Health Insurers Are Denying More Drug Claims, Data Shows

Offering a rare glimpse inside the hidden world of rejected insurance claims, new data shows a steady uptick among major private insurers.

By Sarah Kliff – The New York Times

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Prescription drug denials by private insurers in the United States jumped 25 percent from 2016 to 2023, according to a new analysis of more than four billion claims, a practice that has contributed to rising public outrage about the nation's private health insurance system.

The report, compiled for The New York Times by the health analytics company Komodo Health, shows that denial rates rose from 18.3 percent to 22.9 percent. The rejections went up across many major health plans, including the country's largest private insurer, UnitedHealthcare.

The data offers a rare look into the largely hidden world of rejected insurance claims. While some government-funded health plans are required to publish their denial rates, most private insurers keep that information confidential. Komodo draws from private databases that collect denial details from pharmacies, insurers and intermediaries.

Claim denials are "quite opaque, and a lot of decisions are made by private actors," said Dr. Aaron Schwartz, a health economist at the University of Pennsylvania. "There are legitimate questions about whether they are appropriate."

Widespread resentment toward health insurers boiled over last December after the murder of UnitedHealthcare's chief executive, Brian Thompson. Doctors and patients alike took to social media to share stories of insurers' refusal to pay for what they said was needed medical care.

Experts who have studied denials said the skyrocketing costs of popular new weight loss medications and greater automation of the claims process with artificial intelligence may have contributed to the rising rejection rates.

"The challenge for a lot of people accessing the health care system is that it is a morass of competing interests," said Arif Nathoo, Komodo's chief executive. "At the heart of it is a patient experience that is really suboptimal."

Drug denials by private plans have increased

The new analysis does not show what happens to patients after claims are denied. Often, insurance industry officials said, replacement claims for the same drug are eventually approved. It is unclear how many people end up forgoing their medicine altogether.

Decisions to deny claims are not always made directly by health insurance plans. Much of that work is done by pharmacy benefit managers, middlemen who are contracted to manage prescription drug coverage. Large employers can also play a role, dictating which drugs they want covered for their workers in their provided health plans.

AHIP, the insurance industry's lobbying group, laid some of the blame for denials on pharmacies, doctors and rising drug prices.

"Health plans approve the vast majority of claims they receive, and spending on prescription drugs continues to escalate," said Chris Bond, a spokesman for the group. "However, providers or pharmacies sometimes submit duplicative, inaccurate or incomplete claims that can result in an initial denial — a frustrating outcome for patients."

Last month, major insurers that provide coverage to most Americans pledged to reform their use of a tactic known as prior authorization. It can lead to delays in care because it requires providers to get permission for a treatment before the insurer will cover it. Insurers said they would aim to make 80 percent of prior authorization decisions in real time by 2027 and reduce the use of the method overall.

Prior authorization was responsible for about 10 percent of denied claims in the Komodo data. The analysis found that the most common reason for a drug claim to be rejected was that a refill had been requested "too soon," before the patient was eligible for more medication.

"Appropriate prescription drug denials can happen for numerous reasons, and many can be resolved within minutes," said Greg Lopes, a spokesman for the Pharmacy Care Management Association, a trade group for pharmacy benefit managers.

While UnitedHealthcare has been singled out by the public, the Komodo data shows that five of the largest private insurers have similar rejection rates, all of which have increased since 2016. (The rate of one insurer, Humana, dropped in the last two years of the analysis.)

Denials went up at five major health plans

UnitedHealthcare declined to comment on the new data. A spokesman, Eric Hausman, said in a statement that the company's own analysis of its denial data showed that most rejected claims were followed by a subsequent claim for the same drug that was approved.

"By far the most common reason a prescription is not filled right away is the refill is being sought too soon by the pharmacy and does not affect the member experience," he said.

Representatives for Aetna, Humana and Anthem declined to comment on the data. A Cigna spokeswoman did not respond to repeated requests for comment.

The increase in denials is sharper in the private plans that Americans typically receive through their employers than it is in public insurers like Medicare and Medicaid, the Komodo analysis found. Private plans now have a slightly higher denial rate than traditional Medicare. The rate of rejected claims is still lower than Medicaid, which covers low-income Americans, and private Medicare Advantage plans.

In a 2022 study, Dr. Schwartz of the University of Pennsylvania found a 15 percent increase in rejection rates by Medicare and private Medicare Advantage plans over a similar period, 2014 to 2019. A congressional investigation of those plans last year found that some had denied coverage for rehabilitative care to "boost profits."

The increased denial rates across the industry could reflect years of insurers layering new restrictions on top of one another, Dr. Schwartz suggested. Pricey new GLP-1 weight loss drugs like Ozempic, and other blockbuster medications, may have led insurers to increase restrictions on other drugs as they grappled with ways to offset those growing costs.

Michal Horny, a health economist at the University of Massachusetts, suggested the increased use of artificial intelligence to sort through claims might have also fueled the uptick in denials.

"In 2016 no one would have attempted to use A.I. for anything," he said. "Now A.I. is lot more prevalent in business processes."

It is difficult to track the effects of denials on patients, health economists say, because it requires linking insurer claims data with long-term medical records. But a handful of recent studies have found evidence of harm.

One published in 2023 followed 2,495 cancer patients as their health plan instituted a new prior authorization policy, and compared them against a group with no such restriction.

Image

Warris Bokhari paid $600 out of pocket for inhalers and rationed his doses as fires raged near his home and his insurer denied refills.Credit...Alex Welsh for The New York Times

The cancer patients with prior authorization requirements were more likely to have a sudden interruption in access to their oral chemotherapy medication, the researchers found. They faced, on average, a nearly 10-day delay.

"If you were already taking a drug for leukemia and then had interrupted access, we can view that as a bad outcome," said Michael Anne Kyle, a health economist at the University of Pennsylvania and the study's lead author. "You might think that it turned out fine but, for the person with cancer sitting there thinking 'I don't have the medications I need to live,' that feels terrible."

A 2024 study by a team of Yale economists looked at a spike in drug denials for Medicaid recipients in Louisiana after the state brought in a private contractor to run the public health plan.

In most cases, patients ended up filling a prescription for a cheaper, generic drug or similar medication, and it's unclear whether that had significant health effects.

Jacob Wallace, who led the study, described a hypothetical case of a child who had been taking a long-acting medication to treat A.D.H.D. but was switched to a short-acting one. It's possible that could have detrimental effects, he said, but "we're unlikely to pick that up without being able to link to educational performance data. The big picture is hard to see."

Some prescriptions without easy substitutions simply went unfilled, the study found. These included antibiotics and inhalers.

Dr. Warris Bokhari found himself fighting an inhaler denial this year as wildfires raged in Los Angeles and the flames crept within 200 yards of his home.

Worried that the air quality would aggravate his asthma, Dr. Bokhari tried twice to refill a prescription for an inhaler he had used for more than a decade.

He had recently switched health plans and his new insurer, Aetna, denied coverage both times. His plan covered "several clinical alternatives," an Aetna spokesman, David Whitrap, later told The Times. But Dr. Bokhari had found that the prescribed medication worked better for him. So he paid $600 out of pocket, rationed his doses and relocated to a hotel until the fires subsided.

Soon after, he got to work appealing the denials. He was perhaps uniquely qualified for the task. A former insurance executive at Anthem, he now runs a business that helps patients appeal denials.

On March 4, he sent a 14-page letter to Aetna executives and California insurance regulators, citing academic studies and letters from his doctor to make the case that his inhalers were necessary and should be covered.

The next day, the denials were reversed. The Aetna spokesman said it was a "courtesy exemption."

Reed Abelson and Rebecca Robbins contributed reporting.

An earlier version of this article misstated the location of Medicaid recipients whose denied claims were studied in 2024. It was Louisiana, not Tennessee.