How Crafty Health Insurers Are Denying Care

You can fight back when your health plan says no

By Bernadine Healy M.D.
Posted August 25, 2008

Britain's government-run health system is under siege for restricting new therapies. The outcries became especially sharp this summer after patients and doctors got wind of plans to deny several new cancer drugs that are widely available in Europe and the United States, including Avastin and Sutent, because they aren't "cost-effective." In an op-ed in the *Daily Mail,* one of Britain's leading oncologists, Jonathan Waxman of Imperial College London, decried a "misguided and barbaric decision to ban four kidney cancer drugs" that double life expectancy. And that means years of life in some cases. You may think this is just a British battle over care denial in a country with rigid caps on its health purse and a penchant for rationing. Not so. In the United States, it's private insurance companies, which make hefty profits managing half of America's medical expenditures for the non-Medicare population, that in ways often hidden and arbitrary have the authority to deny coverage—and therefore, in all too many instances, care.

(Getty Images)

Video: Health Insurance Basics

Outrage tends to bubble up when denials become human drama, triggering media interest. There's the 17-year-old girl who died before her liver transplant was approved. Or the people in California whose insurers canceled their policies retroactively after they got sick. What's often missed is that these cases are the tip of an opaque iceberg. An estimated 10 to 15 percent of claims are denied for various reasons, some of them technical, such as not meeting filing deadlines or failing to get pretreatment authorizations. Denials that produce the most disputes are those where insurers judge the care to be unnecessary or unproven, pitting a proverbial sick David against a multibillion-dollar Goliath. What few Davids know is that insurance contracts by law grant companies the legal right to manage a patient's care, including denying it, sight unseen, and give them the final say, if challenged. Unless the state steps in.

Many denials are iffy calls and can appear distinctly arbitrary, with one insurer saying no to a particular therapy or procedure while others reimburse for it. An FDA-approved drug might be denied because it's used off-label, even if it is shown to work in peer-reviewed reports. In cancer care, the generally expensive intravenous chemotherapy drugs given in a doctor's office are typically

covered, while an equivalent, if not better, therapy taken at home orally is not. When insurance authorization is required for each new service or each hospital stay for the same serious illness, who's best to say what's medically necessary? Doctors and their staff will spend hours trying to get the approvals, but patients should be warned that if the company ultimately denies payment, for whatever reason, it's the patients who are responsible—with bill collectors ready at their door.

The problem is bound to grow as insurers make use of sophisticated data tools dubbed "denial engines," which are touted to reduce reimbursements by 3 to 10 percent. Bearing brand names like Ingenix Detection Software and Bloodhound Technologies' ClaimsGuard, they search patient records for any signs that claims have strayed outside company parameters. Weeding out fraud or speeding up processing is one thing; serving up excuses to deny legitimate coverage is another.

More than ever, people must study the details of their health plans. A few insurers, like Aetna, offer on their website a useful list of all services they *won't* cover—and why. And know that every insurance company is mandated to have an internal appeals process, though there is little openness to help those seeking reconsideration, such as information on

similar appeals and their outcome or the data used for denial. Nor do insurers provide much detail about the professionals making decisions. Who are they? What's their experience? Are they moonlighters denying care from New Delhi? (Yes, many large insurers are now outsourcing claims adjudication to India.)

But those with the stamina to endure the many exhausting steps of internal review sometimes win. Even if you lose, completing the formal written internal appeal makes you eligible for an independent external review in 43 states and the District of Columbia. State reviews overturn about half of insurers' decisions, and in most states that's final. Nancy Nielsen, president of the America Medical Association and a former chief medical officer of a nonprofit insurance plan, says, "If health insurers are making coverage decisions that are fair and compassionate, very few will be overturned by the state's external appeal process." The numbers speak for themselves.

The lack of transparency in the face of such mighty discretionary authority is drawing the attention of state attorneys general. Andrew Cuomo of New York has launched a nationwide investigation into schemes that low-ball reimbursement and stick patients with bills insurance companies should have paid. "All too often," Cuomo says, "insurers play a game of deny, delay, and deceive." His pursuit is in full throttle and has the advantages of his bully

pulpit and his power of subpoena to pierce the opaque veil that patients never can.