



Insurers' Black Box

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

Scot J. Paltrow October 21, 2009

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 UnitedHealthcare—if for the purposes of this report they would disclose their overall rates of 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 claims 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 policies so that the medical staff reported to regional business executives. These executives were given the authority to determine 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 rejection 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.¹

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 of minor errors in how patients filled out claim forms, or because the insurance company says a claim was submitted too late after treatment.

Data from California shows high claim denial rates

The California Nurses Association sounded an alarm on claims denials in early September this year after its researchers found data on a state agency web site that had not received public attention. The information was buried in a schedule attached to financial reports filed by insurers with California's Department of Managed Health Care. Data in the reports showed that three of the six largest health insurance companies in the state each

denied 30 percent or more of all claims during the first six months of 2009. The six companies combined have 67 percent of California’s managed care market, which by far is the largest in the country.

California Nurses Association Co-President Deborah Burger said the numbers show that the insurers often deny claims “simply because they don’t want to pay for it.”

The insurance companies strongly reacted to the disclosure and the nurses association’s conclusion that the data indicate high rates of unfair denials, even though the data came from their own reports. They correctly noted that the patients received treatment in most instances even though the companies later denied the reimbursement claims from physicians and hospitals.

California Association of Health Plans CEO Patrick Johnston said the nurses’ disclosure of the denial rates “was a cursory and inaccurate portrayal of the pattern of health care and payments to providers typical in California.”

Queried by CAP about the data, UnitedHealth care Spokeswoman Cheryl Randolph said that 80 percent of total denials at the company’s PacifiCare HMO in California were because physician groups erroneously submitted claims for treatment even though PacifiCare pays the groups a flat rate based on the number of PacifiCare-covered patients they treat under so-called “capitation agreements.” Randolph said the flat rate is supposed to cover all of patient’s treatment costs by the groups, but that the physicians often erroneously submit claims for specific treatments or procedures. She said that the patients did receive the medical treatment even though the company declined to reimburse the physicians.

Randolph said that of the denials for other reasons, “95 percent of those were denied because the individual was ineligible, meaning they were not insured under a PacifiCare plan.”

Cigna Spokesman Christopher Curran also cited bills erroneously sent for patients covered under capitation agreements, which he said accounted for about half of the Cigna denials. He said a large portion of the rest were for “duplicate billings” submitted for treatments that the insurer already had paid for. Curran said that, “Out of all eligible requests for coverage submitted to CIGNA Health care of California in the first half of 2009, more than 95.9 percent were covered and the person received the care recommended by the doctor.”

Yet denials because of capitation agreements aren’t necessarily black-and-white. Physicians may bill for services that aren’t covered under their capitation agreements. And James G. Kahn, president of the California Physicians Alliance and professor of the University of California San Francisco’s Institute for Health Policy Studies, says confusion occurs due to an increasing number of “carve-outs” from capitation agreements. These exempt certain specialized treatments, or may exclude serious diseases such as AIDS. Dr. Kahn says there are often disagreements between physicians and insurers about whether a claim falls under one of the carve-outs.

Percentage of claims denied
January – June 2009

| Company | Percent of claims denied |
|---------------------------------|--------------------------|
| UnitedHealth care’s PacifiCare | 39.6 |
| Cigna Health care of California | 32.7 |
| Health Net | 30.0 |
| Kaiser Permanente | 28.3 |
| Blue Cross | 27.0 |
| Aetna | 6.4 |

Source: California Nurse’s Association and the individual company reports posted on California Department of Managed Health care web site, available at <http://www.calnurses.org/media-center/press-releases/2009/september/california-s-real-death-panels-insurers-deny-21-of-claims.html> and insurers’ reports filed with DMHC, available at <http://wps0.dmhc.ca.gov/fe/search/#top>

Aetna's denial rate of 6.4 percent was significantly lower than its six main competitors in California, but Aetna Spokesman Mohit Ghose declined to comment on the practices of the other insurers. He did say Aetna adheres strictly to the required terms of its coverage, and said, "We take any claims' non-payment very seriously at Aetna."

Insurers pressure their doctors to deny claims

Officials from the biggest health insurers have said publicly at congressional hearings and elsewhere that they base decisions about medical necessity and "experimental" treatments solely on medical criteria. They have stated that these decisions are insulated completely from pressure to boost profits.

Yet former senior doctors at big health insurers said in interviews with CAP that Cigna, Aetna and most of the other top companies made an important change in who their medical staffs report to over the past 10 years. Companies reassigned medical directors, the doctors who approve or deny claims for medical reasons, to report to regional business executives. They previously reported only to the companies' chief medical officer, who was responsible for hiring and firing decisions, promotions, pay raises, and bonuses for medical directors. After the switch, the business managers, whose main responsibility is to bolster profits, had authority over these pay and incentive decisions for the medical staff.

Former Cigna Executive Wendell Potter said that having medical directors report to business managers "means they are part of a team that is very much involved in making sure that the company is profitable at all levels."

Arthur "Abbie" Liebowitz, chief medical officer at Aetna until 2001, said that financial pressures when he was there led to the reassignment of the company's doctors. In an interview for this report, Liebowitz said, "The concept was that business leaders had P and L [profit and loss] responsibility for the region. The business guys said if I have responsibility for profits and losses I have to control for the things that account for my costs. The biggest thing affecting cost was medical delivery decisions."

Liebowitz said he opposed the change. "I fought until the very end," he said. "I didn't think that people should be making medical decisions based on business needs."

Company spokesmen denied that the change affected medical decisions. Aetna spokesman Ghose said the restructuring has had no effect on the decisions that doctors make. "Medical necessity decision[s] are made at Aetna based on medical evidence," he said. "There is no other thing that comes into that equation."

Cigna spokesman Curran said that, “all clinicians are accountable to the chief medical officer for their clinical decisions.” He added that “there are no financial incentives for clinicians to approve or deny” claims. And a UnitedHealth care spokesman said the company’s medical directors are focused only “on supporting our members’ care.”

Rep. Elijah Cummings (D-MD) pressed a panel of senior executives from five of the biggest for-profit health insurers at a House Oversight and Government Reform Subcommittee on Domestic Policy hearing on September 17 to say whether their companies gave medical directors and other employees’ financial incentives to reject claims. None of them mentioned the changes in who their medical directors report to, or that their compensation and promotion is now set by business executives mainly concerned with profits, rather than the companies’ chief doctors.

All of the executives either flatly denied that there is any financial incentive for employees to deny claims, or said that to the best of their knowledge their companies give no such inducements. Cigna Senior Vice President Thomas Richards said, “At Cigna, there are no financial incentives for our clinicians to deny coverage.” Aetna Senior Vice President Patricia Farrell said that to her knowledge, “we have absolutely no incentives, financial incentives, tied to that decision-making process.”

States do not require disclosure and face difficulties in regulation

California and Rhode Island are the only two states that have an independent department—separate from the states’ insurance departments—specifically tasked with regulating managed care organizations. And California is the only state that requires companies to file claims disclosure data—Rhode Island does not collect such data, according to a state spokeswoman.

All other states regulate health insurers through their insurance departments. Kansas Insurance Commissioner Sandy Praeger, recent past president of the National Association of Insurance Commissioners and current chairman of its Health Insurance and Managed Care Committee, said that the issue hadn’t come up in recent decades at NAIC’s meetings to discuss policy issues and propose model laws and standards for all states to adopt. Praeger said she doesn’t know why the regulators haven’t requested it, but said one factor may be regulators’ assumption that insurers would put up a fight rather than turn over more data. “The industry doesn’t readily give anything up,” Praeger said.

Given the potential usefulness of claims denial data in indicating whether insurers are treating customers fairly, it may seem surprising that regulators haven’t asked the companies to provide the data. The apparent lack of interest highlights a larger problem with insurance regulation that will be of increasing concern if health reform legislation goes into effect: Nearly all insurance industry regulation is left to the states.

The Supreme Court ruled in 1869 that the sale of insurance policies did not amount to interstate commerce, and therefore wasn't subject to federal authority.² The Supreme Court reversed its earlier decision in 1944, after the rise of many large insurance companies that sold across state lines, opening the door to federal regulation.³ But insurance executives, panicked that the federal government might impose harsher controls, rushed to lobby, and in 1945 Congress passed the McCarran-Ferguson Act. This law bill preserved state control of insurance regulation and is still in effect.⁴

Most state insurance departments are chronically underfunded and hobbled by the local insurance lobby's influence over state legislatures and other state officials. And the economic downturn has led to further staff reductions at many state insurance departments. What's more, state insurance departments have traditionally been concerned almost exclusively with solvency or ensuring that insurers are financially sound and don't go bust. Only in recent decades have regulators in many states begun focusing on how insurers, including health insurers, treat customers. But their regulatory efforts to date have been small and fitful, partly due to strong opposition from the industry.

Some senators—angered by insurers' tactics in opposing health care reform legislation—are threatening to repeal portions of the McCarran-Ferguson Act that exempt insurers from federal antitrust laws. State insurance departments rely mainly on periodic “market conduct examinations” rather than requiring insurers to routinely turn over data relating to their policyholder obligations. States send examiners into a company to review records and look at customer complaints, timely payment of claims, marketing, and advertising.

Yet states conduct relatively few such exams. There is no nationwide data on the annual number of market conduct examinations specifically of health insurers. But the National Association of Insurance Commissioner's 2008 Insurance Department Resources Report shows that 25 states conducted 10 or fewer market conduct exams of *all* types of insurance companies in 2008. Several states did say, however, that they looked at certain consumer-related issues when performing regular financial examinations of insurers.

The federal government does impose certain requirements on health insurers under the 1996 federal Health Insurance Portability and Accountability Act, such as limiting the restrictions insurers can put on coverage for pre-existing conditions. But the federal government leaves enforcement of these rules almost entirely to the states. As Georgetown University Health Policy Institute's Research Professor Karen Pollitz testified recently, many state insurance departments often have difficulty enforcing HIPAA requirements due to other, conflicting state laws, such as laws that allow for up to two years of “contestability”—that is, enable insurers to rescind a policy based on pre-existing conditions.⁵

HIPAA allows the federal government to act if the states don't enforce its requirements. But the department of Health and Human Services, which has the authority, has so far not intervened.

The health reform measures currently being considered by Congress would impose significant new responsibilities on state regulators. It will require them to draw up standards spelling out more detailed guidelines regarding what information insurers are required to give to consumers about their coverage. Regulators will have to draft and enforce new laws regulating insurance marketing practices. And the House bill H.R. 3200, America's Affordable Health Choices Act of 2009, would require steps to disclose important now-confidential information, such as insurers' claim denial rates.

Yet the pending legislation does not allocate any money to help currently underfunded and understaffed insurance departments. However, insurance departments in many states contribute large amounts to states revenues by collecting insurer licensing fees and taxes. The money goes into the states' general coffers, and state legislatures appropriate relatively small amounts to run the insurance departments. Federal and states governments will clearly need to do more to ensure that insurance departments have the resources and authority they need to properly oversee health insurance companies.

Other data

There is no publicly available nationwide data from regulators or insurers themselves on total rates of claims denials, but several insurance company spokesmen in interviews pointed to data contained in the American Medical Association's "National Health Insurer Report Cards" published in 2008 and 2009. The AMA report cards are meant to rate insurers and Medicare's performance in several categories important to doctors and consumers. The spokesman contended that a column of numbers in the reports show that claims denial rates actually are extremely small.

A close look at the reported cards shows that the column of data cited by the companies—labeled "Percentage of claim lines denied"—actually shows only one portion of the total claims denied. The figure shows, for example, that United Health care's denial rate was 2.02 percent, Cigna's 2.56 percent, and Aetna's 1.81 percent. These percentages include only instances in which entire claims were denied for reasons such as that the individual wasn't actually covered by the company, or when a claim form had been filled out improperly. These numbers do not include instances where companies denied select treatments and procedures rather than the entire claim.

Interviews and a close look at explanations of the data contained in appendices showed that it is necessary to add together two separate sets of figures to come up with an estimate of actual total claims denials. The AMA obtained its data for the report cards from Sacramento, California-based National Health care Exchange Services, a private company that provides software to doctors and hospitals to help them contest underpayments and claims denials by insurers. The company used its own database containing claims payment information provided to it by doctors and hospitals that are its customers. Mark

Rieger, the company’s chief executive officer, said in an interview that to find an estimate of total denial rates it is necessary to add the column cited by the company spokesman with another labeled “claims edits.” That technical term refers to the selective denial of reimbursement for multiple charges on a claim, such as by refusing to reimburse for one treatment but paying for others performed during the same office visit.

Total denial rates derived by adding Metric 11A, “disclosed and undisclosed claim edits,” and Metric 12, “Percentage of claim lines denied.”

The figures are still significantly lower than those in the 30 percent range reported by several of the California insurers, but Rieger said they show relatively high rates of denials and significant variations among the companies—also, the data isn’t comprehensive or nationwide. It is based only on a sampling of claims submitted by doctors and hospitals to insurers during February and March 2009, and does not include claims submitted by patients. The data includes claims from 29 states, including all of the most populous states.

| American Medical Association claim denial estimates | |
|---|------------------------|
| Company | Total denial rates (%) |
| Aetna | 9.51 |
| Anthem | 9.34 |
| CIGNA | 9.06 |
| Coventry | 10.39 |
| Humana | 5.13 |
| UHC | 9.92 |
| Medicare | 5.4 |

Source: American Medical Association 2009 National Health Insurer Report Card, available at <http://www.ama-assn.org/ama1/pub/upload/mm/368/2009-nhirc-long.pdf>.

Conclusion

There is not a certain way to tell whether the commercial companies are denying unfairly large number of claims to limit losses and boost profits without comprehensive data on the insurers’ rates of claims denials. Big portions of the denials are undoubtedly being kept secret for completely legitimate reasons as insurers maintain. But the limited data currently available raises red flags, highlighting the need for much wider disclosure.

The data released in California shows wide variation in denial rates from company to company, and exposes that some companies are denying 30 percent or more of all claims. These findings should cause states to begin looking closely at denial rates, and exploring whether companies are citing valid reasons for denials. Even if nationwide denial percentages turn out to be lower than those in California, such as the roughly 10 percent denial rates indicated for some big companies in the AMA data, that still represents millions of denied claims. States will also need to look at the companies’ compensation structures to see if there is any financial pressure on employees, including medical directors, to turn down claims.

If the current system of relying on state regulation remains in effect, the federal government or state legislatures will have to come up with money to make sure that the insurance departments have adequate resources. State legislatures in many states also will have to show more willingness to pass laws giving the insurance departments the authority they need to thoroughly oversee the insurers they regulate.

Endnotes

- 1 *Bynum v. Cigna Health care of N.C., Inc.*, 287 F.3d 305 (4th Cir. 2002).
- 2 *Paul v. Virginia*, 75 U.S. (8 Wall) 168 (1869).
- 3 *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944).
- 4 *The McCarran-Ferguson Act*, 15 U.S.C. § 1011.
- 5 Karen Pollitz, prepared statement for June 16, 2009 hearing before the House Energy and Commerce Committee's Subcommittee on Oversight and Investigation, available at http://energycommerce.house.gov/Press_111/20090616/testimony_pollitz.pdf.

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