Jon Ossoff

U.S. SENATOR FOR GEORGIA

GEORGIANS' HEALTH AT RISK:

INSURANCE COMPANIES DENYING NECESSARY HEALTH CARE

U.S. Senator Jon Ossoff is continuing his investigation into the impact of rising health care costs, rising insurance premiums, prior authorization issues, and Medicaid cuts on Georgia patients, families, and health care providers. This second staff report focuses on Georgians who have suffered delays or denials of medically necessary health care due to issues with "prior authorization," where a health insurance company must approve a specific medical procedure, treatment, or medication before it can be covered.

Prepared by Staff of Senator Jon Ossoff

August 31, 2026

I. Executive Summary

U.S. Senator Jon Ossoff is continuing his investigation into the impact of rising health care costs, rising insurance premiums, prior authorization issues, and Medicaid cuts on Georgia patients, families, and health care providers. On July 6, 2026, Senator Ossoff released the first of a series of staff reports with stories of Georgians becoming sicker and losing their health insurance since the expiration of the Affordable Care Act's Enhanced Premium Tax Credits ("enhanced ACA tax credits"). This second staff report focuses on Georgians who have suffered delays or denials of medically necessary health care due to issues with "prior authorization," where a health insurance company must approve a specific medical procedure, treatment, or medication before it can be covered.

The Senator's staff has received dozens of reports from Georgia patients, who have reported that prior authorization issues with their insurance companies have resulted in delays and denials of medically necessary health care, leading, in some cases to untreated life-threatening conditions and/or severe financial hardship. Senator Ossoff's investigation into rising health care costs is active and ongoing.

As detailed in Section III, investigative findings to date include:

- Georgia cancer patients who report that delays in medically necessary care due to their insurance companies have put their lives at risk and caused severe suffering—including a mother whose son lost 70 pounds because the insurance company would not approve intravenous nutrition during his cancer treatment;
- Georgia parents who report that delays and denials of medically necessary health care by insurance companies have placed their children at risk of harm, including a one-year-old struggling to breathe whose treatment was delayed by an insurance company decision; and
- Georgia patients—including Georgians with disabilities—who report that their urgent conditions have gone untreated as insurance companies delay and deny their health care, leading to dangerous symptoms and even death—including a father whose son ultimately died by suicide as a result of his untreated condition.

Senator Ossoff's investigation into rising health care costs is active and ongoing. If you are a Georgia patient or provider who wishes to speak with a member of the Senator's staff, please visit Ossoff.senate.gov/HealthStory.

II. Background

Senator Ossoff launched an investigation into the impact of rising health care costs on Georgia patients, families, and health care providers in January 2026, after Congressional Republicans allowed the enhanced Affordable Care Act (ACA) tax credits to expire on December 31, 2025, and made cuts to Medicaid as part of the "One Big Beautiful Bill Act." The Senator's staff has received reports from Georgia patients who have reported rising health care costs, reduced or loss of coverage, and delayed health care since the enhanced ACA tax credits expired, and from providers who report that their patients' care is being delayed due to rising costs. These findings are detailed in the Senator's initial report in this investigation.[1]

Senator Ossoff has been working to prevent insurance companies from delaying or denying medically necessary health care to Georgia families. In April, Senator Ossoff first offered an amendment to a spending bill to prevent insurance companies from denying or delaying needed care, but Senate Republicans blocked his amendment. Then in June, Senator Ossoff offered another amendment[2] to prevent insurance companies from denying or delaying needed health care but was again blocked by Senate Republicans.[3] As part of the Senator's ongoing investigation, the Senator's staff has now received dozens of reports from Georgians focused on prior authorization issues that led to life-threatening conditions and severe suffering, including for children and Georgians with disabilities.

1 https://www.ossoff.senate.gov/wp-content/uploads/2026/07/26.07.06_LOSS-OF-ACA-TAX-CREDITS-%E2%80%94-GEORGIANS-GETTING-SICKER-HIGHER-COSTS-LOSS-OF-HEALTH-CARE.pdf.

2 https://www.ossoff.senate.gov/press-releases/watch-republicans-block-sen-ossoffs-amendment-to-prevent-insurance-companies-from-denying-or-delaying-needed-health-care/..

3 https://www.ossoff.senate.gov/press-releases/video-republicans-block-sen-ossoffs-amendment-to-prevent-insrance-companies-from-denying-or-delaying-needed-health-care/.

III. Findings

Since January 2026, the Senator's staff has received reports from Georgia patients and providers that prior authorization issues have put the lives of cancer patients at increased risk and caused severe suffering, placed children at risk of harm and injury, and led to conditions going untreated, resulting in dangerous symptoms and even deaths.

The accounts described within this report are all based upon statements made to the Senator's office or interviews with the Senator's office by impacted patients and families.

A. Georgia Cancer Patients Report that Delays in Medically Necessary Care Due to Prior Authorization Issues Have Threatened Their Lives and Caused Severe Suffering

Georgia cancer patients and their family members have reported to the Senator's staff that their medically necessary cancer treatments have been delayed and denied by their insurance companies, leading to severe symptoms and, in some cases, to painful deaths.

- Richard Jones, based in Atlanta, is 49 years old and a father to a 13-year-old daughter. He was diagnosed with adenocarcinoma, an aggressive form of prostate cancer. He reported that he has undergone multiple procedures—including the removal of 18 lymph nodes—to remove the cancer, but that his PET scans show the cancer has spread to additional lymph nodes. Even though his oncologist and radiologist prescribed proton therapy as the most effective treatment that would best guarantee Mr. Jones' survival, his insurance company has repeatedly denied his claims, despite letters of support from his doctors. Mr. Jones noted to the Senator's staff, "[My insurance company] deciding what my treatment should be wastes time while the cancer spreads throughout my body. I have a wife and daughter who rely on me. I need to survive." He reported that his insurance company finally agreed to cover the treatment around four months after it was prescribed to him.

- Kathy Lemoine, based in Lawrenceville, is a mother whose son, Andrew, was diagnosed at 29 years old with colon cancer and passed away six months later, shortly after turning 30. Ms. Lemoine reported that the process of watching her son deteriorate was "unbearable." "Many parts of his treatment required prior authorization. And the one thing you don't have

with cancer is time to waste," Ms. Lemoine observed. During his initial hospital stay after having a colostomy bag, Andrew was given and subsequently prescribed certain medications. However, Ms. Lemoine was unable to initially pick up Andrew's medication because his prescriptions required prior authorization, meaning their insurance company had not yet approved them. Ms. Lemoine reported, "stopping these medications would have been life threatening for Andrew." Ms. Lemoine was forced to pay out-of-pocket for the medications. During his chemotherapy, Andrew also suffered from extreme nausea and struggled to eat, and his mother requested that he receive intravenous nutrients. However, his insurance company refused to pay for the nutrient solution reportedly because Andrew was still being seen on an outpatient basis. Ms. Lemoine reported that for close to three months, the insurance company still refused to approve the solution, despite her many requests. Even when Andrew transitioned to inpatient care after being unable to eat, the insurance company still would not approve the solution for another month. Ms. Lemoine reported that during those two months Andrew lost 70 pounds and was constantly nauseated. Ms. Lemoine noted, "Andrew would still be gone today because his cancer was so advanced, but he may have lived longer and suffered so much less if he had proper nutrition."

• Ellen Miller-Mapp, based in Atlanta, is a senior citizen who was diagnosed in 2024 with multiple myeloma, a rare blood cancer. At each stage of her treatment, Ms. Miller-Mapp reported that she experienced "weeks-long" delays in receiving time-sensitive procedures and tests, including bone-marrow biopsies that would allow her doctors to assess whether her treatment was working. Meanwhile, her cancer progressed. "For a corporation to have a finger on the button of your life is ridiculous. They have their minds on profit margins. I just want to be healthy and alive," she said. Ms. Miller-Mapp is now in remission, but she reported that her insurance company took a long time to approve her bone marrow biopsies throughout her treatment because it "didn't like" the way in which the doctors planned to take the biopsy. "Insurance companies are making life-changing decisions, and they are not taking into consideration the people behind them. Executives in suits and ties should not be sitting around a table and deciding that people have no value."

• A Georgia patient based in Greensboro was diagnosed in 2024 with head and neck squamous cell carcinoma. Since his diagnosis, the cancer spread to his hips, causing him severe pain when walking. His oncologist prescribed radiation therapy on his hip, but he

reported that his insurance company refused to cover the treatment. Rather than wait 45 days to undergo the appeals process, which he was informed would be a risky waiting period, the patient decided to act quickly and paid $7,000 out of pocket for the treatment. The patient went from walking with extreme pain to being able to jog a few times per week, and he was finally reimbursed several months later. Then, in 2025, his oncologist prescribed an immunotherapy drug—a drug that he had previously been on—to continue to treat his cancer, which had spread to his bones, but the insurance company declined to cover it, reportedly stating that "[the drug] would not change [his] outcome." The insurance company informed him that he would have to pay out of pocket, which was about $50,000 every three weeks, if he wanted to continue using the drug. A few months later, the insurance company finally approved the medication. In April 2026, he suffered a spinal cord compression due to the cancer and had emergency surgery. Following the surgery, he received a month of rehabilitation, but the insurance company informed him that he could not contemporaneously undergo chemotherapy for the entire month due to "double billing." The patient's family reported that the only reason he was able to continue chemo during this time, and outlive the survival rate for his cancer, was because they fought the insurance company to obtain his treatments. His wife stated, "These insurance companies are trying to play God with people's lives."

• A Georgia patient reported that he had to prove to his insurance company that his prostate cancer was aggressive enough to receive a medically necessary PET scan. He had very high levels of a prostate cancer indicator and requested an MRI before receiving a medically necessary biopsy. His insurance company refused to cover the MRI, and he was forced to pay $650 out of pocket for the MRI. The patient reported that his insurance company approved the MRI 30 days later but refused to reimburse him. The MRI showed a 7mm lesion on his prostate, which the patient said changed his urologist's approach to the biopsy. The biopsy ultimately showed a mix of aggressive and non-aggressive cancer cells. After the biopsy, he needed a PSMA PET scan to ensure the cancer had not spread to other parts of his body—but his insurance company delayed this scan by one month, requiring a second opinion on the results of the biopsy before approving the scan. The patient reported that a second laboratory examined the biopsy and found a higher level of risk than the first lab. Although he ultimately received the scan, he said, "if my cancer had been more aggressive, the delays by [the insurance company] could have cost [me] [my] life."

B. Georgia Parents Report that Delays and Denials of Medically Necessary Health Care by Insurance Companies Have Placed Their Children at Risk

Georgia parents have reported to the Senator's staff that, even when their child's doctor prescribes a specific medication or treatment, insurance companies have delayed or denied medically necessary care, placing their children at unnecessary risk of harm or injury.

- Julia McCool, based in Buford, is a mother who has a two-year-old son. When he was about one year old, he was wheezing and having difficulty breathing, and Mrs. McCool took him to the ER where he was diagnosed with RSV and was prescribed an albuterol inhaler to force his airways open if he had an asthma attack. About one month later, her son started wheezing again, and Mrs. McCool took him back to the ER where she reported his doctors prescribed Flovent, a preventive medication that would lessen the risk of asthma attacks and wheezing over time. However, a day later, after leaving the hospital, Mrs. McCool had not heard from her pharmacy that the prescription had been filled. She called, only to learn that the medication required a prior authorization, which she said had not been approved. When she called her insurance company, they told her to "get the hospital to prescribe something else." Even though the company eventually approved the medication, Mrs. McCool reported that she was "desperate" and "making calls to get this done" while her son was sick and still wheezing: "My child was prescribed his doctor's first choice medication, and that should be what he gets. My insurance company should not decide what medication my child takes."

- Claire Sturgill, based in Chatsworth, is a mother to a three-year-old son with autism. Since fall of 2025, Mrs. Sturgill reported that she has been trying to secure a specialized bed to keep her son safe and stable at night. Even though her son's doctors have reportedly confirmed that the bed is a medical necessity, Mrs. Sturgill reported that her insurance company has refused to cover the cost of the bed, stating that the bed is not a medical necessity. Mrs. Sturgill noted, "As parents, it is incredibly difficult to rest at night, knowing that [my son] has outsmarted every other safety measure we have implemented. We just want to keep him safe."

C. Georgia Patients Report Delays and Denials of Medically Necessary Health Care by Insurance Companies Led to Untreated Conditions, Resulting in Harmful Symptoms and Even Suicide

Georgia patients, including those with disabilities, have reported to the Senator's staff that delays and denials of their medically necessary health care have led to untreated conditions, resulting in extreme pain, risk of injury, dangerous symptoms, financial stress, and even suicide.

- Lindsay Morrison, based in Fayetteville, learned that there was a problem with the discs in her spine in April 2025. She was diagnosed by an orthopedist with degenerative disc disease of the spine and was told she needed an immediate surgery to address one of the discs in her neck. Her doctor told her that if she had the surgery within 15 days, she would be guaranteed not to have nerve issues. The surgery was scheduled for mid-May, and then the day before the surgery, Ms. Morrison said she received a call from her doctor informing her that the insurance company would not cover the surgery because she had not first gone to physical therapy to address the issue. For four months, between May and August, Ms. Morrison said that her insurance company continued to delay and deny her access to the surgery, requiring her to "jump through hoops" to get the approval, including physical therapy sessions and obtaining a third-party opinion from a different doctor. Within two weeks of physical therapy, Ms. Morrison said she was in so much pain that she had to quit therapy and could not even tie her own shoes, take her dog outside, walk around the block, or participate in her daughter's birthday party. Ms. Morrison finally received approval for the surgery from her insurance company in August. She told the Senator's office that she now must take daily medication to deal with nerve issues that have emerged in her arm due to the delay in getting the surgery. "Every aspect of my life was affected," she reports. "Any faith I had in religion or people was completely gone after this experience."

- Paige Jobe, based in Commerce, was diagnosed in 1985 with grand mal seizures. After trying a variety of seizure medications to control the seizures, she started taking Lamictal, which had minimal side effects, around 1992. At the time, there was no generic version available. Mrs. Jobe reported the medication worked well enough for her, that even when she was "stressed, pregnant, or traveling long distances," she did not experience any seizures. Over ten years later, she felt off with the medication and went to her pharmacist, who said

there was now a generic drug, which meant her prescribed medication was much more expensive, even though her doctor had written "Brand Required" on the prescription. She reported, "without my knowledge, I was on the generic drug for about a month." Mrs. Jobe informed her insurance company of her symptoms, and they still would not approve the brand name Lamictal. In order for her to keep taking the Lamictal, she had to pay the difference between the cost of the generic and the brand name, about $500 per month. In 2013, Mrs. Jobe changed jobs and reported that she went through this process with her insurance company all over again. This time, the insurance company refused to cover the Lamictal because "a generic is now available." Mrs. Jobe continued to pay out of pocket, now $2,000 each month, to stay on Lamictal. In 2024, she could no longer afford the Lamictal and, assured by her doctors that the generic has the same amount of medication as the brand name, switched to the generic. In October 2025, she said she had her first seizure in decades. She woke up in an ambulance, strapped down, and terrified. "I live in fear that I'm going to be alone one of these days when I have a seizure, or that I will be driving when I have a seizure," she reports. Although her insurance company agreed to cover the Lamictal after this experience, Mrs. Jobe is still paying $2,200 each month for her medication because she is being charged a penalty for choosing a brand-name medication. In order to remain seizure free, she now has to pay thousands of dollars in penalty each month, which has led to Mrs. Jobe being in substantial debt.

• Nicole Cato, based in Newnan, experienced a high-risk pregnancy in 2024. Ms. Cato, who has a Medicaid managed care plan, struggled with chronic nausea and could not keep down food or water for most of her pregnancy. After several ER visits, she was prescribed an anti-nausea medication often given to cancer patients. She reported that her insurance company refused to cover the cost of her medication. She was eventually diagnosed with malnutrition, putting her and her baby's health at serious risk. She continues to face prior authorization delays and denials this year as she recovers from surviving a different, ectopic pregnancy and while managing her severe asthma.

• Margo Dietrich, based in Peachtree Corners, is a senior citizen who lives alone and who waited almost four months for her insurance company to approve her nerve ablation procedure. While waiting, she was forced to rely upon friends and acquaintances to help with the upkeep of her home. She reported that during the four months she was waiting for her

procedure, she experienced severe pain that required her to spend most of her day in bed, which she said made her weaker because she lost muscle mass. She reported this is the first year she had to wait for prior authorization.

• A Georgia patient based in Fayetteville reported that he lost his wife in 2010 following hospice care after his health insurance company twice refused to cover her cancer treatment due to "business constraints." His son was born with disabilities and struggled to process his mother's death. However, the Georgia patient reported the family's health insurance company only covered a yearly limit on therapy sessions and refused to authorize his son's medication for a three-week period. During this time, the Georgia patient said his son experienced severe depression and suicidal thoughts. The day after his son received his medication, his son took his own life.

• A Georgia patient based in Snellville lives with a chronic endocrine condition. In March 2025, she was prescribed a recently-FDA-approved medication that would help manage her condition. She reported that her insurance company repeatedly refused to cover the cost of the medication, even after she and her doctor appealed the refusal and sent over lab results as evidence of her condition. After the second denial, she said that her insurance company sent her a letter in April 2025 that said the lab results were normal and that she was "not sick enough" to receive this medication—forcing her to stay on her current "cocktail" of four different, daily pills that only "somewhat" treat her symptoms. The patient reports experiencing several symptoms, including being unable to sit for more than a minute without her legs going numb and being unable to prop her head up in her hands without her arms going numb. This new medication would have reportedly addressed these symptoms. "It's frustrating that a billion-dollar insurance company is refusing to pay for my medication, all because they think they know more about it than my doctor."

• A Georgia patient, based in Brookhaven, has an autoimmune disease that requires her to take several medications. According to the patient, her insurance company has "repeatedly" denied covering her medications even though they have been deemed "medically necessary" by her doctors. As a result, she said she has paid more than $30,000 out of pocket this year to continue to treat her condition. Each month, she must decide if her symptoms have abated enough that she can go without the medication, or else pay out of pocket or wait for a lengthy approval.