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Insurers' Black Box

Now-Secret Claims Denial Rates Could Tell Consumers a Lot About Their Insurance Company



SOURCE: iStockphoto

Claims data showing wide variations between companies in rejection rates, or that an insurer greatly increased claims rejections from one year to the next, could be an alarm for regulators to investigate.

By Scot J. Paltrow | October 23, 2009

[Read the full memo](#) (pdf)

Key points

- The rate at which insurance companies deny claims is critical for consumers to know when shopping for insurance—but today insurance companies are keeping those rates secret.
- Claims denial rates have been released in only one state—California—and the data shows dramatic variations in denial rates among companies, which one expert says should raise an alarm for regulators.
- When it comes to claim denials, insurers may be putting profits ahead of patients' best interests. Most major insurance companies have reassigned their medical directors—the doctors who approve or deny claims for medical reasons—to report to their business managers, whose main responsibility is to boost profits.

Introduction

The health care reform bills pending in Congress would require nearly every American to have health insurance. Millions of people would have to shop for coverage for the first time. Yet some of the most useful information for choosing a policy remains top secret—locked away in health insurers' computers.

Consumers have a strong interest in picking a company that will reliably pay their legitimate claims when they need medical treatment. But health insurance companies don't disclose the percentage of claims they reject and decline to pay. And inquiries by the Center for American Progress show that the nation's insurance regulators have not asked them to do so.

CAP in recent weeks launched an investigation to determine whether data on commercial health insurers' claim denial rates is available nationwide or in any states. The research included interviews with multiple senior officials of the National Association of Insurance Commissioners, other current and former insurance regulators and government officials in states around the country, officials at health insurance companies, academic experts, and others. All said that no such data is available. No state insurance regulators or federal agencies require insurers to disclose their claim denial rates, except in California. California's Department of Managed Health Care requires insurers to include it in reports they file.

CAP also asked each of the nation's seven largest for-profit health insurers—Aetna, Anthem Blue Cross Blue Shield, Cigna, Coventry, Health Net, Humana, and UnitedHealth care—if for the purposes of this report they would disclose their overall rates claims denials and breakdowns by reason for the denials. All of the companies declined or did not give any direct response to the request. Spokesmen for the companies in general said that the insurers pay the vast majority of claims, and that denials are fair with most occurring for routine reasons such as a patient erroneously submitting the same claim twice or a physician sending a claim to the wrong company.

But the reports from California indicate why health insurance companies may be reluctant to disclose their claim denial rates. That data shows that three of the six largest health insurance companies in the state each denied 30 percent or more of all claim filed in the first six months of 2009. It also showed wide variations in denial rates among the companies.

The California Nurses Association—which disclosed the data—says that the high percentage of denials by some California health insurers strongly suggests that the insurers are going beyond reasonable standards to reject claims and may be improperly using claims to boost profits. California Attorney General Jerry Brown has launched an investigation into the claims denials in response to this new data, although the California insurers deny making improper denials and say the raw percentages of rejections are misleading.

Other evidence also suggests that insurers may be rejecting significant numbers of valid claims due to constant pressure to boost profits and satisfy shareholders. Information has emerged recently in congressional hearings on the health care debate, press accounts of individuals' confrontations with insurers over payment for treatment, and from scores of interviews by the Center for American Progress.

"Claims denials are probably the most effective way the industry has to manage medical expenses," says Wendell Potter, who in 2008 resigned as a senior public relations executive at health insurance company Cigna Corp. Potter is now an outspoken critic of health insurers and said the companies put pressure on employees to help control losses and meet the companies' financial goals including doctors and nurses who make decisions on whether to allow or reject claims based on medical necessity.

Questions about reliable claims payment will be particularly important if Congress passes federal health care legislation, because it would require the government to subsidize, through tax credits, insurance coverage for low-income individuals. Members of Congress and the public may demand to know if the government is getting its money's worth.

Blurring the lines of "medical necessity"

A claims denial occurs when an insurer declines to pay requested reimbursement for specific services for a patient, such as doctor visits, treatment, medical procedures, or hospital stays. Denials fall into three categories: Eligibility issues, which occurs when a patient's coverage has expired or a type of treatment, such as cosmetic surgery, is explicitly excluded in the health insurance policy; administrative issues, such as when a claim form is filled out improperly; and appropriateness issues, or decisions that certain treatments aren't medically necessary, or are experimental and not yet proved effective.

The most sensitive and potentially controversial claims are those based on medical criteria—such as whether a treatment is medically necessary or should not be covered because it is deemed experimental. CAP learned in interviews with former senior medical personnel at several of the largest insurers that big insurers—including Aetna, Cigna, and UnitedHealth care—made internal changes in recent years that gave business executives more direct authority over the companies' doctors who evaluate claims based on these medical criteria.

Insurance companies had previously maintained a separation between the medical evaluation staff and the executives responsible for financial performance. The doctors and nurses reported to the companies' chief doctor—known as the chief medical officer—who had final say on whether coverage for a particular individual's treatment should be granted or denied based on medical criteria. But beginning about a decade ago, in a shakeup that evidently received no public attention, companies changed their

the doctors' pay, bonuses, and promotion, and consequently they gained the power to influence the doctors' decisions. The new systems generally kept "dotted line" reporting to the chief medical office, who would still weigh in on the most difficult claims decisions.

Insurers likely deny millions of claims annually

Kevin Lembo, the Connecticut state government's health care advocate for HMO and managed care patients, said disclosure of claims denial rates, "Would be incredibly useful. As a straight consumer choice issue, really at the end of the day what do consumers want? They want their insurance carriers to pay their bills."

Former Indiana Insurance Commissioner Sally McCarty said claims data showing wide variations between companies in reject rates, or that an insurer greatly increased claims rejections from one year to the next, could be an alarm for regulators to investigate.

The issue of rejected claims has received relatively little public attention in the health care debate, while news coverage has focused more on disclosures in congressional committee hearings about other practices, such as rescissions. Rescissions are much less common than claim rejections and occur when health insurers cancel an individual's coverage altogether, often when a policyholder files a claim for an expensive treatment. The companies involved commonly justify rescissions on the grounds that the policyholder had improperly failed to disclose a pre-existing condition, even if this was minor and unrelated to the illness prompting the claim.

There is no reliable estimate of the total number of health care claims that insurers deny annually. But Mark Rieger, chief executive of National Health care Exchange Services, which collects claims data from physicians, says the number certainly is in the millions annually. Rescissions are estimated to be only in the thousands.

Insurers say that they base decisions to turn down claims only on objective, clear-cut standards, but individual stories highlight that companies at times can take wide latitude in applying them. For example, records from a federal lawsuit in North Carolina show that Cigna of North Carolina refused to pay for specialized treatment for a baby born with a severely deformed skull. The baby's doctors wanted to use an orthotic device to help mold her head into a more normal shape as she grew. The doctors said that without the treatment more medical problems could ensue, such as a worsening malformation of her jaw. Cigna declined to pay on the ground that such treatment was a "cosmetic procedure." A 2002 federal appeals court decision noted that Cigna never provided any definition of "cosmetic procedure" in its policy and ordered the company to pay.

John Powell, a New York State insurance department official who monitors health insurers, says some seize on technicalities or minor flaws in claims to make what he calls "gotcha denials" of doubtful validity. These, he said, can include rejections because minor errors in how patients filled out claim forms, or because the insurance company says a claim was submitted too late after treatment.

[Read the full memo \(pdf\)](#)

For more information on health reform, see:

- [Financing Health Care Reform: A Plan to Ensure the Cost of Reform Is Budget-Neutral](#)
- [Too Sick for Health Care: How Insurers Limit and Deny Care in the Individual Health Insurance Market](#)
- [The Two Trillion Dollar Solution: Saving Money by Modernizing the Health Care System](#)
- [Payment Reform to Improve Health Care: Ways to Move Forward](#)
- [Coverage When It Counts: How Much Protection Does Health Insurance Offer and How Can Consumers Know?](#)

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