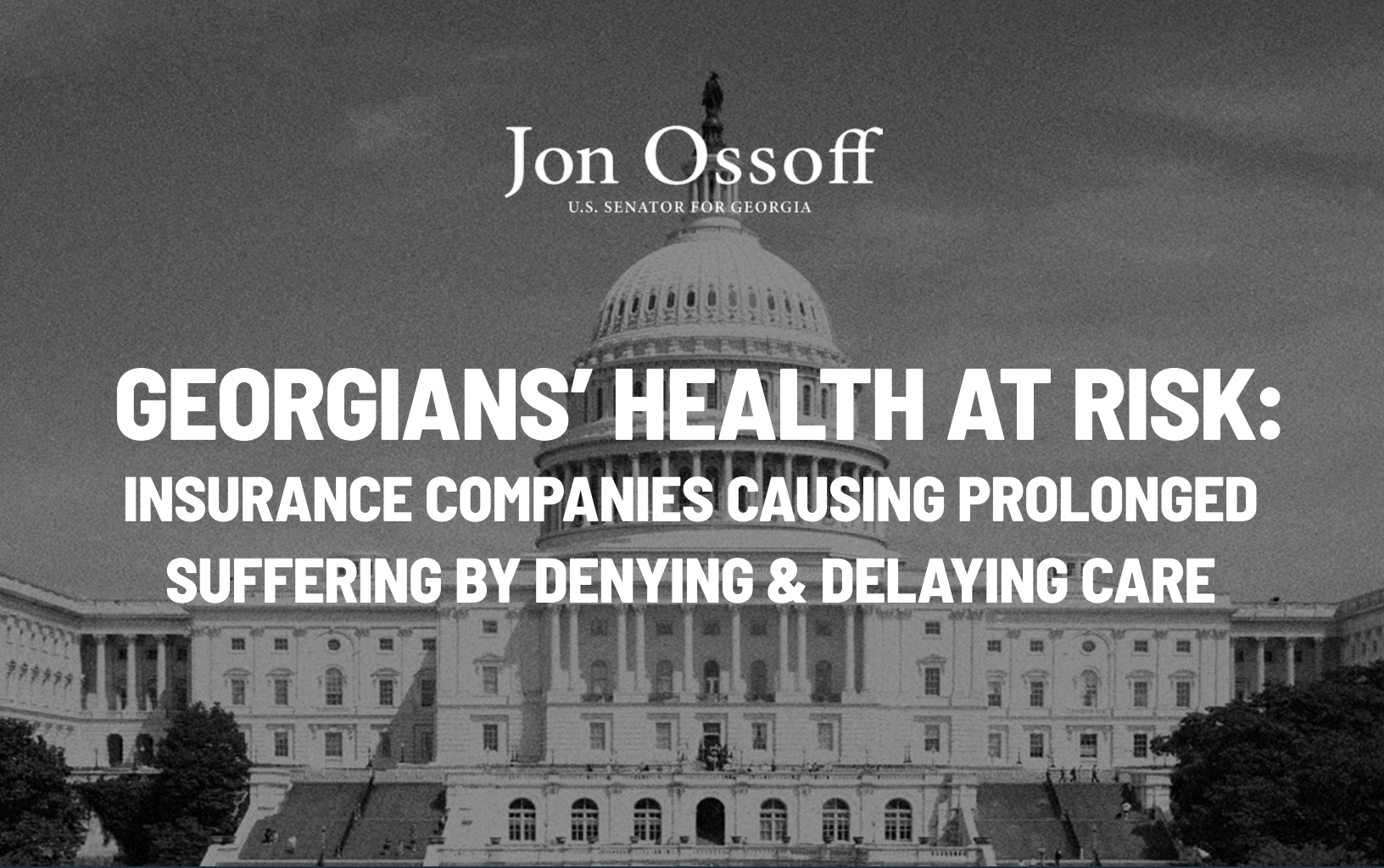




Jon Ossoff  
U.S. SENATOR FOR GEORGIA

# **GEORGIANS' HEALTH AT RISK: INSURANCE COMPANIES CAUSING PROLONGED SUFFERING BY DENYING & DELAYING 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. This fourth staff report highlights reports that the Senator's staff has received from dozens of Georgia patients who have reported that prior authorization issues have resulted in delays and denials of medically necessary health care, leading, in some cases, to untreated life-threatening conditions and severe financial hardship.

Prepared by Staff of Senator Jon Ossoff

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# **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 a first report with stories of Georgians becoming sicker and losing their health insurance since the Affordable Care Act's Enhanced Premium Tax Credits ("enhanced ACA tax credits") expired. On August 31 and September 18, Senator Ossoff released two additional reports focused on Georgians who say they 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.

This fourth staff report continues the Senator's investigation and highlights reports that the Senator's staff has received from dozens of Georgia patients who have said that prior authorization issues have resulted in delays and denials of medically necessary health care, in some cases leading to prolonged pain and suffering and serious, untreated conditions. Senator Ossoff's investigation into rising health care costs is active and ongoing.

As detailed in Section III, the Senator's findings in this staff report include:

- Denials in medically necessary procedures have reportedly caused Georgians pain and suffering and led to conditions going untreated, including a patient whose knee replacement surgery was denied three times, which he said left him in extreme pain and unable to walk without crutches for over six months; and a man who said his heart procedure was denied, forcing him to seek care at the emergency room.
- Georgia patients report insurance companies have delayed authorizing prescribed medications, including a woman with cystic fibrosis who relies on multiple prescribed medications, many of which she said were repeatedly denied due to prior authorization issues.

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](https://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 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 hundreds of 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.

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 large spending bill to prevent insurance companies from denying or delaying needed care, but Senate Republicans blocked his amendment.<sup>1</sup> Then again in June, Senator Ossoff offered another amendment to prevent insurance companies from denying or delaying needed health care but was again blocked by Republicans.<sup>2</sup>

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. The Senator released two subsequent reports detailing these accounts on August 31 and September 18.<sup>3</sup> This staff report, the fourth in the Senator’s ongoing investigation, reveals additional cases illustrating the harmful impacts on Georgians from prior authorization issues.

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.

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- 1 Press Release, “WATCH: Republicans Block Sen. Ossoff’s Amendment to Prevent Insurance Companies from Denying or Delaying Needed Health Care,” Office of Senator Ossoff (April 23, 2026), <https://www.ossoff.senate.gov/press-releases/watch-republicans-block-sen-ossoffs-amendment-to-prevent-insurance-companies-from-denying-or-delaying-needed-health-care/>.
  - 2 Press Release, “VIDEO: Republicans Block Sen. Ossoff’s Amendment to Prevent Insurance Companies from Denying or Delaying Needed Health Care,” Office of Senator Ossoff (June 4, 2026), <https://www.ossoff.senate.gov/press-releases/video-republicans-block-sen-ossoffs-amendment-to-prevent-insurance-companies-from-denying-or-delaying-needed-health-care/>.
  - 3 Press Release, “Georgians Report Experiencing Prolonged Pain as Insurance Companies Deny or Delay Care Doctors Say They Need,” Office of Senator Ossoff (Sept. 18, 2026), <https://www.ossoff.senate.gov/press-releases/new-georgians-report-experiencing-prolonged-pain-as-insurance-companies-deny-or-delay-care-doctors-say-they-need/>.

# III. Findings

Since January 2026, the Senator’s staff has received dozens of reports from Georgia patients that prior authorization issues have prolonged their pain and suffering, and led to conditions going untreated, resulting in dangerous symptoms and possibly even deaths. This report includes accounts from Georgians who report delays and denials in obtaining medically necessary health care procedures, including placement of a heart stent and replacement knee surgery, in addition to accessing prescribed medications. Georgia patients described the pain and suffering they endured as a result of the delays and denials, and the ways in which their health was threatened.<sup>4</sup>

- Matt Conley, from Martinez, reports that his 83-year-old father, Larry Conley, suffered a stroke affecting his left side on October 31, 2025. He says that within a week, the doctors stabilized his father’s vitals, located the plaque that caused the stroke, and prescribed medications to dissolve it. He reports that his father’s doctors and physical therapist informed him that his father was an excellent candidate for rehabilitation. The insurance company denied the request for transfer to physical therapy about three weeks after submitting the request, because he “did not meet the eligibility requirements for physical therapy.” Mr. Conley says that the insurance company “refused to accept an appeal of the denial from the family and demanded that it come from the patient,” Mr. Conley’s father. Mr. Conley reports that his father, “still coherent, requested an expedited appeal,” which was ultimately approved. Mr. Conley reports that his father was recovering well, but after being bedridden for over a month, his father soon developed signs of pneumonia and required a course of antibiotics, after which he was moved back to the general hospital floor. In respiratory distress, he was ultimately transferred to the emergency room and passed away on December 29, 2025. Mr. Conley said, “There is no doubt in my mind that if he’d been transferred to physical therapy when the doctors prescribed it, he would be alive today. He was forced to lie in bed for over a month, which made him susceptible to the pneumonia that ultimately killed him.”
- Lisa Agostoni, a Smyrna resident living with cystic fibrosis, relies on multiple life-saving medications. Ms. Agostoni reports that in 2026 alone, her insurance company has denied 10 of 13 medications prescribed by her doctor, some of which she has been taking for decades.

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<sup>4</sup> Every account in this report is drawn from statements or interviews that impacted patients and families shared directly with Senator’s Ossoff’s office.

The insurance company has denied them citing they are medically unnecessary, missing prior authorizations, or because they were not in the formulary of the company and the insurer prefers another drug that she cannot tolerate. Ms. Agostoni appealed the 10 denials and more than half of them were denied again. Her doctor then had to go through an appeals process requiring letters of medical necessity and decades-old medical files. All her medications were finally approved except for one new medication called Brinsupri that treats airway damage from years of infections. Ms. Agostoni reports that it takes her insurer 10-14 days on average to approve medications her doctor prescribes. She reports that she has had to ration Alyftrek, a medication that is essential to keep her alive, three times this year and that delays routinely stretch from weeks to over a month, disrupting her continuity of care.

- A patient from Marietta was diagnosed with breast cancer in 2022. Her doctor prescribed an aromatase inhibitor medication as a cancer treatment therapy. To help with the side effects of this therapy her physician prescribed her an additional medication to be taken alongside the aromatase inhibitor. After two years of taking this medication for severe side effects, her husband's employer changed insurance companies in December 2025. Her new insurer denied the medication and instead approved her to take an estrogen-based medication, which her physician advised against because with her type of cancer, estrogen can cause any lingering cancer cells to grow and spread. Her doctor tried to call the insurer to do a peer-to-peer review but reports that the insurer did not answer or return calls. The insurer finally approved the medication after the patient filed a complaint with the Georgia Office of Insurance and Safety Fire and appealed the denial to a third party. She was able to get samples from her doctor to cover the 2-week delay in approval. She reports that the insurer also denied a camera endoscopy that her doctor prescribed for a suspected gastrointestinal bleed, stating that the endoscopy was not "medically necessary." The treatment was only approved after intervention from a patient advocate and the doctor's office.

- Kim Archer, based in Marietta, reports that in February 2026, she went to the emergency room (ER) after experiencing painful indigestion and abdominal swelling. She reported that after one night in the ER, she was transferred to the hospital and underwent gallbladder surgery. Ms. Archer states that a few days after the surgery, she received a letter in the mail

from her insurance company denying her hospital stay because her stay in the hospital was not serious enough to warrant “an acute inpatient stay at the hospital.” The insurer finally covered the cost of the surgery but only after her employer’s human resources (HR) department intervened. If her HR had not intervened, Ms. Archer would have had to pay \$74,500 out of pocket. Ms. Archer reports experiencing perimenopause symptoms, including hot flashes, weight gain, hair loss, mood swings, tinnitus and increased ADHD symptoms. In late June, her gynecologist informed her that her estrogen and testosterone levels were “at zero” and prescribed Ms. Archer with estrogen patches. Ms. Archer reports that after being on the estrogen patches for a month, her gynecologist prescribed her with testosterone cream. Ms. Archer reports that coverage of the medication was not approved due to not being “medically necessary,” and that she would have to pay out of pocket. Ms. Archer reports that ultimately, she was never reimbursed by her insurance company. She states, “There are likely thousands of people who don’t know how to push back on insurance companies and so go without care because they feel like they don’t have alternatives. The insurance companies prey upon that.”

- Karin Fisher, based in Statesboro, is a special education professor at Georgia Southern University. She has a 22-year-old son with autism who suffers from severe depression. Dr. Fisher reports that her son’s insurer denied coverage of his depression medication, Spravato, because not enough information was provided to justify coverage and that her son became suicidal during the two-month delay. The insurance company eventually approved the medication after the psychiatric practice appealed the denial. In addition, her son attends a weekly social skills group for young adults with autism. Dr. Fisher reports she has been in a persistent battle with her insurance company to get her son’s out-patient care covered. She says the insurer alleges her son’s autism is not confirmed—despite a diagnosis since the age of two, and a re-diagnosis in January 2026—and therefore the treatment is not “medically necessary.” She now pays \$65 a week for him to attend the weekly groups and is in the process of going through a second appeal.

- Mark Cornman, from Williamson, reports that in March 2026, he saw a doctor for knee

pain and swelling, having already undergone three prior knee surgeries. His doctor diagnosed him with arthritis and determined he needed a knee replacement and scheduled surgery for early June. Mr. Cornman reports that one week before the surgery, his insurance company denied the surgery as not “medically necessary.” Mr. Cornman reports that his doctor appealed the denial and the insurer conducted a peer-to-peer review, but denied the surgery again, this time requiring six weeks of physical therapy first. Mr. Cornman completed the physical therapy, and his doctor rescheduled the surgery for August 19. The insurance company denied the surgery again, stating that his arthritis was not severe enough to warrant the surgery. His doctor is now appealing that decision. Mr. Cornman, a machinist who is on his feet roughly 10 hours a day during the week, says that “he can’t get around without crutches” due to the pain and has missed workdays as a result.

- Brittany Crowell, from Atlanta, reports extensive delays obtaining approval for reconstructive breast surgery following a double mastectomy, calling it “the biggest stressor of 2026 for my family.” She was diagnosed with stage three breast cancer in late 2024, and most of her treatment—including double mastectomy, several rounds of radiation therapy, and several rounds of immunotherapy—was covered by insurance. When her family changed insurance providers in 2026, Mrs. Crowell was immediately approved for a continuity of care program with the new insurer, which was meant to cover her pre-op visits and reconstructive breast surgery, scheduled for August 2026. Despite written approval for both the surgery and pre-op visits, every visit was subsequently denied, and she spent hours on hold trying to resolve the issue. She was ultimately forced to reschedule her surgery with a different surgeon for an initial consult, not even the reconstructive surgery itself, for March 2027. “The delays are extremely frustrating and take a heavy toll on me, especially because we should be celebrating the end to a difficult road,” she says. The extended delay has left Mrs. Crowell living with tissue expanders far longer than anticipated, causing daily discomfort from what were meant to be temporary devices.

- One patient, a 62-year-old resident of Gainesville, went to his doctor reporting pressure in his chest, dizziness and fatigue. He reports that his doctor conducted routine testing which revealed a significant blockage in a coronary artery in his heart. After additional testing, his cardiologist recommended a stent and scheduled it, but his insurer denied authorization on

the grounds that he was “asymptomatic.” He reports that the insurance company denied the procedure again following a peer-to-peer review. Still experiencing symptoms and concerned for his health, two days later, he went to the emergency room, where doctors determined the artery was approximately 90% blocked and they immediately placed a stent. He states, “It’s extremely frustrating when your doctor tells you how serious your health is and comes up with a medical plan and then the insurance company refuses to do anything about it.”