Designed to Fail:
How Insurance Denials Really Work

BOB COLEMAN:

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[Beat]

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[MUSIC]

HOST:

A $31,000 medical bill.
A four-week delay for a critical test.
And this didn’t happen to someone unfamiliar with the system –
It happened to someone who spent decades working inside it.

Welcome to ***Code WACK!*** — where we break down how health care really works in America... and what it means for you and your family.

Today, we're talking about insurance denials, hidden incentives… and why getting care can feel like navigating a system designed to stop you.

Our guest is **Bob Coleman**, a retired healthcare professional who spent more than 40 years serving veterans through the U.S. Department of Veterans Affairs—as a clinical pharmacist, medical informaticist, and researcher. His work included focusing on improving patient outcomes through evidence-based medicine.

Since retiring, he's turned his attention to healthcare system reform—authoring the e-books ***Unnecessary Deaths: How the Trump Administration Undercut Global and U.S. Healthcare and Medical Science*** and ***Hostile Takeover: How Wall Street and Congress Hijacked American Healthcare and How We Can Take It Back.***

HOST:

Welcome to Code WACK! Bob.

COLEMAN:

Thank you, Brenda.

HOST:

So you opened the ebook ***Hostile Takeover: How Wall Street and Congress Hijacked American Healthcare and How We Can Take It Back*** with a personal story about receiving an unexpectedly high bill for diagnostic tests. Can you share what that experience revealed to you about the system?

COLEMAN:

I had a set of specialized diagnostic tests at a cancer center in Seattle, and what I expected, was led to believe was my insurance would cover the cost.

But when the $31,000-plus bill came, It was a total shock.

There essentially was no transparency beforehand and no simple explanation afterwards.

And what struck me [was] that after even decades of healthcare experience, it was difficult to understand what and why I was charged, how that price was determined.

The experience made something very clear. Billing operates in a different system than care, and patients are largely outside that system.

HOST:

You contested the bill and, following multiple phone calls and discussions, resolved the matter by paying $1,200.

And that wasn't the only issue you ran into.

COLEMAN:

One of the things that was ordered for me was a bone marrow biopsy, and that bone marrow biopsy – prior authorization – was not approved.

It took an interaction with my hematologist and the back and forth, and finally, I got my bone marrow biopsy approved, but it took me four weeks to get a bone marrow biopsy.

Host: ***Wow.***

COLEMAN:

And that could have been life-threatening.
So these experiences reinforce a broader truth.

The system isn't organized around the patient. It is organized around billing and the payment process.

HOST:

If you've ever waited for approval…
or gotten a bill you didn't understand…
That's not necessarily a mistake.
It may reflect how the system is purposely designed.

So tell us a bit about yourself. Who are you and what experiences or turning points led you to become a healthcare reform advocate?

COLEMAN:

Initially, I had a 40-year career in the VA. I worked as a clinical pharmacist. I was director of Clinical Pharmacy Services at the VA in Palo Alta. Being in the VA, you really come out with a patient focus and not a financial focus. Finances are not an issue in this system, and everything is sort of pointed at the patient.

I retired in 2013. Particularly during the COVID crisis, I realized that the US had real problems with its health care.

It amazed me that we had 1.5 million COVID deaths, 20% to 40% unnecessary and it barely got a blip in the media. And what unnecessary means that if public health policies had to been followed and vaccine [recommendations] would've been followed, that those deaths would not have happened.

When you compare the United States to other countries, the per capita death rate in the United States was twice that of Canada, three times that of Australia.
And so what we were seeing is a lot of unnecessary deaths in the most expensive healthcare system in the world.

HOST:

Your new e-book Hostile Takeover builds on themes from your earlier e-book Unnecessary Deaths. At a high level, what do you see as the root causes of dysfunction in the U.S. healthcare system, and why is this moment especially urgent?

At the center of his answer is something he calls the "denial playbook."

COLEMAN:

The denial playbook is a set of standard tools that insurers use to control utilization and manage costs.

The most common tools include prior authorization before care and this is required before treatment can proceed and often involves multiple submissions and delays to get approval.

The other tactic is claims' denial. Both of these I've experienced. After care, services are rejected for reasons like "not medically necessary," "documentation of coding differences," fairly nebulous claims.

And the other strategy is what's called step therapy or fail first. And basically, patients must try lower cost treatments that the doctor recommends and feels are necessary first, even when the clinician recommends a different option.

There are other little things... narrow networks... and administrative complexity. All of these create friction and make it difficult for doctors and patients to get paid for their care. And in many cases, this delays or alters treatment.

Denials are increasing because No. 1, there is a direct financial incentive to limit payout.

Automation, AI technology and algorithms now allow decisions to be made faster at a higher volume and with less individual review.

Denial isn't an accident, it's a business process.

HOST:

When care is delayed or denied…
it's often not just about your specific case.
It's part of a larger system designed to control costs.

So what do you think most people misunderstand about insurance denials?

COLEMAN:

I think most patients assume that if care is denied, there must be a clear medical reason for it.

But in reality, most denials are never appealed and when appealed, many are overturned.

That tells us something important. A denial is often not the final decision. It is the beginning of a process.

Many patients don't know they can appeal, don't have the time or support to appeal, or are discouraged by the complexity of the appeal process.

You can't appeal online….You have to send in a letter. And sometimes those letters seem to get lost in the insurance company's process of handling mail. That's happened to my wife.

So the appeal process is made as difficult as possible.
And a denial is often the beginning of the negotiation, not the end of the decision."

HOST:

You also write about the human toll of the system—not just financial, but professional. How does the current model affect physicians' ability to exercise their own clinical judgment?

COLEMAN:

Physicians are trained for their clinical judgment to guide care.
But today those decisions are often filtered through prior authorization, insurance rules, administrative processes.

That changes their role from clinician to clinician plus administrator or clinician plus negotiator. It reduces the time of patients and increases frustration.

And over time contributes to burnout, loss of autonomy and moral distress.
Doctors are still responsible for care, but they no longer are fully in control of it.

HOST:

Yeah, and I'm sure that must be also very frustrating knowing that they're not able to deliver the care they want to patients.

COLEMAN:

My daughter is a primary care provider who used to work for Kaiser [Permanente], and she was seeing three to four patients an hour.

It was sort of like a factory. They sort of got evaluated by how many patients they saw, rather than how good their care was.

She basically left Kaiser because of that.

She was so disillusioned.

That was actually one of the reasons I wrote this book. There was my own run-ins with the healthcare system, but there was the experience of having somebody very close to me in the healthcare system and being totally burned out and frustrated by it.

HOST:

Yes, and just curious, so you said she left Kaiser and who is she working for now?

COLEMAN:

She’s working for the University of Washington in telemedicine, so she's providing telemedicine care. I think the university is considerably more reasonable, and so it's not quite as dominated by corporate practices. And it shows up a little bit, but she seems much more satisfied.

HOST:

So what happens when a healthcare system is built around billing…
instead of patients?
You get confusion.
You get delays.
And sometimes, you get harm.

That’s it for today’s episode of Code WACK!.

Next time, we look at what can actually be done to fix these problems as we continue our chat with Bob Coleman.

If you’ve had a healthcare experience like this, we want to hear from you.
Visit heal-ca.org and share your story.

And if you find this episode helpful, be sure to follow and share it.

Thanks for listening and stay healthy.

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