TRANSPARENCY IN HEALTH INSURANCE DENIALS

A.B. 682 Assemblymember Liz Ortega

BACKGROUND

In the United States, 18 percent of adults with health insurance reported having a health insurance claim denied in the past year, and 85 percent of insured adults want regulators to mandate that health insurers report and disclose how often they deny claims.[1] However, because health insurers largely are not required to report claims denial data to regulators, information on the number and reasons for health insurance denials is largely unknown to the public.[2]

In the past, California's Department of Managed Health Care (DMHC) included the number of claims denied every month in the Annual Financial Report for each health care service plan.[3] However, this information was removed from DMHC's public reports beginning in 2010 because the department was not statutorily required to publicly report this information.

Even when health insurance denial data is reported to regulators, it is limited and inconsistent at best. For example, studies estimate these Affordable Care Act (ACA) marketplace plans deny patient claims at a rate ranging from 2 percent to 49 percent.[4] But aggregate claims denial for subsets of health plans provide little to no information about variations or trends in denial practices or rates across plans.

Even for the limited subset of health plans that disclose claims denials to federal regulators, like Medicare Advantage plans, information about the **why** an insurer denied a claim is not included in publicly reported claims data.[5] Health insurance claims may be denied before or after treatment is rendered and may be denied for a range of reasons including lack of prior authorization, lack of medical necessity, lack of coverage, ineligibility, out-of-network provider, insufficient information, or other reasons.

ISSUE

The lack of public transparency on health insurance denials ultimately harms patients' access to safe and effective health care. While patients and doctors report that health insurance denials are steadily on the rise, there are little to no requirements that insurers disclose and regulators publish data on health insurance denials.[6] Moreover, insurers' rationale behind these decisions to deny payment and coverage for health care services remain opaque for patients, providers, and regulators. Information on health insurance denials was described in a recent investigative report as "so crude, inconsistent and confusing that it's essentially meaningless."[7]

Transparency in health insurance denials can help patients, providers, and policymakers identify wrongful denials and harmful insurance practices or policies. Information about a health plan's claims denial practices can help patients identify when or if their plan is being incorrectly or inconsistently applied in their own insurance claims.

The absence of disaggregated information about claims denials also prevents regulators and lawmakers from identifying harmful insurance practices, like high rates of denials for certain types of treatment or patterns of denials that may result in discrimination. The lack of transparency in health insurance denials prevents policymakers from understanding whether and to what extent health insurance denials are contributing to increasing medical debt and other barriers to care.

SOLUTION

This bill will amend the Health and Safety Code to require DMHC to collect and publicly report monthly claims denial information on each health care service plan regulated by the Department. Specifically, the bill requires

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regulated health plans to include information about the number and costs of denied claims in Annual Financial Statements to DMHC.

The bill would also amend the Insurance Code to similarly require collection and reporting of claims denial information by the California Department of Insurance (CDI) for other health insurers.

The bill also requires health plans to report and both DMHC and CDI to publicly disclose the number of claims denied each month disaggregated by reason for the denial, including information on denials based on lack of prior authorization, out-of-network provider, medical necessity, experimental or investigational treatment, excluded service, insufficient information, ineligibility, untimely filing, or other reasons. The bill also requires health plan reporting and public disclosure of the number of prior authorization requests denied, in-network claims denied, and claims denied using predictive algorithms.

CONTACT

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ENDNOTES

1 *KFF*, "**Consumer Survey Highlights Problems with Denied Health Insurance Claims**" (Sept. 2023).

2 *ProPublica*, "**How Often Do Health Insurers Say No to Patients? No One Knows**" (Jun. 2023).

3 Monthly claims denial data was previously included in Schedule G of DMHC's Annual Financial Report for health care service plans.

4 *KFF*, "**Claims Denials and Appeals in ACA Marketplace Plans 2021**" (Feb. 2023).

5 *Health Affairs*, "**Coverage Denials: Government and Private Insurer Policies for Medical Necessity in Medicare**" (Jan. 2022).

6 *Washington Post*, "**Deny and delay: The practices fueling anger at U.S. health insurers**" (Dec. 2024).

7 *ProPublica*, "**How Often Do Health Insurers Say No to Patients? No One Knows**" (Jun. 2023).