Stuck in the Health Appeals Process

Doctors complain that insurance denials are worse than ever.

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Health insurers issue millions of denials every year. Many patients find themselves stuck in a convoluted appeals process marked by long wait times, frustrating customer service encounters and decisions by medical professionals they've never met who may lack relevant training.

Recent federal and state efforts as well as changes undertaken by insurance companies themselves have attempted to improve a 50-year-old system that disproportionately burdens some of the sickest patients at the worst times. And yet many doctors complain that insurance denials are worse than ever, as the use of prior authorization has ramped up in recent years, reporting by KFF Health News and NBC News found.

While the killing of UnitedHealthcare chief executive Brian Thompson in 2024 incited a fresh wave of public fury about denials, there is almost no hope of meaningful change on the horizon, said Jay Pickern, DBA, an assistant professor of health services administration at Auburn University.

Prior authorization varies by plan but often requires patients or their providers to get permission (also called precertification, preauthorization or preapproval) before filling prescriptions or scheduling imaging, surgery or an inpatient hospital stay, among other expenses.

The practice isn't new. Insurers have used prior authorization for decades to limit fraud, prevent patient harm and control costs. In some cases, it is used to intentionally generate profits for health insurers, according to a 2024 U.S. Senate report. By denying costly care, companies pay less for health care expenses while still collecting premiums.

For most patients, though, the process works seamlessly. Prior authorization mostly happens behind the scenes, almost always electronically, and nearly all requests are quickly, or even instantly, approved.

But the use of prior authorization has also increased in recent years. That’s partly due to the growth of enrollment in Medicare Advantage plans, which rely heavily on prior authorization compared with original Medicare. Some health policy experts also point to the passage of the Affordable Care Act in 2010, which prohibited health insurers from denying coverage to patients with preexisting conditions, prompting companies to find other ways to control costs.

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