

Payer Barriers



Identifying the systematic
barriers in healthcare.

What Are Utilization Tools and How Have They Evolved?

Health insurers, commonly referred to as **payers**, are organizations that pool risk and manage health plan spending through **utilization management tools**.

Originally designed as guardrails against unnecessary spending, these tools have gradually shifted control of treatment decisions from providers to payers, and the administrative infrastructure built around them has grown far beyond their original intent.

\$1 trillion

U.S. healthcare spends roughly \$1 trillion on administration.



20-25%

of all healthcare costs are administrative.



Prior Authorization (PA) : a cost-control process that requires healthcare providers to obtain approval from a health insurance plan before providing specific services, treatments, or medications.



Drug formulary : an approved list of covered prescription medications separated into different tiers to determine coverage extent or whether a medicine is covered by an insurance plan.



Step therapy protocols : a coverage limit employed by insurance companies. Requires patients to try a lower-cost or preferred medication before prescribed treatment is covered.

Over decades, these tools have become significant barriers that providers and patients must navigate. Today, the U.S. healthcare system is known not just for its high costs but for delayed access to care.

How Prior Authorization Delays Care

Payers attach roughly 5,000 unique PA codes to procedures, diagnostics, drugs, and sites of care, creating a complex administrative process that sits between a provider's recommendation and a patient receiving care.

The Prior Authorization Process - Simplified

Physician orders treatment.

Provider submits PA request.

Insurer reviews request.

If denied — appeal process begins.

Care delivered — or abandoned.

Payers attach roughly

5,000

unique PA codes to procedures, diagnostics, drugs, and sites of care.

Physicians complete

43 PAs

per week.

Equal to more than

16 hours

of filling out forms and appealing denials.

The Impact on Patients and Providers

PA paperwork can lead to [treatment delays](#), [coverage denials](#), and [appeals](#). A study on children with inflammatory bowel disease found PA delayed treatment by 10 to 24 days and led to a 12.9% increased risk of hospitalization, surgery, or an emergency department visit within six months. Research shows that these delays can drive patients toward more intensive hospital care, undermining the original goal of managing costs.

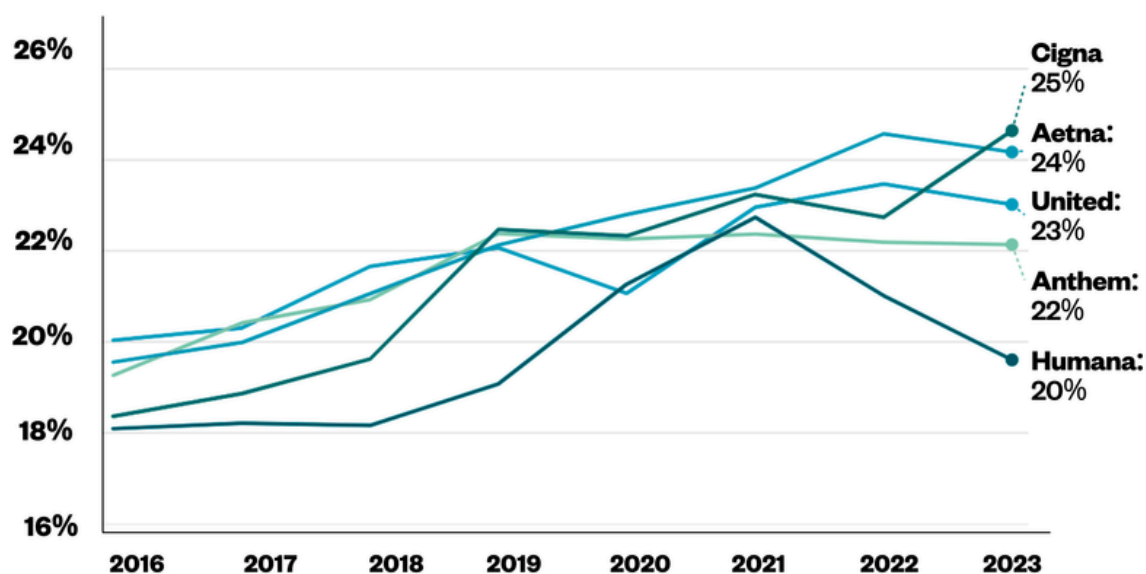
More than

90%

of 1,147 U.S. clinicians surveyed
said PAs delay care and impact patient
outcomes.

The Downstream Impact on Patients and Providers

DENIALS WENT UP AT FIVE MAJOR HEALTH PLANS



Source: Komodo Health

Across five major insurers, denial rates have steadily climbed since 2016, reaching 25% at Cigna, 24% at Aetna, and 23% at UnitedHealthcare in 2023.

The impacts of PA extend beyond the initial denial, potentially increasing patients' out-of-pocket costs. When coverage is denied, patients may face limited options, including paying full retail prices, pursuing less effective alternatives, or abandoning treatment altogether. Drug formularies compound this effect, leading to physician reluctance to prescribe newer and potentially more effective treatments.

7%

of all prescription claims are rejected due to PA requirements.

37%

of those rejected prescriptions are abandoned entirely.

Key Takeaway

Utilization management tools have increased administrative complexity while creating barriers between patients and the care their providers recommend. Long-term reform should focus on restoring provider control over clinical decision-making.

Source: Chapter 17 of Innovation is the Best Medicine