THE DENIAL ON TRIAL

A Framework for Medical Due Process Reform

Proposed by Michael Kissling | AbilityForge.net | In support of S.3829 & the Clinical Integrity & Patient Safety Amendment

THE CORE PROBLEM: A RIGGED PROCEEDING

The current insurance appeals system asks patients to prove they deserve care — while the insurer who denied them controls the evidence, employs the reviewing physician, and faces no consequence if they are wrong.

This is not a medical judgment system. It is a financial extraction system dressed in clinical language.

85.2% of UnitedHealthcare prior authorization denials in 2023 that reach independent review were overturned in 2023 compared to Medicare's overturn rate, less than 30%. This is not a medical disagreement rate. It is a fraud rate. The Industry average was 81.7% with 5 companies providing the bulk of the disparity.

THE FRAUD MECHANISM: PRIOR KNOWLEDGE OMISSION

Insurance medical directors deny legitimate claims by deliberately ignoring qualifying information already in their possession. This pattern — termed Prior Knowledge Omission — is not error. It is policy.

How it works: The insurer acknowledges a patient's qualifying status, then six months later denies a related claim while possessing direct evidence of that same status. The reviewer excludes objective clinical data on procedural pretexts.

What it costs: In documented cases, denial of a $55,000 preventative procedure cascades into over $1.1 million in taxpayer-funded emergency care, permanent disability, and lost productive capacity.

Who pays: Not the insurer. The patient pays with their body. The taxpayer pays with their dollars. The physician pays with their helplessness. The insurer pays nothing, but collect premiums from patients, employers, and the government. This creates self-replicating loops to provide increased payouts to shareholders as well.

THE SOLUTION: MEDICAL DUE PROCESS

The Denial on Trial framework applies the logic of Gideon v. Wainwright to healthcare: you cannot have a fair proceeding when one side has no counsel. The current IRE system asks a single body to be both judge and patient advocate simultaneously. That is structurally identical to the injustice that created the public defender system.

The fix is a separation of roles — turning the appeals process into a genuine adversarial proceeding with enforceable accountability on all sides.

CURRENT SYSTEM vs. DENIAL ON TRIAL MODEL

	CURRENT SYSTEM	DENIAL ON TRIAL MODEL
ROLE	Neutral arbitrator	**Patient advocate (Public Defender)**
BURDEN OF PROOF	Patient must prove need	**Insurer must prove denial is justified**
MEDICAL EVIDENCE	Reviewer may exclude data outside their note	**All submitted clinical data must be reviewed under penalty of perjury**
RULING AUTHORITY	IRE acts as judge and advocate simultaneously	**Administrative Law Judge rules independently**
PHYSICIAN ACCOUNTABILITY	No consequence for wrongful denial	**Mandatory State Medical Board referral on IRE overturn**
FRAUD MECHANISM	Prior Knowledge Omission goes unpunished	**Suppression of known qualifying evidence = malpractice trigger**

THE THREE ROLES

- **PROSECUTION:** The insurer files the denial — and bears the burden of proving it is justified against the established medical record.
- **PUBLIC DEFENDER (IRE):** The IRE advocates for the patient's complete clinical record against that denial — as a Public Defender, not a neutral arbitrator.
- **ADJUDICATOR:** An Administrative Law Judge rules independently — with authority to trigger financial penalties and mandatory board reporting.

THE LEGISLATIVE ARCHITECTURE

The Denial on Trial framework is not a standalone bill. It is the missing infrastructure that makes existing legislation functional:

- S.3829 (Corporate Crimes Against Healthcare Act) creates criminal and civil penalties for executives — but leaves medical directors unaccountable. The Clinical Integrity Amendment closes this gap by mandating State Medical Board referral when an IRE overturn demonstrates Prior Knowledge Omission.
- Warren's 500% clawback penalty generates revenue from bad-faith denials. The Patient Safety Buffer Fund routes that revenue to provisionally cover patients during the appeals process — so the insurer funds the safety net their denials require.
- H.R. 6852 (Advanced Wound Care Access and Reform Act) addresses the clinical harm caused by delayed wound treatment. The Denial on Trial framework provides the enforcement mechanism that gives H.R. 6852 teeth.

S.3829 is the sword.
The Clinical Integrity Amendment is the shield.
The Buffer Fund is the refuge needed to heal.
The Department of Recovery becomes the courthouse.

THE CAPACITY PROBLEM: WHY WE NEED A DEPARTMENT OF RECOVERY

S.3829's higher stakes — 300-500% clawbacks, mandatory board reporting, malpractice triggers — will cause insurers to fight every case harder. The current IRE infrastructure, already under strain, will be overwhelmed.

Private IREs rule case by case. They do not aggregate patterns. They do not notice that a single reviewing pediatrician is adjudicating hundreds of adult bariatric claims monthly. A federally-staffed Recovery Coordination Office would:

- Absorb IRE overflow volume created by the new penalty structure
- Maintain the cross-case pattern data that converts individual fraud into prosecutable systemic fraud
- Administer the Patient Safety Buffer Fund with federal accountability
- Feed the mandatory board reporting pipeline that the Clinical Integrity Amendment requires

S.3829 should require a capacity study of the IRE system prior to implementation. That study will find what advocates already know: the courthouse needs a staff.

"Long after the sensationalism of a verdict fades, the legislative reform that finally dismantles the Wrongful Denial Echo Chamber is what will endure."

— Michael Kissling, AbilityForge.net

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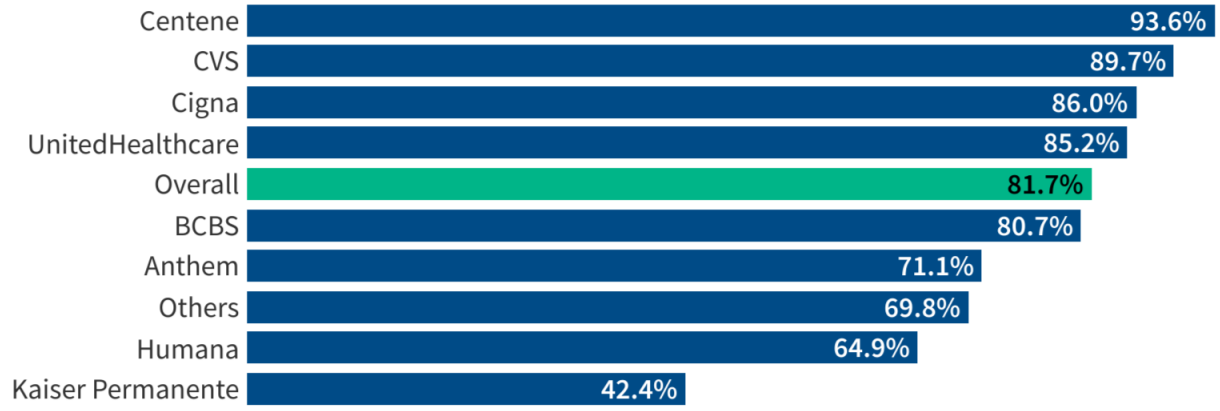
Figure 9

Across Most Firms, at Least Two-Thirds of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2023



Note: Data for Anthem BCBS is not included because of data quality issues.

Source: Limited Data Set, Contract Year 2023 Part C and D Reporting Requirements Data

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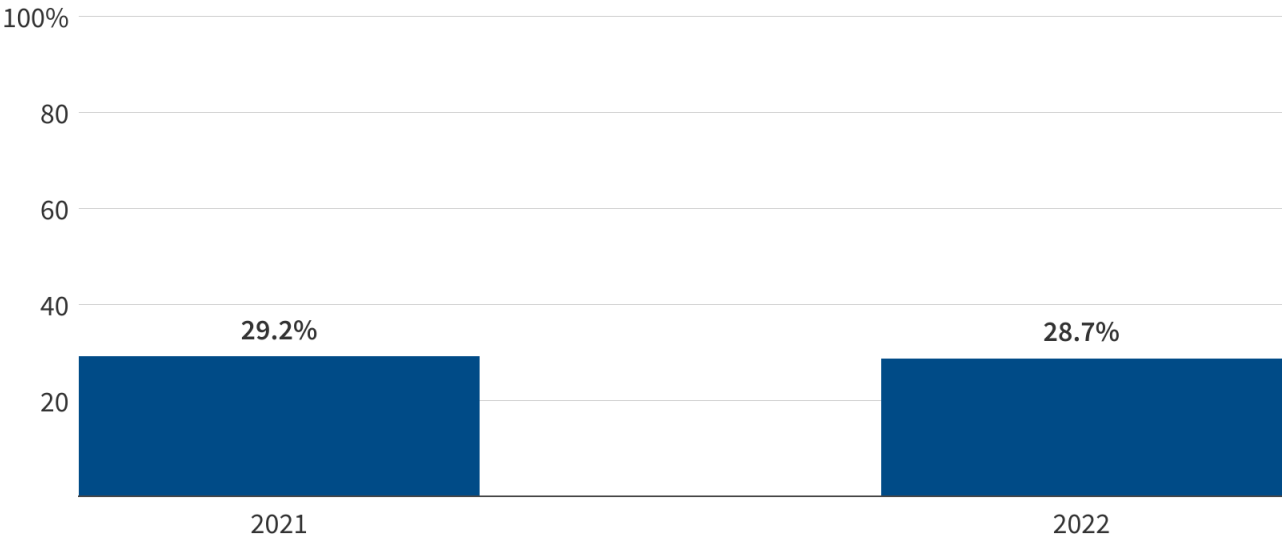
Figure 13

Just Over One-Quarter of Appeals Overturned Initial Denial of Prior Authorization Request in Traditional Medicare

Share of non-affirmed reviews appealed to level 1 that were overturned during the fiscal year



Source: CMS, "Prior Authorization and Pre-Claim Review Program Stats," September 15, 2023.

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