HPM researchers are focusing on burdens that keep people from insurance coverage and health care

In 2023, it was estimated that 26 million Americans, or 8 percent of the population, lacked health insurance. That number has been halved from the 49 million who lacked insurance before the Affordable Care Act. Substantial barriers to coverage and care remain even with more affordable plans and options.

The American Recovery Act and Inflation Reduction Act have made high-quality zero-premium plans available to millions, but some have yet to sign up.

“While enrollment surged, millions of people still did not sign up for coverage,” said Coleman Drake, associate professor of health policy and management, whose research focuses on health insurance marketplaces. “The issue was clearly not premiums, nor was it the quality of coverage—Marketplace coverage is often better than job-based coverage these days. Rather, the issue was administrative burdens. People weren't aware of the coverage available to them.”

HPM assistant professor Miranda Yaver, who also studies administrative burdens, says issues can often be divided into three categories, as defined in Pam Herd and Don Moynihan’s book *Administrative Burden: Policymaking by Other Means:* learning costs, compliance costs and psychological costs.

“At one point, Arkansas implemented work requirements on Medicaid that led to 18,000 people losing health coverage, not because they weren’t working, but because of administrative burdens,” said Yaver. “The people affected didn’t know about the requirements or that it applied to them – the learning cost. Documenting work hours or exemptions (compliance cost) was onerous, and there was a sense of being overwhelmed and anxious (psychological cost). All are burdens that differ between going to the doctor when you need one versus having an insurance plan that essentially hopes you don’t get sick.”

Drake says the same burdens can affect people who don’t sign up for insurance under the ACA. They are unaware of the options, and navigating the enrollment process and prerequisite paperwork can be difficult.

Most administrative burden analysis focuses on public programs, says Yaver, who has also researched burdens in employer-sponsored insurance and job-based coverage. Drake, who primarily studies enrollment, says a common issue he sees is lower-income enrollees having trouble paying the monthly premiums.

“It's not necessarily the affordability of the premium that's the problem—that can be just a few dollars—but needing to send in a money order or check every month when you lack access to credit cards or banks can be difficult,” he said.

In private insurance, Yaver says the problem isn’t so much the ease of payments—many private insurance plans are provided by employers that have payment systems in place—but things like prior authorizations for procedures or required pre-approval for prescribed care. “While most prior authorizations are approved, they are a key vehicle for coverage denials, which thrust patients and their physicians into a sea of burden.”

Some insurers require providers to undertake a peer-to-peer discussion with a physician employed by the insurance company, who may not be a specialist in the same area. They may also require appeal letters from care providers or ask the patient to coordinate between the company and physician—all burdens that require not just time and effort but also health literacy, which the patient may not possess.

Enrollees signing up for Medicare face another burden: numerous plan choices: traditional Medicare, which can have hundreds of plan options depending on where an enrollee lives, or Medicare Advantage, which can have more than 40 plans to choose from. Add in gap coverage and Part D prescription drug coverage, which makes a lot for anyone, even experts, to sort through.

Since some of the problems around administrative burdens were created when ACA marketplaces were closed, Drake and Yaver say policymakers at the state and federal levels play a significant role in determining whether administrative burdens are a barrier to coverage.

“Recent changes to the marketplaces in the 2025 federal tax and spending bill like shortening open enrollment periods, ending year-long open enrollment for the lowest income enrollees, and creating onerous income verification requirements were deliberate choices to increase the burdens in enrollment, said Drake. “The Congressional Budget Office acknowledges these burdens in their projections on how the new law will affect enrollment, estimating that they will increase the number of uninsured by over a million people.”

In 2023, insurers participating in HealthCare.gov (the marketplaces created by the ACA) denied nearly one out of every five claims, with 37 percent of out-of-network claims facing rejection; less than one percent of the denials were appealed.

“Something by which I was struck in my examination of health insurance appeals was the process of independent medical reviews —that is, appeals external to the health insurer,” said Yaver.

Pennsylvania utilizes this independent medical review process, but results from the program's first year were underwhelming. While 50 percent of denials were reversed, only 517 were filed in a state of 13 million people.

“The limited number of independent medical reviews in Pennsylvania is not uncommon, but rather reflects a broader set of state policies that the patient must go through internal appeal processes with their insurer first — but we know many people do not do so,” said Yaver. “Some states add additional burdens, too. Some require that individuals pay $25 to file an external appeal, and while some allow for electronic filing, others require that the appeal be physically mailed.”

Those burdens and others, says Yaver, add up to make things harder for patients that policy makers can legislate away if they want to and can handle what would likely be an increase in volume of appeals. “Connecticut has an outstanding Consumer Assistance Program to assist patients with appeals and broader health care and health insurance navigation; many states do not,” said Yaver. “This is an area for improvement when resources permit. But we also know that many states like to find clever ways, like burden amplification rather than reduction, to subtly undercut the reach of public programs that don’t get the public’s attention.”

Congress has tried to tackle part of the administrative burden issue with legislation requiring prior authorizations to be processed promptly. Some states have enacted laws that allow physicians to be exempted from prior authorization for certain procedures. However, as Yaver points out, the exemption process can add to the physician's burden to apply for exemptions with each insurer rather than with the licensing board or other authority.

The Employee Retirement Income Security Act, more commonly known as ERISA, hinders many legislative efforts to reduce administrative burdens. ERISA preempts state health policies that "relate to" its provisions concerning self-insured (or self-funded) employer-sponsored health plans, in which about two-thirds of covered workers are enrolled. That means that anything states want to do to reduce prior authorization burdens won't touch the majority of employer-sponsored insurance, the dominant health insurance model in the U.S.

Administrative burdens disproportionately affect lower-income people, according to both Drake and Yaver. “In my forthcoming book, *Coverage Denied: How Health Insurers Drive Inequality in the United States,* I examined the extent to which people denied coverage appeal their denial to insurers, and the extent to which they win,” said Yaver.

The most common reason a denial wasn't appealed was that patients were unaware they could, reflecting the learning cost burden. Other reasons for not appealing were assumptions that people rarely win, despite data showing a 50 percent reversal rate. Lower-income patients were nine percent less likely to appeal, according to Yaver, who also found that Black and non-White Hispanic patients were less likely to win an appeal on a denial, as were people in worse physical health.

A significant factor adding to the burdens is the rollout of AI tools by insurance companies to process claims, prior authorization requests or appeals. While this improves speed and efficiency in some ways, it can be vulnerable to missing critical information, leading to erroneous coverage denials, which have become the subject of lawsuits against several major insurance companies.

With changes at the federal policy level, Drake says 2025 has not been suitable for those who want to reduce administrative burdens, but there are solutions. "States could potentially decrease Marketplace income verification requirements by using the information they already have from other programs, such as SNAP, so that they only have to verify a person's income once, rather than each time they sign up for a different state-managed program," he said.

-Mike Friend