

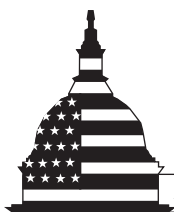
GAO

Report to the Secretary of Health and
Human Services and the Secretary of
Labor

March 2011

PRIVATE HEALTH INSURANCE

Data on Application and Coverage Denials



G A O

Accountability * Integrity * Reliability

Highlights of [GAO-11-268](#), a report to the Secretary of Health and Human Services and the Secretary of Labor

Why GAO Did This Study

The large percentage of Americans that rely on private health insurance for health care coverage could expand with enactment of the Patient Protection and Affordable Care Act (PPACA) of 2010. Until PPACA is fully implemented, some consumers seeking coverage can have their applications for enrollment denied, and those enrolled may face denials of coverage for specific medical services. PPACA required GAO to study the rates of such application and coverage denials. GAO reviewed the data available on denials of (1) applications for enrollment and (2) coverage for medical services.

GAO reviewed newly available nationwide data collected by the Department of Health and Human Services (HHS) from 459 insurers operating in the individual market on application denials from January through March 2010. GAO also reviewed a year or more of the available data from six states on the rates of application and coverage denials and the rates and outcomes of appeals related to coverage denials. The six states included all states identified by experts and in the literature as collecting data on the rates of application or coverage denials and together represented over 20 percent of private health insurance enrollment nationally. GAO conducted a literature review to identify studies related to application and coverage denials and reviewed data from selected studies. GAO interviewed HHS and state officials and researchers about factors to consider when interpreting the data.

View [GAO-11-268](#) or key components. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

March 2011

PRIVATE HEALTH INSURANCE

Data on Application and Coverage Denials

What GAO Found

The available data indicated variation in application denial rates, and there are several issues to consider in interpreting those rates. Nationwide data collected by HHS from insurers showed that the aggregate application denial rate for the first quarter of 2010 was 19 percent, but that denial rates varied significantly across insurers. For example, just over a quarter of insurers had application denial rates from 0 percent to 15 percent while another quarter of insurers had rates of 40 percent or higher. Data reported by Maryland—the only of the six states in GAO's review identified as collecting data on the incidence of application denials—indicated that variation in application denial rates across insurers has occurred for several years, with rates ranging from about 6 percent to over 30 percent in each of 3 years. The available data provided little information on the reasons that applications were denied. There are also several issues to consider when interpreting application denial rates. For example, the rates may not provide a clear estimate of the number of individuals that were ultimately able to secure coverage, as individuals can apply to multiple insurers, and the rates do not reflect applicants that have been offered coverage with a premium that is higher than the standard rate.

The available data from the six states in GAO's review and others indicated that the rates of coverage denials, including rates of denials of preauthorizations and claims, also varied significantly. The state data indicated that coverage denial rates varied significantly across states, with aggregate rates of claim denials ranging from 11 percent to 24 percent across the three states that collected such data. In addition, rates varied significantly across insurers, with data from one state indicating a range in claim denial rates from 6 percent to 40 percent across six large insurers operating in the state. There are several factors that may have contributed to the variation in rates across states and insurers, such as states varying in the types of denials they require insurers to report. The data also indicated that coverage denials occurred for a variety of reasons, frequently for billing errors, such as duplicate claims or missing information on the claim, and eligibility issues, such as services being provided before coverage was initiated, and less often for judgments about the appropriateness of a service. Further, the data GAO reviewed indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor. For example, data from four of the six states on the outcomes of appeals filed with insurers indicated that 39 percent to 59 percent of appeals resulted in the insurer reversing its original coverage denial. Data from a national study conducted by a trade association for insurance companies on the outcomes of appeals filed with states for an independent, external review indicated that coverage denials were reversed about 40 percent of the time.

GAO provided a draft of the report to HHS and the Department of Labor (DOL). HHS agreed with GAO's findings, noting the need to improve the quality and scope of existing data, and suggested clarifications, which were incorporated. HHS and DOL also provided technical comments, which were incorporated as appropriate.

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Abbreviations

AHIP	America’s Health Insurance Plans
AMA	American Medical Association
DOL	Department of Labor
ERISA	Employee Retirement Income Security Act of 1974
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HRP	high-risk health insurance pool
NAIC	National Association of Insurance Commissioners
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization

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United States Government Accountability Office
Washington, DC 20548

March 16, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services

The Honorable Hilda L. Solis
Secretary of Labor

A large majority of Americans—nearly 64 percent as of 2009—rely on private insurance for health care coverage, most through employer-sponsored group health coverage.¹ With the enactment of the Patient Protection and Affordable Care Act (PPACA) in March 2010,² enrollment in private health insurance could expand significantly, particularly for individuals and families that do not have access to group coverage through their employer. While there are certain federal requirements protecting against the denial of applications for enrollment for individuals eligible for group coverage, until PPACA is fully implemented, these protections do not apply to some consumers seeking individual coverage from private health insurers.³ In addition, once consumers are enrolled in either group or individual coverage, coverage can be denied for specific medical services, either through a denial of authorization of a service before it has been provided or payment for a service that has been delivered.⁴ There are some national data on the extent to which applications for enrollment are being denied; however, there is not yet any comprehensive, national information on the extent to which coverage for medical services is being denied when consumers seek health care. The federal government plans to

¹Private health insurance includes all forms of health insurance that are not funded by the government and may be purchased on an individual or group basis.

²Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

³Throughout this report, the term “insurer” refers to commercial, state-licensed issuers of health insurance coverage and entities such as health maintenance organizations (HMO). Insurers can offer coverage in the group market, individual market, or both. In this report, the term “insurer” does not include self-funded group health plans where instead of purchasing health insurance from an insurance company an employer sets aside its own funds to pay for at least some of its employees’ health care.

⁴Throughout this report, we refer to denials of authorization for services not yet provided as “preauthorization denials” and denials of payment for services rendered as “claim denials.”

collect additional information on the extent of denials of applications for enrollment and coverage for medical services and the reasons for those denials, with the intent to make it easier for consumers to shop for coverage. According to experts, those data may also help with government oversight of private health insurance.

Oversight of private health insurance has been a responsibility of state departments of insurance, and states vary in what they require of insurers and the degree to which they track insurers' activities, including the extent to which insurers are denying applications and coverage. The federal government's role in the oversight of private health insurance has included, for example, the establishment of certain consumer protections for states to enforce. It also includes oversight of employer-based coverage performed by the Department of Labor (DOL). However, the federal government's role has expanded with the enactment of PPACA. PPACA required the Department of Health and Human Services (HHS) to begin collecting, monitoring, and publishing information on health insurance products. HHS began publishing data from insurers on denials of applications for enrollment in October 2010 and intends to collect data in the future on denials of coverage for medical services.

PPACA directed us to study denials of applications for enrollment and coverage for medical services by considering samples of data related to such denials, including the reasons for the denials and favorably resolved disputes resulting from the denials.⁵ Specifically, we reviewed (1) the data available on denials of applications for enrollment and (2) the data available on denials of coverage for medical services.

To describe the data available on denials of applications for enrollment—referred to as application denials in this report—we reviewed federal, state, and other data including data on the rates of and reasons for such denials. First, we reviewed data recently collected by HHS from 459 insurers operating in the individual market in all 50 states and the District of Columbia.⁶ The data included application denial rates by insurer for a 3-month period—January through March—in 2010.⁷ To supplement the

⁵PPACA also directed that we submit our report to the Secretaries of HHS and DOL. Pub. L. No. 111-148, § 10107, 124 Stat. 911-2.

⁶The data were reported by state-licensed health insurers offering coverage in the individual market.

⁷This is the only quarter of data that HHS had collected as of December 2010.

single calendar quarter of HHS data, we contacted insurance department officials in six states regarding data on application and coverage denials.⁸ The six states include all the states identified by experts and in the literature as states that collect data from insurers on the incidence of application denials, coverage denials, or both. Because we did not survey all states to determine whether they collect data on the incidence of application or coverage denials, or both, there may be other states that collect such data that were not known to experts or discussed in the literature.⁹ Of the six states, we identified one, Maryland, that collected data on application denials. We reviewed data from Maryland for 2008, 2009, and the first half of 2010 on the rate of application denials by insurers operating in the individual market in that state. (See app. I for more information about our methodology for selecting states and the state data we reviewed.) We also conducted a structured literature review to identify studies related to application and coverage denials.¹⁰ We determined that a study was directly relevant to our objective on application denial data if it included empirical analyses of the frequency of application denials. Through our review, we identified four studies that met our criteria. Two of these four studies, produced by America's Health Insurance Plans (AHIP), included data on application denial rates in 2006 and 2008, and we reviewed those data. (See app. II for a description of the literature review methodology and the list of studies identified through the review.) Finally, we interviewed officials from HHS, Maryland, and AHIP about factors to consider when interpreting the data. We also interviewed officials from three large insurance companies about the data they collect on application denials.¹¹

⁸The six states we selected to contact were California, Connecticut, Florida, Maryland, New York, and Ohio.

⁹For example, through the course of our work, we found that Texas requires certain insurers to report on the number of requests for preauthorization of coverage for proposed services that insurers declined.

¹⁰To conduct this review, we searched a number of reference databases, such as EconLit and Social SciSearch, for peer-reviewed, industry, or government studies published from January 2000 through July 2010. In addition, we checked the bibliographies of the studies and interviewed a number of experts regarding the research done on private health insurance denials to identify other relevant studies.

¹¹The insurance companies we contacted offered coverage in both the individual and group markets and, according to AHIP, were among the 10 largest by enrollment, together accounting for nearly 26 million enrollees.

To describe the data available on denials of coverage for medical services—referred to as coverage denials in this report—we reviewed state and other data, including data on the rates of and reasons for denials and the outcomes of appeals related to denials, such as disputes resolved in favor of consumers. First, of the same six states we contacted regarding application denial data, we reviewed the most recent year of data available on the rate of coverage denials from the four that reported collecting such data.¹² Second, we reviewed data on the outcomes of appeals related to coverage denials from all of the six states for the most recent year available. We also interviewed officials from departments of insurance and other departments involved in overseeing insurance or responding to appeals in the six states about considerations for interpreting the data. To supplement the information from selected states, we reviewed data reported by 49 states and the District of Columbia to the National Association of Insurance Commissioners (NAIC) on the number of complaints related to coverage denials resolved in 2009 and the reasons for and outcomes of those complaints.¹³ We also reviewed information on the outcomes of complaints and appeals submitted by 35 states and the District of Columbia to HHS in applications for Consumer Assistance Program grants.¹⁴ As part of our literature review, we identified studies that included empirical analyses of the frequency of coverage denials, the reasons for such denials, the frequency of appeals of coverage denials, or the outcomes of such appeals. Through the review, we identified annual studies produced by the American Medical Association (AMA) in 2008, 2009, and 2010 that included data on the incidence and reasons for claim

¹²The data obtained from states on the incidence of coverage denials were not broken out by the types of medical services being denied.

¹³State regulators established NAIC to help promote effective insurance regulation, to encourage uniformity in approaches to regulation, and to help coordinate states' activities. Among other activities, NAIC collects data from state regulators on insurers, including complaints about insurer practices filed by consumers with states. We requested NAIC to provide us with data on the number of complaints reported by states that were related to coverage denials. The complaint data did not include information on the type of service for which coverage was denied.

¹⁴Under PPACA, \$30 million was appropriated to the Secretary of HHS for the award of federal grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsmen programs. Pub. L. No. 111-148, § 1002, 124 Stat. 138. To receive these grants, called Consumer Assistance Program grants, states must ensure that their programs assist consumers with such tasks as enrolling in health coverage and filing complaints and appeals. In the applications for the grants, HHS directed states to report on complaints and appeals. States varied in the data they included in their application and the time frames for those data.

denials. We reviewed data from the 2010 study and interviewed AMA officials about factors to consider when interpreting the data. Finally, we reviewed data from DOL on complaints related to coverage denials for those with employer-sponsored coverage from fiscal year 2010, including the number and value of financial recoveries made by the department on behalf of consumers as a result of complaints.

To assess the reliability of the data we reviewed on the incidence of application and coverage denials, the reasons for such denials, and the outcomes of appeals and complaints related to those denials, we interviewed federal, state, and other officials about their efforts to ensure the quality of the data. This included discussing whether they required insurers to certify the accuracy of data reported on the incidence of application or coverage denials and what steps were taken to ensure the quality of data tracked by states and DOL on the outcomes of appeals and complaints related to denials. We also asked officials about the limitations of the data and reviewed any statements about data limitations in published reports of the data. We determined the data to be sufficiently reliable for the purposes of describing the (1) denial rates, (2) reasons for denials, and (3) outcomes of appeals related to denials indicated by the data; where relevant we stated the limitations of the data in the findings.

We conducted our performance audit from September 2010 through January 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In 2009, approximately 156 million nonelderly individuals obtained health insurance through their employer and another 16.7 million purchased health insurance in the individual market. Of those with employer-sponsored group health plans, in 2009, 43 percent were covered under a fully insured plan where the employer pays a per-employee premium to an insurance company.¹⁵ The remaining 57 percent were covered under self-

¹⁵Throughout this report, the term “group health plan” refers to employer-sponsored health plans, including both fully insured and self-funded plans.

funded plans where instead of purchasing health insurance from an insurance company the employer sets aside its own funds to pay for at least some of its employees' health care.¹⁶

Application Denials

Application denials result when an insurer determines that it will not offer coverage to an applicant either because the applicant does not meet eligibility requirements or because the insurer determines that the applicant is too high of a risk to insure. Underwriting is a process conducted by insurers to assess an applicant's health status and other risk factors to determine whether and on what terms to offer coverage to an applicant.

Many consumers are protected from having their application for enrollment denied. Consumers who obtain health coverage through their employment by enrolling in a group health plan sponsored by their employer have certain protections against application denials. For example, under federal law, individuals enrolling in group health plan coverage are protected from being denied enrollment because of their health status.¹⁷ Under federal law, insurers also generally are prohibited from denying applications for individual health coverage for certain

¹⁶As of 2009, 85 percent of small employers, those with 3 to 199 employees, that offered health benefits were fully insured while 88 percent of large employers, those with 5,000 or more employees, offered self-funded plans. See The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2009 Annual Survey* (2009).

¹⁷Group health plans and health insurance issuers offering group coverage are prohibited from implementing eligibility rules based on health-status-related factors defined as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. See, for example, 42 U.S.C. § 300gg-1 (2006). PPACA extends this prohibition to health insurance issuers offering coverage in the individual market for plan years beginning on or after January 1, 2014. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

Health insurance issuers that offer coverage in the small group market in a state generally are required to accept every small employer that applies for health coverage in that state. In addition, issuers cannot deny an application for enrollment by individuals employed by such employers due to health-status-related factors if the individuals apply when they are first eligible. See 42 U.S.C. § 300gg-11 (2006). For plan years beginning on or after January 1, 2014, PPACA requires health insurance issuers offering group or individual coverage in a state to accept every employer and individual that applies for coverage in that state, subject to certain requirements. Pub. L. No. 111-148, § 1201(4), 124 Stat. 156.

individuals leaving group health plan coverage and applying for coverage in the individual market.¹⁸

Currently, some consumers who apply for private health insurance through the individual market can have their applications denied for eligibility reasons or as a result of underwriting. For example, applications filed by some consumers with preexisting health conditions can be denied, unless prohibited by state or federal law.¹⁹ Additionally, insurers may accept the application but offer coverage at a premium level that is higher than the standard rate or that excludes coverage for certain benefits. The options for appealing application denials in the individual market can be limited to filing a complaint with the state department of insurance. However, in 35 states, individuals who—due to a preexisting health condition—have been denied enrollment or charged higher premiums in the individual market are typically eligible for coverage through high-risk health insurance pools (HRP).²⁰ Additionally, as required under PPACA, individuals who have preexisting health conditions and have been

¹⁸Health insurance issuers offering individual coverage are prohibited from denying coverage for individuals who (1) have had at least 18 months of prior creditable coverage with no break of more than 63 days; (2) have exhausted any available continuation of coverage; (3) are uninsured and are not eligible for other group coverage, Medicare, or Medicaid; and (4) did not lose group coverage because of the nonpayment of premiums or fraud. See 42 U.S.C. § 300gg-41 (2006). As referenced above, PPACA requires health insurance issuers to guarantee coverage to all individuals seeking coverage in that state for plan years beginning on or after January 1, 2014, subject to certain requirements.

¹⁹According to data from the Kaiser Family Foundation, as of January 2010, six states have guaranteed issue requirements that prohibit any insurer from denying coverage to an individual based on their current medical conditions or risk of poor health. Another seven states have guaranteed issue requirements that only apply to certain insurance plans or during limited times during the year.

As referenced above, in certain circumstances, federal law also protects consumers seeking individual coverage from application denials. For example, health insurance issuers cannot deny applications for eligible consumers who had prior group or other coverage.

²⁰See GAO, *Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools*, [GAO-09-730R](#) (Washington, D.C.: July 22, 2009).

uninsured for 6 months are eligible for enrollment in a temporary national HRP program.²¹

Coverage Denials

Coverage for medical services can be denied before or after the service has been provided, either through denial of preauthorization requests or denial of claims for payment. As a condition for coverage of some services, providers or consumers are required to request authorization prior to providing or receiving the service. Preauthorization denials occur when a determination is made that (1) the consumer is not eligible to receive the requested service, for example, because the service is not covered under the individual's policy, or (2) the service is not appropriate, meaning that it is not medically necessary or is experimental or investigational. Denials of claims occur for various reasons. Claims may be denied for billing reasons, such as the provider failing to include a piece of required information on the claim, such as documentation that the provider received preauthorization for a service, or submitting a duplicate claim. Claims may also be denied because of eligibility issues. For example, a claim may be submitted for a service provided before an individual's coverage began or after it was terminated, or a claim may be submitted for a service that has been excluded from coverage under an individual's policy. Another reason for denials reported by some insurers is that the individual has not met the cost-sharing requirements of his or her policy, such as the required deductible. Finally, claim denials can occur when a determination is made that the service provided was not appropriate, specifically that the service was not medically necessary or was experimental or investigational. Depending on the reason for a claim denial, either the provider or the consumer may bear the financial responsibility for the denied coverage amount. Claims that are denied because of such billing errors as the provider not providing a required piece of information can be resubmitted and ultimately paid.

²¹The temporary national HRP program will terminate in 2014. Pub. L. No. 111-148, § 1101, 124 Stat. 141. As referenced above, for plan years beginning on or after January 1, 2014, PPACA prohibits health insurance issuers offering individual coverage from implementing eligibility rules based on health status-related factors and requires health insurance issuers offering individual coverage to accept every individual in the state who applies for coverage, subject to certain requirements. In addition, PPACA prohibits group health plans and insurers offering group and individual coverage from excluding coverage for pre-existing health conditions. This prohibition is generally effective for plan years beginning on or after January 1, 2014 for adults and plan years beginning on or after September 23, 2010 for individuals under age 19. Pub. L. No. 111-148, § 1201(2), 10103(e), (f), 124 Stat. 154, 895.

For claim denials, the full claim may be denied or, if the claim contained multiple lines, such as a surgery with charges for multiple procedures and supplies, only certain lines of the claim may be denied. How insurers and self-funded group health plans track claim denials and the reasons for denials may vary. For example, AMA officials noted that there is no guidebook for how reason codes should be assigned to claim denials. Officials noted that denials are often assigned the code for the most general reason even though the denial may be for a more specific reason.

Consumers have several avenues available to dispute coverage denials. First, consumers can file an appeal of a denial with the insurer or self-funded group health plan for review, referred to as an internal appeal. Internal appeals can result in the denial being upheld or reversed. In addition, consumers in most states can have their appeal reviewed by an external party, such as an independent medical review panel established by the state.²² These appeals, referred to as external appeals, can also result in denials being reversed and in states recovering funds for consumers for the cost of the denied service. State external appeal options may only be available once the consumer has exhausted the internal appeal process or for consumers with certain types of coverage. Historically, those with self-funded group health plans generally did not have access to an external appeal process, but consumers could file suit against a health plan in court to challenge a denial. PPACA, however, required that group health plans, including self-funded plans, provide access to an external appeal process that meets federal standards for plan years beginning on or after September 2010.²³ Finally, consumers may file complaints regarding coverage denials with the state, generally the department of insurance, or, for those with group health plans, with DOL.

²²According to research completed by AHIP, as of January 2006, 44 states and the District of Columbia operated external review programs. Such programs are generally available to consumers purchasing coverage from insurers regulated by states.

²³Under PPACA and implementing regulations, group health plans and health insurance issuers offering group or individual coverage, subject to certain exceptions, must comply with a state external review process that, at a minimum, includes consumer protections identified in the NAIC Uniform External Review Model Act. If a state external review process does not incorporate these consumer protections or a self-insured group health plan is not required to comply with the state external review process, then the health plan must follow a federal external review process. Pub. L. No. 111-148, §§ 1001(5), 10101(g), 124 Stat. 137, 887; *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under PPACA*, 75 Fed. Reg. 43,330 (July 23, 2010).

Filing a complaint can be a less formal mechanism for disputing a coverage denial than filing an appeal; however, complaints can result in reversals of denials and in financial recoveries for consumers.

State and Federal Oversight of Private Health Insurance

States have responsibility for regulating private health insurance, including insurers operating in the individual market and the fully insured group market. In overseeing insurer activity, states vary in the data they require insurers to submit on denials and internal appeals of denials. According to NAIC officials, few states require insurers to report data regularly on the frequency of denials and internal appeals, and NAIC has not issued any model laws or regulations that include requirements for insurers to report such data. States also may use data on complaints and external appeals to identify trends in the practices of insurers and target examinations of specific insurers' practices. Nearly all states and the District of Columbia regularly report complaint data, which includes information on the numbers of, reasons for, and outcomes of complaints, to NAIC.

Historically, the federal government's role in oversight of private health insurance has included establishing requirements for states to enforce. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established consumer protections on access, portability, and renewability of coverage.²⁴ In addition, with respect to group health plans, the federal government enforces disclosure, reporting, fiduciary, and claims-filing requirements under the Employee Retirement Income

²⁴For example, with respect to those leaving group coverage and applying for coverage in the individual market, HIPAA prohibited health insurance issuers from denying coverage for individuals who (1) have had at least 18 months of prior creditable coverage with no break of more than 63 days; (2) have exhausted any available continuation of coverage; (3) are uninsured and are not eligible for other group coverage, Medicare, or Medicaid; and (4) did not lose group coverage because of the nonpayment of premiums or fraud. See 42 U.S.C. § 300gg-41 (2006).

Security Act of 1974 (ERISA).²⁵ DOL conducts a number of efforts to enforce the ERISA requirements. For example, the department conducts civil investigations that can result in corrective actions, such as monetary recoveries for consumers who are enrolled in employment-based plans. In addition to these formal methods, DOL also works to resolve complaints filed with the department. These efforts are considered informal resolutions, although complaints can also serve as a trigger for formal enforcement actions.

PPACA expanded the federal oversight role by requiring HHS to begin collecting, monitoring, and publishing data from certain insurers. Specifically, PPACA required the establishment of an internet Web site through which individuals can identify affordable health insurance coverage options in their state.²⁶ To implement this requirement, in May 2010, HHS issued an interim final rule requiring insurers in the individual and small group markets to submit data to HHS on their products, including data on the number of enrollees, geographic availability of the products, and customer service contact information, by May 21, 2010, and annually after that.²⁷ In July 2010, HHS began publishing these data on the new Web site, which is designed for individuals and small businesses to obtain information on coverage options available in their state. In October 2010, HHS began posting additional data collected from insurers, including data on the percentage of applications denied for each product offered in the individual market. The interim final rule also required insurers to submit other data, such as data on the percentage of claims denied in the individual and small group markets, and the number and outcomes of

²⁵ERISA established certain federal requirements that apply when employers offer their employees, retirees, and dependents employee benefit plans that include health coverage, retirement plans such as pensions, and other benefits such as life insurance. See Pub. L. No. 93-406, 88 Stat. 829 (1974). ERISA requirements generally apply regardless of the size of the business, although some requirements are streamlined for smaller employers. ERISA imposes certain reporting and disclosure requirements, fiduciary obligations, and requirements for claims-filing procedures. ERISA is enforced through DOL's Employee Benefits Security Administration. PPACA expands upon ERISA's requirements for claims-filing procedures by applying new standards for internal claims appeals and for external claims review processes, as referenced above. Pub. L. No. 111-148, §§ 1001(5), 10101(g), 137, 887.

²⁶Pub. L. No. 111-148, §§ 1103, 10102(b), 124 Stat. 146, 892. The Web site is www.healthcare.gov.

²⁷Health Care Reform Insurance Web Portal Requirements, 75 Fed. Reg. 24,470 (May, 5, 2010).

appeals of denials to insure, pay claims, and provide preauthorization, in accordance with guidance to be issued by HHS. As of December 2010, HHS had not issued any guidance on reporting these additional data.

Federal, State, and Other Data Indicated Variation in Application Denial Rates and Provided Little Information on the Reasons for Denials

Nationwide data from HHS showed variation in application denial rates across insurers operating in the individual market. Specifically, data collected by HHS from 459 state-licensed insurers on the number of applications received and denied from January through March 2010 indicated that, while the aggregate rate of application denials was 19 percent nationally, the rate varied significantly across insurers. For example, just over a quarter of insurers had application denial rates from 0 percent to 15 percent while another quarter of insurers had rates of 40 percent or higher.²⁸ However, the insurers with rates of 40 percent or higher reported fewer applications. See table 1 for additional information on the range in application denial rates across insurers.

Table 1: Range of Application Denial Rates among State-Licensed Insurers, Based on HHS Data, January-March 2010

Application denial rates (percentage of applications denied)	Number of insurers reporting rates in range ^a	Number of applications received ^b
0 to 15	132	499,239
16 to 23	102	471,878
24 to 39	113	230,846
40 or higher	112 ^c	57,923

Source: GAO analysis of HHS data.

^aData were reported to HHS by 459 state-licensed insurers operating in 50 states and the District of Columbia. Data on insurers operating in states with guaranteed issue requirements that prohibit any insurer from denying coverage to an individual based on his or her current medical conditions or risk of poor health were included in the analysis.

^bInsurers were instructed to report the number of applications received for products offering comprehensive medical coverage. HHS officials told us that they identified instances where insurers included data on applications for more limited products, such as one that covers only hospital services. The application data may also include applications for products being sold for only a portion of the 3-month period.

^cThe data indicated that two insurers had denial rates of 100 percent and each of these insurers reported receiving one application in the 3-month reporting period.

²⁸The data indicated that two insurers had denial rates of 100 percent and each of these insurers reported receiving one application in the 3-month reporting period.

HHS officials noted that the data the department collected on application denials, which represent a single calendar quarter of applications, are only a starting point. They told us that as insurers report additional quarters of data, the value and usefulness of the data will increase. In addition, officials said that they have taken steps to ensure the accuracy of the data and noted that the accuracy of these data is critical to HHS, because no other source of information on private health insurance has a complete catalog of insurers operating in the individual market and what products those insurers are selling.

Data reported by Maryland—the only state we identified as collecting data on the incidence of application denials—indicated that variation in application denial rates across insurers operating in the state’s individual market has occurred in that state for several years. Maryland data showed that the range of application denial rates across insurers was 26 percentage points or more in each of three reporting periods, 2008, 2009, and the first half of 2010. (See table 2 for the range in denial rates in the data reported by Maryland.)

Table 2: Range in Application Denial Rates across Insurers Licensed in Maryland, 2008-2010

Data year	Range in application denial rates (percentage of applications denied)	Number of insurers represented in the data	Number of applications received	Aggregate application denial rate (percentage)
2008	6 to 34	11	98,612	14
2009	7 to 33	11	107,617	14
2010 (first half)	6 to 45	11	47,791	16

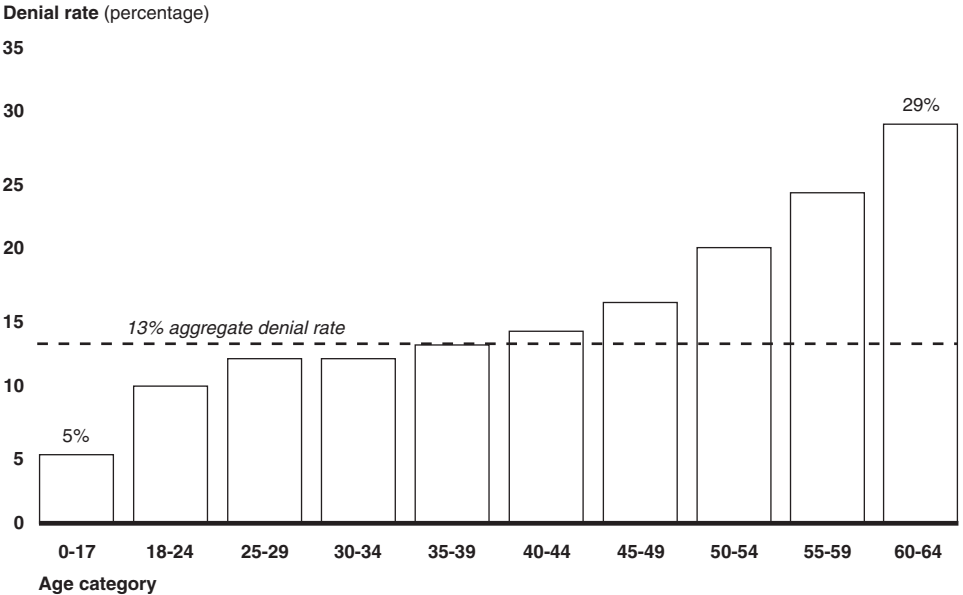
Source: GAO analysis of data from Maryland.

Note: Data are from 2008, 2009, and the first two quarters of calendar year 2010 and reported by insurers to Maryland.

Data reported in studies by AHIP also showed variation in application denial rates. The AHIP data illustrated that application denial rates varied across age groups, with denial rates increasing as the age of the primary applicant increased. In 2008, when AHIP data showed that 13 percent of all

medically underwritten applications were denied,²⁹ in general the denial rate progressively increased as the applicant's age increased, from a low of 5 percent for applicants under 18 years of age to a high of 29 percent for applicants from 60 to 64 years of age.³⁰ Similar variation in AHIP application denial rates was seen in data from 2006.³¹ (See fig. 1.)

Figure 1: Application Denial Rates by Age Group for 2008, as Reported by AHIP



Source: GAO analysis of data reported by AHIP.

Note: Data are from AHIP, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2009).

²⁹In 2008, according to AHIP data, 84 percent of applications were medically underwritten and 16 percent were not medically underwritten. Just over 1 percent of applications were denied before going through medical underwriting, and those denials were unrelated to the applicant's health status.

³⁰America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2009). (See app. II for references to the AHIP study and other studies with information on application denial rates identified through our literature review.)

³¹America's Health Insurance Plans, *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, D.C.: 2007).

The available data on application denial rates provided little information on the reasons that applications were denied. For instance, the HHS and Maryland data did not include any information on the reasons for application denials. The AHIP data, however, provided limited information. Specifically, AHIP's data showed that a higher percentage of applications were denied because of the applicant's health status than for nonmedical reasons, such as the plan not being offered in the applicant's geographic area. AHIP data showed that in 2008, of the 1.8 million applications for enrollment that insurers either denied or made offers of coverage, 1 percent were denied for nonmedical reasons and 12 percent were denied after underwriting when the applicant's health status and other risk factors were assessed. According to an AHIP official, applications that were denied after underwriting were presumably denied because the applicant's medical questionnaire responses were beyond the insurer's threshold for issuing a policy.

There are several issues to consider when interpreting application denial rates. First, application denial rates may not provide a clear estimate of the number of individuals that were ultimately able to secure health coverage, because individuals may submit applications with more than one insurer and be denied by one insurer but offered enrollment by another. Second, denial rates also do not reflect applications that have been withdrawn. For example, AHIP data for 2008 indicated that 8 percent of applicants withdrew their applications before underwriting occurred. Experts also noted that some individuals may not submit applications for health coverage because they believe or have been advised, for example by an insurance agent, that their application would likely be denied. Third, an insurer's denial rates may be affected by requirements of the states in which the insurer operates. For example, officials from one insurance company explained that for applicants in the state for which they are the insurer of last resort, state law prohibits them from denying applications for enrollment based on the health status of the applicant.³² Officials told us that a denial can occur only for nonmedical eligibility reasons, which the AHIP data indicate are far less frequent.

³²According to data from the Kaiser Family Foundation, as of January 2010, four states—Michigan, Pennsylvania, Rhode Island, and Virginia—and the District of Columbia have insurers of last resort, which are insurers that typically accept consumers with health conditions that prevent those consumers from obtaining coverage in the individual market.

Another consideration when interpreting application denial rates is that the rates do not reflect applications that have been accepted by an insurer but for coverage with a premium that is higher than the standard rate or with exclusions for coverage of specified services. Data from HHS, Maryland, and AHIP all indicated that some portion of applicants received offers at a premium that was higher than the standard rate. For example, the HHS data demonstrated that from January through March of 2010, about 20 percent of individual market applicants were offered coverage with premiums higher than the standard rate. Maryland data also indicated that for the first half of 2010, 8 percent of applicants were offered either coverage with premiums higher than the standard rate or coverage that excluded specified health conditions. Finally, AHIP data from 2008 showed that 34 percent of offers for coverage were for coverage at a higher premium rate. The AHIP data also showed that 6 percent of offers for coverage were for coverage that excluded specified health conditions.

State and Other Data Indicated That Coverage Denial Rates and the Reasons for Denials Vary and That Denials, If Appealed, Are Often Reversed

Data from selected states and others indicated that the rates of coverage denials, including denials for preauthorizations and claims, varied significantly, and a number of factors may have contributed to that variation. The data also indicated that coverage denials occurred for a variety of reasons, frequently for billing errors and eligibility issues and less often for judgments about the appropriateness of a service. Further, the data we reviewed indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor and that appeals and complaints related to coverage denials sometimes resulted in financial recoveries for consumers.

State and Other Data Indicated Wide-Ranging Coverage Denial Rates, and a Number of Factors May Have Contributed to This Variation

State data that we reviewed showed that rates of coverage denials by insurers operating in the group and individual markets varied significantly across states. Specifically, aggregate claim denial rates for the three states that we identified as collecting such data ranged from 11 percent in Ohio in 2009 to 24 percent in California in the same year.³³ Data reported by the remaining state, Maryland, indicated a claim denial rate of 16 percent in 2007.³⁴ A fourth state, Connecticut, collected data on a different measure, preauthorization denials, and these data indicated a denial rate of 14 percent in 2009.³⁵ In addition, claim denial rates indicated by AMA data—3 percent during 2 months of 2010—varied from coverage denial rates in the four states.³⁶

Several factors may have contributed to the variation in rates across the four states and the AMA data. For example, Ohio and AMA data were based on denials of electronic claims.³⁷ AMA officials told us that providers with electronic billing systems and insurers that accept electronic claims are more sophisticated in terms of billing management,

³³The Ohio data included the number of electronically submitted claims paid and denied in the first and third quarters of calendar year 2009 and represented all insurers licensed in Ohio. The California data included the number of claims received and denied by six of the largest managed care insurers licensed in the state, each with enrollment in 2009 of over 400,000. We obtained these data from the Department of Managed Health Care's Web site from June through September 2010 (www.wpsso.dmhcc.ca.gov/fe/search).

³⁴The Maryland data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007* and represented data for calendar year 2007 from 41 insurers licensed in the state.

³⁵The Connecticut data were obtained from the Connecticut Insurance Department's *Consumer Report Card on Health Insurance Carriers in Connecticut* and represented data for calendar year 2009 from 21 managed care insurers licensed in the state.

³⁶The data were reported to GAO by AMA and represented claims from February 1, 2010, through March 31, 2010. The data indicated the total number of claim lines—charges for specific services included in the claim—that were denied. AMA defines a denial as a claim line where the amount allowed and the amount billed were equal, but the amount paid was \$0. Though not included in the claim denial rate, AMA also reported data indicating that 5 percent of claim lines were edited, that is, the claim lines were automatically reduced to a payment of \$0 by the insurer's payment system. According to AMA officials, both claim-line denials and claim-line edits result in no payment for the service, and therefore are denials from the perspective of the provider. The data on claim lines denied and edited were used as the basis for rates reported in AMA's *2010 National Health Insurer Report Card*. See citations to the 2010 report card and previous AMA report cards as well as other studies related to coverage denials in app. II.

³⁷Providers can submit paper or electronic claims. According to Ohio and AMA officials, electronic claims represented roughly 70 to 80 percent of their total claims activity.

and therefore the denial rates calculated by AMA may be lower than rates of denials for all claims, including both electronic and paper-based. In another example, Maryland's rate was calculated using data for categories of denials that accounted for about 90 percent of all claims denied. In contrast, according to California officials, California's data represented all claim denials.³⁸ Differences in the time frames for the data may have also contributed to the variation. AMA officials noted that their data were from a 2-month period of the year (February through March) when there was less contractual activity, such as open enrollment periods, and when denials related to meeting deductible requirements—which according to officials from one insurance company can be significant—have already been resolved. In contrast, data from the four states, except Ohio, covered a full year and therefore reflect all denials for the year, including those related to enrollment and deductible issues. See table 3 for the rates of coverage denials indicated by state data and a description of the characteristics of the data, some of which may have contributed to the variation in rates.

³⁸ California officials told us they currently require plans to report on their full “inventory” of denials but the state is revising its claim denial reporting instructions to clarify the denials that should be included and excluded from the numbers reported.

Table 3: Rates of Claim or Preauthorization Denials across States in GAO’s Review and Characteristics of the State Data

State	Rate of claim or preauthorization denials	Data year ^a	Characteristics of the data
Ohio	11 percent across all insurers licensed in the state	2009	Data limited to denials of electronic claims in the first and third quarters of the fiscal year ^b
Connecticut	14 percent across 21 managed care organizations licensed in the state	2009	Data were limited to denials of preauthorization for services and did not include data on denials of claims ^c
Maryland	16 percent across 41 insurers licensed in the state	2007	Data were limited to 16 categories of denials of claims, representing 90 percent of total claim denials ^d
California	24 percent across six of the largest managed care organizations licensed in the state	2009	Data were limited to denials of claims and reflected each insurer’s inventory of denials, which means that some insurers may have reported denials for government-sponsored health coverage, such as Medicaid ^e

Source: GAO analysis of data reported by insurers to states.

^aThe data years cited represent calendar years and the data reflect the most recent complete year of data available.

^bData were reported to GAO by the Ohio Department of Insurance.

^cData were obtained from Connecticut’s *Consumer Report Card on Health Insurance Carriers in Connecticut* (Hartford, Conn.: 2010).

^dData were obtained from the Maryland Insurance Administration’s *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007* (Baltimore, Md.: 2009).

^eData were obtained from the Department of Managed Health Care’s Web site from June through September 2010 (www.wpsa.dmhc.ca.gov/fe/search).

In addition to variation across states in aggregated rates, state and other data also indicated that coverage denial rates varied significantly across insurers. For example, the California data indicated that in 2009 claim denial rates ranged from 6 percent to 40 percent across six of the largest managed care organizations operating in the state. Similarly, preauthorization denial rates in Connecticut varied across 21 insurers, with rates among the seven largest insurers ranging from 4 percent to 29 percent in 2009. Somewhat narrower variation across insurers was also evident in the AMA data, with claim denial rates in 2010 that ranged from

less than 1 percent to over 4 percent across the seven insurers represented in those data.³⁹

State and other officials told us about several factors that may have contributed to the variation across insurers and make it difficult to compare data across insurers. First, California officials told us that insurers may interpret a state's reporting requirements differently and noted that some insurers may count certain claims transactions as denials that the state would not consider a denial. This was evidenced by discussions with one insurer who told us that if asked to report the number of claims denied, some insurers might include claims where the service was approved but the insurer paid nothing because the member was liable for the charge, which California officials would not characterize as a denial. Officials from the insurer said that their current overall denial rate is 27 percent, but it would be 18 percent if member liability denials were excluded. Officials from California and AMA also indicated that circumstances unique to an insurer may affect their denial rate. For example, California officials told us one insurer's denials rose sharply in a month because providers were submitting claims to the insurer's HMO when they should have gone to the preferred provider organization (PPO). Rather than transferring the claims, the HMO denied all of them, and then the PPO paid the claims shortly after that.

**State and Other Data
Indicated That Coverage
Denials Occurred for
Various Reasons and
That Denials, If Appealed,
Were Frequently Reversed**

According to state and other data, coverage denials occurred for various reasons. For example:

- Claim denials were often made for billing errors such as duplicate claims and missing information on the claim. For example, data from Maryland showed that the most prevalent reason for claim denials in 2007 was duplicate claim submissions, accounting for 32 percent of all denials.⁴⁰ Among six of the largest managed care organizations in California, the four that reported on the most prevalent reasons for claim denials in 2009 all reported duplicate claims as one of those reasons. With regard to claims missing required information, the 2010 AMA data indicated that five of the seven insurers represented in the data made 15 percent or more of

³⁹ According to officials, the AMA claim data included data for insured products offered by the companies represented and self-insured products administered by the companies.

⁴⁰ The calendar year 2007 data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007*.

denials on the basis that the claim was missing information, such as documentation of preauthorization. Data from Maryland showed that 74 percent of denied claims did not meet the state's criteria for "clean" claims, those claims that include all of the required information needed for processing.⁴¹

- Denials of claims also frequently resulted from eligibility issues. For example, for six of the seven insurers in the 2010 AMA data, over 20 percent of claim denials occurred as a result of eligibility issues such as services being provided before coverage was initiated or after coverage was terminated.
- Insurers also denied preauthorizations and claims as a result of judgments about the appropriateness of the service, such as that the service was not medically necessary or was experimental or investigational, although less frequently than for billing errors and eligibility issues. Data from Maryland showed that in 2007 insurers denied nearly 40,000 preauthorizations or claims because they determined the services were not medically necessary.⁴² This was a relatively small number compared to the 6.3 million claim denials reported in the same year.⁴³ The 2010 AMA data showed that only one of the seven insurers denied claims on the basis that services were not appropriate, specifically that the service was experimental or investigational, with about 9 percent of denials made for that reason.⁴⁴ NAIC data on complaints filed with states in 2009 also provided some information on coverage denials related to the appropriateness of services. Specifically, the data showed that of the

⁴¹Maryland reports the total claim denial rate, as well as a denial rate for "clean claims"—those health care claims submitted by a health care provider on one of two widely used industry standard billing forms and that also include all of the essential information needed by a plan for processing—in their Semi-Annual Claims Data Filing Reports.

⁴²The data were obtained from The Maryland Insurance Administration's *2007 Report on the Health Care Appeals & Grievances Law*.

⁴³The data were obtained from the Maryland Insurance Administration's *Report on Semi-Annual Claims Data Filing for Calendar Years 2005-2007*.

⁴⁴The data on the reasons for claim denials reflect the reasons assigned by the insurer that denied the claim. According to AMA officials, there is no requirement that insurers assign the most specific reason for the claim denial, and they sometimes assign more general reasons. For example, although a denial may have occurred because the insurer determined a service was not medically necessary, the insurer may document that the claim was denied because the service was not covered, which could be for reasons other than that the service was not medically necessary.

approximately 14,000 complaints related to coverage denials, at least 8 percent were related to the insurer's determination that the service was not medically necessary and 2 percent were related to the determination that the service was experimental.

State and other data indicated that coverage denials, if appealed, were frequently reversed in the consumer's favor.⁴⁵ The data from the four states that we identified as collecting data on the outcomes of internal appeals filed with insurers indicated that at least 39 percent of internal appeals resulted in the insurer reversing its original coverage denial. Officials from two insurance companies explained that denials are frequently reversed because the consumer or provider submits additional information, such as the consumer's medical records. Officials from one of these insurance companies also explained that because insurers receive additional information through the appeals process, reversals of denials are expected even when the company is using accepted medical criteria to make the initial assessment of the appropriateness of the service; and regulators are sometimes concerned when few appeals result in reversals of denials. See table 4 for a summary of the outcomes of internal appeals reported by insurers to Connecticut, Maryland, New York, and Ohio.

⁴⁵Reversals of coverage denials were limited to denials for which an appeal was initiated. The data we reviewed did not allow for a systematic calculation of an "appeal rate"—the number of coverage denials for which an appeal was initiated—for several reasons, including different data sources or data years for denials and appeals data. Data from Ohio did provide limited information; specifically, for the first quarter of calendar year 2010, Ohio data indicated that 0.5 percent of claim denials were internally appealed.

Table 4: Number and Outcomes of Internal Appeals Filed with Insurers across States in GAO’s Review

State	Type of insurer reporting ^a	Data year ^b	Number of internal appeals	Percentage of internal appeals where initial determination was reversed
Connecticut ^c	HMOs	2009	1,932	53
	Indemnity managed care organizations	2009	1,797	59
Maryland ^d	HMOs, nonprofit health service plans, and commercial insurers	2009	4,844	50
New York ^e	HMOs	2009	5,968	39
	Commercial insurers	2009	71,787	47
	Nonprofit indemnity insurers	2009	8,946	48
Ohio ^f	All insurers	2010 (1 st quarter)	6,434	48

Source: GAO analysis of data reported by insurers to states.

^aThe types of insurers reported in this column are the categories used by each state and may not be comparable across states.

^bThe data years cited represent calendar years and reflect the most recent complete year of data available, unless indicated otherwise.

^cData were obtained from Connecticut’s *Consumer Report Card on Health Insurance Carriers in Connecticut* (Hartford, Conn.: 2010). The reversal rates represent the aggregate reversal rates for 6 HMOs and 15 indemnity managed care organizations.

^dData were obtained from the Maryland Insurance Administration’s *2009 Report on the Health Care Appeals & Grievances Law* (Baltimore, Md.: 2010).

^eData were obtained from the *2010 New York Consumer Guide to Health Insurers* (Albany, N.Y.: 2010). The reversal rates represent the aggregate reversal rates for 12 HMOs, 28 commercial insurers, and 5 nonprofit indemnity insurers.

^fData were reported to GAO by Ohio and represent internal appeals filed by all insurers licensed in Ohio.

Data on the results of appeals filed with states for external review also indicated that denials were frequently reversed. A study conducted by AHIP on 37 states’ external appeal programs showed that for 2003 and 2004, about 40 percent of external appeals resulted in denials being reversed.⁴⁶ More recent data from the six states we contacted indicated

⁴⁶America’s Health Insurance Plans, *Update on State External Review* (Washington, D.C.: 2006).

similar rates of denials being reversed upon external appeal. See table 5 for a summary of the outcomes of external appeals indicated by state data.

Table 5: Number and Outcomes of Appeals Submitted for External Review across States in GAO’s Review

State	Types of insurers for which denials were appealed ^a	Data year ^b	Number of external appeals resolved	Percentage of appeals where insurer determination was reversed or revised
California ^c	Managed care organizations with enrollment over 400,000	2009	1,606	54
Connecticut ^d	Managed care organizations	2009	184	40
Florida ^e	Managed care organizations	State fiscal year 2010	186	49
Maryland ^f	HMOs, nonprofit health service plans, and commercial insurers	2009	915	54
New York ^g	HMOs	2009	570	38
	Commercial insurers	2009	812	42
	Nonprofit indemnity insurers	2009	395	41
Ohio ^h	Traditional health insurers, PPOs, HMOs, and Public Employee Health Benefit Plans	2008	311	23

Source: GAO analysis of data reported by states.

^aThe types of insurers reported in this column are the categories used by each state and may not be comparable across states.

^bThe data years cited represent calendar years unless indicated otherwise, and the data reflect the most recent complete year of data available.

^cData were obtained from the California Department of Managed Health Care’s *2009 Independent Medical Review and Complaint Results* report.

^dData were reported to GAO by the Connecticut Insurance Department.

^eData were reported to GAO by the Florida Agency for Health Care Administration.

^fData were obtained from the Maryland Insurance Administration’s *2009 Report on the Health Care Appeals & Grievances Law* (Baltimore, Md: 2010).

^gData were obtained from the *2010 New York Consumer Guide to Health Insurers* (Albany, N.Y.: 2010). The reversal rates represent the aggregate reversal rates across 12 HMOs, 28 commercial insurers, and 5 nonprofit indemnity insurers.

⁴⁶Data were obtained from the Ohio Department of Insurance's *Patient Protection Act Report for the Year 2008* (Columbus, Ohio: 2009). The data represent external reviews for denials because the service was not appropriate and denials for contractual reasons, which were less frequently reversed than denials because the service was not appropriate.

The data on the outcomes of external appeals also indicated that the rate at which denials are reversed, if appealed, may vary depending on the reason for the denial and the type of service denied. For example, one study identified through our literature review looked at 740 external appeal decisions in California in 2001 and 2002. The study showed that appeals resulted in denials being reversed in 42 percent of cases where the denial resulted from the determination that services were not medically necessary and 20 percent of cases where services were determined to be experimental and investigational.⁴⁷ Further, the study showed that reversals of denials were more likely for certain services, such as gastric bypass surgery, stem cell transplants, and breast reduction surgery, than for other services, such as residential behavioral health care. Data from Florida also indicated variation in outcomes of external appeals based on the reason for the denial and the type of service denied. For example, for state fiscal year 2010, denials were reversed in 49 percent of cases where the denial resulted from the determination that services were not medically necessary and in 60 percent of cases where the service was deemed experimental or investigational, although there were fewer appeals of coverage denials for this reason.⁴⁸ Further, the data showed that appeals were more likely to result in a denial being reversed when the denial was for diagnostic testing and pharmaceuticals than for other services, such as cosmetic surgery and durable medical equipment.

Finally, federal and state data indicated that appeals and complaints related to coverage denials sometimes resulted in financial recoveries for consumers. According to data from DOL, more than 9,600 complaints related to coverage denials by group health plans resulted in about 500 recoveries of payments totaling nearly \$7 million in fiscal year 2010. Data

⁴⁷C. R. Gresenz and D. M. Studdert, "External Review of Coverage Denials by Managed Care Organizations in California" (RAND Institute for Civil Justice, Santa Monica, Calif.: 2005). See app. II for the list of studies that included external appeal data by the reason for the denial being appealed and the type of service being denied.

⁴⁸Data were reported to GAO by the Florida Agency for Health Care Administration. Maryland's data, obtained from the Maryland Insurance Administration's *2009 Report on the Health Care Appeals & Grievances Law*, also included some information on external appeals by the type of service being denied.

reported by states to HHS in applications for the Consumer Assistance Program grants also documented that complaints and appeals resulted in recoveries.⁴⁹ Specifically, 21 of the 35 states submitting applications reported financial recoveries. For example, Maryland reported recovering more than \$1.4 million for consumers in fiscal year 2009 as a result of internal appeals. NAIC data on complaints filed with states also gave some indication of recoveries. For example, NAIC's 2009 data indicated that of the approximately 14,000 complaints related to coverage denials, over 4 percent resulted in an outcome where money or benefits were returned to the consumer and about 7 percent resulted in the insurer paying more of a claim than was initially paid.

Agency Comments and Our Evaluation

HHS provided us with written comments on a draft version of this report. These comments are reprinted in appendix III. HHS agreed with our findings, noting in particular the need to improve the quality and scope of existing data, and suggested clarifications, which we incorporated. HHS and DOL also provided technical comments to the draft report, which we incorporated as appropriate.

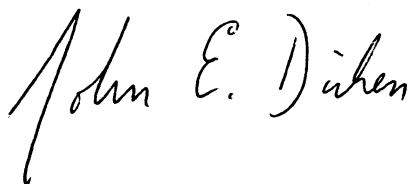
In its written comments, HHS emphasized the importance—for policymakers, regulators, and consumers—of data on health insurance application and coverage denials. HHS noted that data on application and coverage denials can help increase transparency in the private health insurance market and that these data can also provide an important baseline measure for evaluating the impact of changes resulting from PPACA. In its comments, HHS also noted that data collection on application and coverage denials has been uneven across insurers, plans, and states and that very little information is available to help analysts understand the causes or sources of variation in the data that are available. According to HHS, more effort is needed to improve the quality and scope of existing data collection to give policymakers and regulators better and richer data to evaluate health insurance plan practices and market changes and to produce measures that may be useful to consumers when they are shopping for insurance.

⁴⁹In October 2010, HHS awarded nearly \$30 million in Consumer Assistance Program grants to 35 states and the District of Columbia. States receiving the grants are required to begin reporting data 6 months after the award notice on the number of inquiries filed with the state about health coverage, the reasons for the inquiries, and the outcomes of the inquiries.

In its written comments, HHS also identified a limitation to our data that needed some clarification. Specifically, HHS pointed out—correctly—that while our draft report provided information on the percentage of claims that were denied, as well as data on the outcomes of internal appeals and external reviews of denied claims, our draft report did not provide data on the frequency with which claim denials are appealed by consumers. These data were not included in the report because the data we reviewed did not allow for a systematic calculation of an “appeal rate”—the number of coverage denials for which an appeal was initiated—for several reasons, including different sources or years of denials and appeals data we reviewed. In response to HHS’ comments, we added language to the report clarifying this limitation. For context, we also added information on the appeal rate from one quarter for one state—the only information we identified on internal claims appeal rates. HHS also noted that the statement in our draft report that “denials are frequently reversed” upon appeal may be confusing, because readers may assume a large number of claim denials are ultimately overturned. We revised the language in our draft report to prevent this misinterpretation of our data, by stating that coverage denials, if appealed, were frequently reversed in the consumer’s favor.

We are sending copies of this report to the Secretaries of HHS and DOL, the congressional committees of jurisdiction, and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial "J" and "D".

John E. Dicken
Director, Health Care

Appendix I: Methodology for Selecting States and State Data Reviewed by GAO

In order to describe the data on denials of applications for enrollment and coverage of medical services, we contacted six states to interview officials and to obtain data the states collect and track on denials and appeals related to denials. The six states we selected included states identified in the literature, through searches of state insurance department Web sites, or in interviews with experts as a state collecting data on the incidence of application or coverage denials.¹ These also included states that collect or track data on appeals related to coverage denials reviewed by insurers (internal appeals) or reviewed by external parties (external appeals). The six states accounted for at least 20 percent of national enrollment in private health insurance.

Once we selected the states, we asked officials from each state whether they collected the following types of data: (1) incidence of application denials; (2) incidence of coverage denials, including incidence of denials of preauthorizations and claims; (3) incidence and outcomes of appeals reviewed by insurers (that is, internal appeals); and (4) incidence and outcomes of appeals reviewed by external parties (that is, external appeals). If state officials reported collecting the data, we reviewed at least the most recent year of data available. We reviewed data from one state on the incidence of application denials, from four states on the incidence of coverage denials, from four states on the number and outcomes of internal appeals, and from all six states on the number and outcomes of external appeals. (See table 6.)

¹Because we did not survey all states to determine whether they collect data on the incidence of application or coverage denials, there may be other states that collect such data that were not known to experts or discussed in the literature. For example, through the course of our work, we found that Texas requires certain insurers to report on the number of requests for verification of coverage for proposed services that insurers declined.

Table 6: Information on Denial Data Collected by and Private Health Insurance Enrollment for States in GAO's Review

State	Reported collecting data on the incidence of application denials	Reported collecting data on the incidence of coverage denials	Reported collecting data on internal appeals, including outcomes	Reported collecting data on external appeals, including outcomes	Total number of people enrolled in private health insurance in 2008 (in thousands)	Percentage of national enrollment
California		✓		✓	22,848	11.4
Connecticut		✓	✓	✓	2,575	1.3
Florida				✓	11,129	5.5
Maryland	✓	✓	✓	✓	4,171	2.1
New York			✓	✓	12,567	6.3
Ohio		✓	✓	✓	8,109	4.0

Source: GAO summary of state and U.S. Census Bureau data.

Note: Table includes data that officials from selected states reported collecting. U.S. Census Bureau data are from the bureau's Current Population Survey, 2009 Annual Social and Economic Supplement.

Appendix II: Methodology for and Studies Identified by Structured Literature Review

To identify research that examined private health insurance denials, including the incidence of denials of applications for enrollment and of coverage for medical services (i.e., “coverage denials”) and the incidence and outcomes of appeal related to coverage denials, we conducted a structured literature review. This review resulted in 24 studies that we determined to be relevant to our objectives. To conduct this review, we searched 23 reference databases for articles or studies published from January 2000 through July 2010,¹ using a combination of search terms, such as “denial” and “insurer.”² We determined that a study was directly relevant to our objectives if it: (1) included empirical analysis related to the incidence of application denials, the incidence of coverage denials, or the incidence and outcomes of appeals related to such denials; and (2) analyzed, at minimum, denial or appeal data from an entire state or two or more insurers. In addition to searching the reference databases, we checked the bibliographies of the relevant studies to identify other potentially relevant research and interviewed several private health insurance experts about research done on denials.

We identified 24 studies in the literature that included empirical analyses examining (1) the frequency of denials of applications for enrollment or (2) the frequency of or reasons for denials of coverage for medical services and outcomes of appeals related to such denials. Table 7 identifies the number of studies that address these topics, with some studies addressing more than one topic.

¹The 23 databases were BIOSIS Previews, NTIS: National Technical Information Service, Social SciSearch, ABI/INFORM, Gale Group PROMT, SciSearch: a Cited Reference Science Database, Pharmaceutical News Index, EMCare, Elsevier BIOBASE, EMBASE, Gale Group Business A.R.T.S., General Science Abstracts, Wilson Applied Science & Technology Abstracts, EconLit, Readers’ Guide Abstracts, Wilson Social Sciences Abstracts, Gale Group Trade & Industry Database, Gale Group Legal Resource Index, MEDLINE, CANCERLIT, EMBASE Alert, Periodical Abstracts PlusText, and Wilson Business Abstracts.

²We searched the reference databases for the terms “denial” or “refusal” and “health plan,” “insurer,” “carrier,” or “issuer” with all of the following combinations of terms: (1) “application” or “enrollment;” (2) “coverage,” “claim,” or “preauthorization;” and (3) “complaint,” “appeal,” or “dispute” and “coverage,” “claim,” “service,” or “preauthorization.”

Table 7: Index of Studies Examining Private Health Insurance Denials, by Topic

Topic	Study numbers	Total number of studies
Frequency of denials of applications for enrollment	2, 3, 11, 20	4
Frequency of denials of coverage for medical services	5, 6, 7, 10, 16, 17, 19, 22, 24	9
Reasons for denials of coverage	5, 6, 7, 17, 19	5
Outcomes of appeals related to denials of coverage	1, 4, 8, 9, 12, 13, 14, 15, 18, 21, 23, 24	12
By reason for denial being appealed	9, 12, 13, 23	4
By type of service being denied	9, 13, 23	3

Source: GAO.

The 24 studies that GAO identified in the literature are as follows:

1. American Association of Health Plans. *Independent Medical Review of Health Plan Coverage Decisions: Empowering Consumers with Solutions*. Washington, D.C., 2001.
2. America's Health Insurance Plans. *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits*. Washington, D.C., 2009.
3. ———. *Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits*. Washington, D.C., 2007.
4. ———. *Update on State External Review Programs*. Washington, D.C., 2006.
5. American Medical Association. *2010 National Health Insurer Report Card*. Chicago, Ill., 2010.
6. ———. *2009 National Health Insurer Report Card*. Chicago, Ill., 2009.
7. ———. *2008 National Health Insurer Report Card*. Chicago, Ill., 2008.
8. California Healthcare Foundation. *Independent Medical Review Experiences in California, Phase I: Cases of Investigational/Experimental Treatments*. Prepared by the Institute for Medical Quality for the California Healthcare Foundation, Oakland, Calif., 2002.

9. Chuang, K. H., W. M. Aubry, and R. A. Dudley. "Independent Medical Review of Health Plan Coverage Denials: Early Trends." *Health Affairs*, vol. 23, no. 6 (November/December 2004), 163-169.
10. Collins, S. R., J. L. Kriss, M. M. Doty, and S. D. Rustgi. *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007*. New York, N.Y., 2008.
11. Doty, M. M., S. R. Collins, J. L. Nicholson, and S. D. Rustgi. *Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007*. New York, N.Y., 2009.
12. Foote, S. B., B. A. Virnig, L. Bockstedt, and Z. Lomax. "External Review of Health Plan Denials of Mental Health Services: Lessons from Minnesota." *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 34 (2007), 38-44.
13. Gresenz, C. R., and D. M. Studdert. *External Review of Coverage Denials by Managed Care Organizations in California*. Working Paper No. WR-264-ICJ, RAND Institute for Civil Justice, Santa Monica, Calif., 2005.
14. Gresenz, C. R., D. M. Studdert, N. Campbell, and D. R. Hensler. "Patients In Conflict With Managed Care: A Profile of Appeals in Two HMOs." *Health Affairs*, vol. 21, no. 4 (July/August 2002), 189-196.
15. Gresenz, C. R., and D. M. Studdert. "Disputes over Coverage of Emergency Department Services: A Study of Two Health Maintenance Organizations." *Annals of Emergency Medicine*, vol. 43, no. 2 (February 2004), 155-162.
16. Kaiser Family Foundation / Harvard School of Public Health. *National Survey on Consumer Experiences With and Attitudes Toward Health Plans: Key Findings*. Washington, D.C., 2001.
17. Kapur, K., C. R. Gresenz, and D. M. Studdert. "Managed Care: Utilization Review in Action at Two Capitated Medical Groups." *Health Affairs*, Web exclusive (2003), W3-275-282.
18. Karp, N., and E. Wood. *Understanding Health Plan Dispute Resolution Practices*. Washington, D.C., 2000.

19. Pearson, S. D. "Patient Reports of Coverage Denial: Association with Ratings of Health Plan Quality and Trust in Physician." *The American Journal of Managed Care* (March 2003), 238-244.
20. Pollitz, K., R. Sorian, and K. Thomas. *How Accessible is Individual Health Insurance for consumers in less-than-perfect health?* Prepared for the Henry J. Kaiser Family Foundation, Menlo Park, Calif., 2001.
21. Pollitz, K., J. Crowley, K. Lucia, and E. Bangit. *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*. Prepared for the Henry J. Kaiser Family Foundation, Menlo Park, Calif., 2002.
22. Schauffler, H. H., S. McMenamin, J. Cubanski, and H. S. Hanley. "Differences in the Kinds of Problems Consumers Report in Staff/Group Health Maintenance Organizations, Independent Practice Association/Network Health Maintenance Organizations, and Preferred Provider Organizations in California." *Medical Care*, vol. 39, no. 1 (2001), 15-25.
23. Studdert, D. M., and C. R. Gresenz. "Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations." *The Journal of the American Medical Association*, vol. 289, no. 7 (Feb. 19, 2003), 864-870.
24. Young, G. P., J. Ellis, J. Becher, C. Yeh, J. Kovar, and M. A. Levitt. "Managed Care Gatekeeping, Emergency Medicine Coding, and Insurance Reimbursement Outcomes for 980 Emergency Department Visits from Four States Nationwide." *Annals of Emergency Medicine*, vol. 39, no. 1 (January 2002), 24-30.

Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 16 2011

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "PRIVATE HEALTH INSURANCE: Data on Application and Coverage Denials" (GAO 11-268).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script, reading "Jim R. Esquea", is positioned above the typed name.

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS" (GAO-11-268)

The Department appreciates the opportunity to review and comment on this draft report.

The Affordable Care Act (ACA) of 2010 required GAO to study the rates of such application and coverage denials. GAO reviewed the data available on denials of the applications of enrollment and coverage for medical services.

We would like to emphasize the importance—for policy makers, regulators and consumers—of the data presented in your report, and make note of Center for Consumer Information and Insurance Oversight's (CCIIO) role in improving and expanding data collection on application and coverage denials to help bring about increased transparency in private health insurance.

We would like to also bring your attention to an important piece of data not included in your analysis. Although GAO's draft report provides information on the percentage of claims that are denied by private health insurance plans, as well as data on the outcomes of internal appeals and external review of denied claims, it does not provide data on the frequency with which claims denials are appealed by consumers. This letter offers views on why the gap matters and what might be done to close that data gap. It also highlights HHS' role, together with our Federal partners in the Departments of Labor (DoL) and Treasury, in crafting federal regulations to both create more uniform federal protections for internal appeals and external review and enforce notice requirements so that consumers are aware of their appeal rights, as required by the ACA.

Why the Data on Application and Coverage Denials Matter

Data on application and coverage denials help increase transparency in private health insurance. However, more effort is needed to improve the quality and scope of existing data collections to give policymakers and regulators better and richer data to evaluate health insurance plan practices and market changes, and to produce measures that may be useful to consumers when they are shopping for insurance.

The GAO's draft report makes it abundantly clear that data collection on application and coverage denials have been uneven across insurers and plans and across states. The report also reveals that very little information is available to help analysts understand the causes or sources of variation in the data that are available. For example, the GAO analyzed data—collected by CCIIO and displayed in the individual market plan finder on HealthCare.gov—on applications denials by plans in the individual health insurance market. The data perform an important function—alerting consumers to the uncertainty that goes along with applying for private coverage in the current market. The data also provide an important baseline measure for evaluating the impact of the ACA. We should, for example, expect to see a sharp reduction in these application denials over time, since denials for pre-existing conditions will be a thing of the past after 2014.

Similarly, the GAO's analysis of claims denials primarily serves to illustrate that there is variation across issuers. Unfortunately, not much more can be said about these data. Although the data illustrate wide variation in the reported rate of claims denial, the GAO was unable to describe the sources or significance of that variation. Further, it is possible that the states that do

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provide data are also the states with stronger appeals protections such that the reported rates are not representative of the national picture.

The GAO report also reveals that the scope of existing data collection needs to be expanded to assure transparency across the health insurance market.

How Often Do Consumers Appeal Claims Denials and What Obstacles Do They Face?

Together with our Federal partners in DOL and Treasury, HHS has crafted Federal regulations to create more uniform Federal protections for internal appeals and external review and to implement improved notice requirements for consumers. In order for the Departments to provide oversight for those new protections, data on the rate at which claims denials are appealed (and the outcomes of those internal appeals and external reviews) are needed.

ACA directed the GAO to study data on denials including denials where a "health plan later approves such coverage." Unfortunately, due to the limitations of existing data collections, the GAO, with one small exception, was not able to report data on the frequency with which claims denials are appealed in any segment of the market. Consequently, the GAO risks confusion when it states that "denials are frequently reversed." Readers may reasonably assume that a large percentage of claim denials are ultimately overturned (with a consumer receiving a previously denied benefit payment). It is unclear that this is the case, especially in the pre-ACA patchwork of appeals protections. For example, in its own discussion, the GAO seems to suggest that reversals and recoveries for consumers may be rare, citing a favorable outcome for a plan enrollee in 5.2 percent of reported cases (i.e., the GAO reports that recoveries were made in 500 cases out of 9,600 complaints about benefit denials received by the DOL from enrollees in self-funded plans).

Systematic, standardized and richer data collection on claims denials and appeals is needed across market segments—in both the commercially insured market and in self-funded group plans—to provide transparency for consumers and meaningful information for policymakers.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Susan Barnidge; Krister Friday; Jawaria Gilani; Teresa Tam; and Hemi Tewarson made key contributions to this report.

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