The Harmful Role of Prior Authorization and Claim Denials in New York Health Insurance

EXECUTIVE SUMMARY

Our analysis of publicly available prior authorization and claims data from New York state serves as a case study that reveals that denials are incredibly pervasive, costly, and harmful — more than readers of our report may assume. Rather than anything remotely resembling a well-oiled machine, the health insurance claims adjudication process is leaving millions to navigate the massive hurdles of the appeals process in order to receive medically necessary care. Meanwhile, the vast majority of people receiving denials do not attempt an appeal, meaning many end up forgoing necessary care or going into medical debt. The impact of these harms is not borne evenly across the population — chronically ill and vulnerable groups carry a disproportionate burden. Despite insurers claiming that denials occur for innocuous or even altruistic reasons, the data suggests insurers may be making decisions about whether to pay for medically necessary care based on financial motivations.

Background

In this report, we examine publicly available data on prior authorization and claim denials in New York state to better elucidate the scope and character of this problem through one state as a case study that may shine light on patterns in other places around the U.S.

We have undertaken this report because prior authorization and claim denials are a serious problem impacting tens of millions of Americans. In fact, this is a phenomenon that most insured Americans are familiar with, though it has not gotten widespread media attention until recently.

In the lead-up to and since the passage of the Affordable Care Act (ACA) in 2010, much of the conversation in the U.S. health care reform ecosystem has been centered on coverage. The ACA dramatically expanded the American population covered by health insurance, and advocacy efforts since then have focused largely on further expanding populations eligible for coverage and services Medicaid and marketplace plans cover. This work has been important, but it has been based on a faulty assumption that having a health insurance plan enables one to access care.

At People's Action Institute, we began noticing in 2021 that our members across the country, most of whom had health insurance coverage of some kind, were having trouble accessing care that they needed. We began work to address this issue through our Care Over Cost campaign in 2022, and as we reached out to people asking about their experiences with denials from their insurers, we found dozens of egregious stories of people suffering and on the brink of despair because an insurance company was denying the care they needed.

What we found among our membership was further reinforced when we saw the outpouring of anger about insurance denials on social media in December 2024.

While there is a plethora of anecdotal examples of prior authorization and claim denials and their impacts, there is not a lot of publicly available data, as private insurers are often not required to make their data public and choose not to when given the opportunity. That is why we undertook this report. Here, we analyze the limited publicly available data on prior authorization and claim denials in New York state to draw conclusions we believe are both important and relevant across the country.

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Foundational Concepts

As alluded to above, we believe health insurance companies are not delivering on the ostensible purpose of insurance. A National Institutes of Health report describes the purpose of health insurance as the following: "...promoting health, obtaining health care for individuals and families, and protecting people financially from exceptional health care costs. Health insurance pools the risks and resources of a large group of people so that each is protected from financially disruptive medical expenses resulting from an illness, accident, or disability."[1] This matches the common understanding many of us share: that health insurance exists to enable us to get care when we need it, without significant financial burden. But that is not the lived reality for many Americans. There are a number of different reasons for that in our convoluted health care system. In this report, we focus on prior authorization and claim denials.

Below are definitions of a few terms we will use in this summary:

- **Prior authorization denial:** Insurance companies often place a requirement that they sign off on both 1) medical necessity and 2) plan coverage of a planned treatment prior to the patient receiving it. Functionally, they must sign off before the provider is able to administer the treatment that they and the patient agree is best for them.
- **Post-service claim denial:** In other instances, an individual moves forward with a course of treatment, the provider sends a bill to the insurance company, and the insurance company refuses to pay it. Then, the provider or the patient is left bearing the cost.
- **Internal appeals** refer to appeals filed with the insurance company itself. This is generally the first appeal that is submitted for a denied service, and it can be submitted by the patient or the provider. The insurance company that denied the service makes the decision about whether to uphold their denial or overturn it and pay for the care.
- **External appeals** refer to appeals filed with a third-party external adjudicator. Whereas the insurance companies may have incentives to uphold their own denials, the third parties that decide external appeals are generally more impartial. Typically, external appeals are only filed after an internal appeal has already been upheld.
- The term **provider** can refer to an individual health care practitioner like a physician or nurse practitioner, or to an institution that administers care like a hospital or private practice.

Data We Examine

In this report, we limit our scope to data on prior authorization and claim denials from New York state. We made this choice so that we could take a deeper look at trends within a set of data on denials, in hopes that we may identify patterns that could shed light on what is happening across the country. We chose New York as the case study because it is one of the states with the most robust publicly available data on prior authorization and claim denials.

The data that we analyze in this report comes from two sources:

- **Health Care Claim Reports:** These are spreadsheets that have been released by New York's Department of Financial Services (DFS) quarterly since 2022. The spreadsheets contain information about post-service claims submitted, claims denied, claims appealed, and associated monetary values for state-regulated New York insurers across four market segments.
- **External Appeal Database:** This is a database that has been regularly updated and maintained by New York's Department of Financial Services since 2019. The database records document individual independent medical reviews (IMRs), or external appeals, of health insurance coverage denials (both prior authorization and post-service denials) within the state.

Key Findings

While the data we analyzed is specific to New York state, we believe the trends we saw are likely to bear out across the country, as the way insurance companies operate is relatively consistent across states and nationally. New York has a health insurance regulatory framework that is more robust than most states, so if anything, we would expect to see these harmful patterns exacerbated in states with less stringent regulatory frameworks.

Key Finding #1: Claim denials are very common and tens of billions of dollars are tied up in them per year. Specifically, claims are denied at a rate of at least 20% across market segments. These denied claims taken together across markets amount to over 59 million denials per year in the state of New York alone, totaling over $89 billion in billed charges.

Key Finding #2: The internal appeals process is playing an inappropriately outsized role in New York. In 2023, successful appeals of denied claims shifted the responsibility of payment from patients and providers to insurers at a massive scale. The billed totals for

1 Coverage Matters: Insurance and Health Care. Institute of Medicine (US) Committee on the Consequences of Uninsurance. Washington (DC): National Academies Press (US); 2001.

successfully appealed claims was over $3.1 billion. Because insurers typically pay a negotiated rate for care, which is less than what is billed to a patient, what the insurers ended up paying for those successfully appealed claims was $538 million. Either figure represents a significant amount of money, but it is important to remember that these figures only take into account the claims that were appealed and in which the appeal was successful. Considering that appeal rates are incredibly low — less than 2.5% across the markets considered in this report, these figures are likely just the tip of the iceberg.

If similar adjudication errors occur among non-appealed denials (which vastly outnumber appealed denials), then a substantial volume of expensive, inappropriately denied care remains unaddressed by appeals. This has deeply troubling implications for patients, including the risk of physical harm caused by forgone care and financial harm caused by medical debt.

The appeals process should help protect patients in rare cases of adjudication mistakes, rather than serve as a mechanism to effectively pass costs on to those who do not appeal, and serve as a barrier to coverage for those who do.

Key Finding #3: External appeal overturn rates are worryingly high. Across insurance types, external appeals are overturned at rates above 30%. The rate at which external appeals are overturned in Managed Long Term Care and the Children's Health Insurance Program insurance markets, with relatively vulnerable populations, is particularly troubling: 72.12% and 59.84% overturned rates, respectively. These high rates suggest that internal appeal reviews are not working, and this could be due to financial incentives.

Key Finding #4: External appeal overturn rates suggest that certain subpopulations of patients, with particular types of diagnoses and medical situations, are facing inappropriate denials administered at disproportionately high rates. Examples of diagnoses this is true for are autism, substance use disorder, and cancer. This means chronically ill and/or already vulnerable populations are bearing a disproportionately heavy portion of the impact of denials.

Key Finding #5: Across markets, the average billed values for overturned internal appeals are higher than for upheld appeals. This pattern could indicate that companies are initially denying high-cost claims more aggressively than is warranted, knowing they can selectively reverse course on internal appeal. This finding raises questions about whether claim review processes are being applied consistently and fairly across claims, or whether financial considerations are inappropriately influencing what should be decisions based on coverage rules.

Conclusions

Just analyzing the publicly available data, it is clear there are massive systemic problems with the way insurance companies are making decisions about prior authorizations and claim payments. The insurers have access to much more data than what they are mandated to make publicly available. So, the question becomes: why do wrongful denials of expensive care persist at large scale, when insurers have the data they need to systematically identify it, begin to address it, and measure improvement?

While a reduction in wrongful denials of expensive care would improve outcomes for patients, it would also decrease insurer profits. Whether or not this is the reason that insurers have not yet addressed this problem, it is true that a reduction in wrongful denials would not be in their financial interest. While it may be financially advantageous for insurance corporations to maintain the status quo, improving initial adjudication accuracy would better align with the supposed core purpose of health insurance: ensuring people can access and afford expensive, necessary medical care through risk pooling.

Policy Recommendations

High internal appeal overturn rates coupled with low internal appeal utilization suggests inappropriate denials are not sufficiently disincentivized. The financial repercussions of wrongful denials can be severe for patients and providers, and they should be made correspondingly serious for insurers.

While there is much room to improve enforcement and policy in New York, it is important to note that the state has a health insurance regulatory apparatus in place that is more robust than that of many states, and which already takes many actions to help protect patients. In particular, one area in which New York can serve as a model for other states is in their collection and public reporting of denial and appeal data. None of our findings in this report would have been possible without the state's work to release and maintain such data.

Data that is particularly useful that other states should consider collecting and making publicly available includes:

- Health care claims reports with monetary values disclosed. Most states do not have this, so only those who can afford expensive proprietary data are empowered to analyze the monetary consequences of claim denials.
- An external appeal database. Most states do not have this, and it provides crucial information about the extent to which wrongful denials are pervasive and internal appeals processes are fair. The information in this database also provides strong evidence of inequities in administration of wrongful

denials, which has long been clear to those on the front lines, but which is currently hard to support with large-scale data.

Regulatory bodies in the state also already monitor the data we analyze in various ways and take important associated actions to help protect patients regularly. Our proposals are rooted in an acknowledgement and appreciation for the regulatory work already being done. They are predicated on the premise that regulators ought to be empowered with the resources necessary to adequately address the complex and difficult problems our findings expose. While the collection, analysis, public dissemination, and continuous monitoring of the data we analyze is an important part of protecting patients, the sufficiency of regulatory oversight ought to be measured by outcomes, and the data shows there is much work to be done.

Policies to improve upon New York's existing regulatory framework, that other states should also consider implementing:

- Require all state-regulated health plans to automatically forward eligible upheld internal appeals for external review.
- Continue to audit denials of coverage that risk physical harm (e.g., urgent prior authorization) and involve expensive care (e.g., hospital inpatient denials), and report the findings publicly. Identify patterns of inappropriate denials causing the greatest harm and incentivize reductions.
- Collect racial demographic data associated with claims, if not already collected, and report the data publicly with the health care claims reports and external appeal data to inform questions about racial equity in the administration of health insurance coverage adjudication.
- Financially penalize insurers with high external appeal overturn rates to incentivize accurate internal appeal adjudication. Adjust the penalties as necessary to achieve low overturn rates across individual markets and types of care.
- Disincentivize wrongful denials through rules targeting high internal appeal overturn rates (to be effective, this policy must be paired with automatic forwarding and financial penalization for high external appeal overturn rates).
- Investigate and publicly report findings on the frequent use of the "other" rationale category in the Health care claims reports, and revise reporting schemas to ensure most denial rationales are explicitly specified.
- Continue to implement measures to encourage patients and providers to appeal denials more frequently, including regulations to simplify internal appeals processes.

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