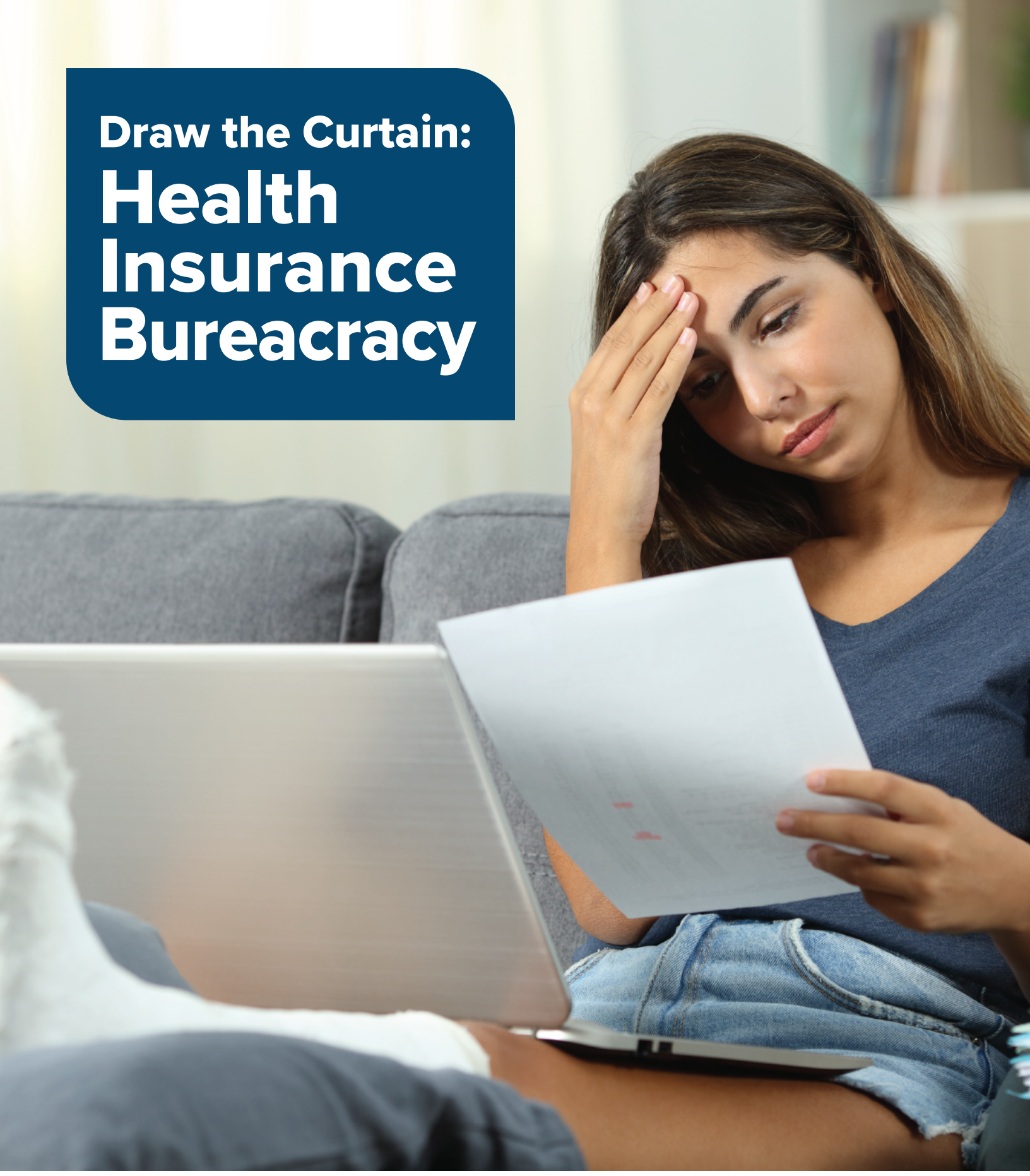

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OKLAHOMA STATE MEDICAL ASSOCIATION

OKLAHOMA STATE MEDICAL ASSOCIATION Fact Sheet: Health Insurance Bureacracy

Why Is the Oklahoma State Medical Association (OSMA) Concerned About Health Insurance Bureaucracy?

From increasing regulations and paperwork to dictating patient care, health insurance companies are frequently coming between physicians and their patients. As the leading voice for Oklahoma physicians and a strong advocate for the health of all Oklahomans, the OSMA is opposed to increasingly unnecessary red tape and bureaucracy that places barriers to quality patient care.

Health Insurance Claim Denials Are on the Rise

According to a recent KFF (formerly Kaiser Family Foundation) study of denials in the Affordable Care Act (ACA) marketplace, insurance companies rejected an average of 17% of claims in 2021, even when patients saw an in-network physician or other health care provider.[1]

Denied Claims Cost Hospitals, Doctors and Consumers Billions of Dollars a Year

While current figures are not available, according to a study by the Healthcare Financial Management Association, $252 billion in health care claims were denied in 2017, averaging a loss of $5 million a year per physician/health care provider.[2]

Denied insurance claims not only place a burden on patients and physicians; they also grow the cost of healthcare by increasing the need for paperwork, additional staff for filing and appeals, diverting physicians' time from patient care and discouraging patients from seeking preventative care.

Technology Has Made It Easier, and Quicker, for Insurers to Deny Claims

An investigation from ProPublica found that one health insurance company's processing system enabled reviewers to deny 50 claims every 10 seconds without even looking at the patient file. Using this system, the insurer processed approximately 300,000 claim denials in just two months, and helped drive the company's $6.7 billion in profits in 2022.[3]

The implications of Artificial Intelligence (AI) in claims processing are of extreme concern. AI-based denials are generated by false means and are not based on the evaluation or treatment of patients.

Prior Authorization Denials Lead to Worse Patient Outcomes, More Administrative Burden

Big insurance companies continue to require more procedures and medications go through costly and burdensome prior authorization processes that unnecessarily delay and deny patient care. According to a recent survey, the average physician practice completes 45 prior authorization requests per week. While health insurers claim they deny these claims to lower costs, 46% of physicians surveyed report prior authorization has led to immediate care or ER visits, driving up health care spending. [4]

Insurance Companies Know Many Denied Claims Will Not Be Appealed

Despite the potentially dire impact that denials have on patients' health or finances, data shows that denied claims are appealed only once in every 500 cases.[1]

Sources

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