It may even make them more reluctant to seek future treatment.

Herd and Moynihan conceptualize administrative burden as being comprised of three components: learning costs (learning about a program and how to navigate its complexities), compliance costs (the documentation and time costs associated with following administrative rules), and psychological costs (the emotional toll and experience of loss of autonomy). While administrative burdens are typically discussed in the context of public programs (such as Medicaid and SNAP), this framework can be extended to patients' navigation of the increasingly privatized health insurance setting, which is laden with prior authorizations that induce delays and denials of coverage.

These administrative burdens are quite impactful. Despite appeal processes being in place, researchers at the Kaiser Family Foundation have found when looking at ACA marketplace plans that fewer than 1% of denied claims are appealed.

When examining appeal processes of health insurers, it's little wonder why so many people opt out of appealing. Some UnitedHealthcare plans

have appeal packets as long as 14 single-spaced pages, detailing three levels of standard and three levels of expedited appeals. And if the patient is not in a life-threatening situation, the standard appeal can take quite some time: The insurer has 30 days to respond to the initial appeal and 15 days to respond to an internal appeal. It may take up to 26 days to receive the determination from an independent medical review.

In the meantime, the patient may be left untreated or receiving suboptimal treatment because they do not know or have the energy to navigate these barriers to health insurance coverage and, in turn, care.