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DENIED

*THE HARMFUL ROLE OF
PRIOR AUTHORIZATION
& CLAIM DENIALS*

in New York Health Insurance

PEOPLE'S
ACTION
INSTITUTE

CONTENTS

- 1 Introduction.....1
- 2 New York Health Insurance Markets.....2
- 3 New York Claims Data6
 - 3.1 Health Care Claims Reports.....6
 - 3.1.1 Background.....6
 - 3.1.2 Definitions and Methodology.....7
 - 3.1.3 Analysis: Breakdown By Market Segment.....9
 - 3.1.4 Analysis: Breakdown By Provider Category.....17
 - 3.2 External Appeal Database.....14
 - 3.2.1 Background24
 - 3.2.2 Analysis: Breakdown By Market Segment 25
 - 3.2.3 Analysis: Breakdown By Diagnosis.....27
 - 3.2.4 Analysis: Breakdown By Treatment32
- 4 Policy Recommendations37
- Appendices.....41

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Health insurance coverage denials are a critical barrier to health care access in the United States, with far-reaching consequences for patients, providers, and the health care system as a whole. Wrongful denials cause forgone and delayed care for patients, burden patients with debilitating medical debt, and place undue financial burdens on providers. In this report we analyze data from New York's state-regulated health insurance markets to quantify the scope and financial impact of these denials. We are particularly interested in understanding the extent to which financial incentives cause harm to patients, and in measuring the occurrence of wrongful coverage denials. Our findings reveal that post-service claim denials in New York amounted to tens of billions of dollars in billed charges annually. Moreover, they suggest that high cost claims may be inappropriately denied at disproportionately high rates, with overturned denials taking higher average values than the broader

pool of appealed claims across all market segments. The data shows that denials overturned through internal appeal processes amounted to over \$3 billion in billed charges in New York in 2023 – a figure that excludes the administrative costs borne by patients, providers, and insurers alike, and fails to capture inappropriate denials that go unappealed or remain upheld on appeal despite appeal merit. The data suggests financial incentives may influence inappropriate denial patterns, contributing to delayed or foregone care, exacerbating medical debt, and straining provider operations. This analysis provides limited but crucial evidence for policymakers, regulators, and health care advocates working to address systemic issues in health insurance administration and ensure equitable access to covered medical services. Our findings suggest the need for numerous policy changes to improve understanding, accountability, and patient protection.

Introduction

When health insurers inappropriately deny coverage for medical care, the consequences for patients can be devastating. Patients facing pre and post-service denials forgo care, have their care delayed, shoulder tremendous administrative burdens, and are saddled with medical debt. Those who forgo care or have care delayed face worsening health conditions, deteriorating quality of life, and in some cases, preventable deaths [GCRM24] [Sau23]. Financially, these denials contribute to administrative waste and to America's staggering medical debt crisis – affecting at least tens of millions of Americans and driving many into bankruptcy [RRC+24]. Health care providers also suffer, as they struggle with revenue cycle complications that threaten their financial stability. These problems are particularly impactful for smaller practices and rural hospitals already operating on thin margins.

This report examines these issues through the lens of health insurance coverage denials in New York state. Each time an insured patient attempts to use their health insurance to cover a portion of a bill, a post-service claim is submitted to their insurance administrator. The claim records details about the care received and its cost, which the insurer uses to make payment determinations. Insurance administrators are responsible for adjudicating these claims based on relevant law, contracts, and medical policies. They are also responsible for reviewing and adjudicating pre-service coverage authorization requests. In this report we analyze coverage denials corresponding to state-regulated health insurance plans in New York. Most, but not all, of the denial data we study corresponds to post-service claim denials.

Coverage denials occur for many reasons. Some are administrative, like denials for duplicate or incorrectly submitted claims. Others are blatantly problematic: administrators fail to follow contractual obligations or state law, policies incorrectly deem evidence-backed treatments 'experimental', or administrators ignore medical documentation validating the merits of a claim. All shades of gray between these extremes can and do occur. And all of these types of denials can lead to patients delaying or forgoing necessary treatment.

We are primarily interested in uncovering the extent and harm of inappropriate denials made on the basis of arguments inconsistent with law, contracts, medical records, or medical policies and literature. This is, however, a challenging problem given public data and reporting standards; there is a paucity of data-driven evidence that

can directly address our primary questions of interest at large scale. Instead, most large scale analyses inform the extent and scale of coverage denials overall, without isolating the effects of those which are wrongful or harmful. In this report we focus our analyses on proxies for wrongful denials like overturn rates, volumes, and billed values associated with appeals. While the proxies are imperfect measures of wrongful denials, they reflect features of the true distribution that overall denial volumes do not, and can in some cases yield lower bounds.

Despite the paucity of *large scale* data-driven evidence, growing evidence from research [Fox22] [Pol21], journalism [Kon10] [ARM23a] [RAM23] [ARM23b] [MAR24] [Fie23], and litigation¹ suggests perverse financial incentives may be inappropriately – and illegally – influencing coverage decisions and insurance administration. There is evidence that suggests the impact of inappropriate denials falls disproportionately on vulnerable populations with fewer resources and those from historically marginalized groups [HYH24] [LGB+22] [LNGC21] [Gar23a].

For patients, the consequences extend beyond immediate financial strain. Many delay or abandon recommended treatments due to denials, resulting in preventable harm and emergency interventions that can cost the health care system more [GCRM24] [PLWL23] [Sau23]. Providers and patients alike also face substantial administrative burdens contesting denials, with hospitals employing dedicated staff to appeal denied claims – resources that could otherwise support patient care. Small practices without such resources often absorb losses or pass costs to patients, further straining the health care system, and propagating and strengthening inequities.

Understanding, monitoring, and reducing inappropriate denials is therefore a pressing social justice and public health issue critical to improving equitable access and outcomes. This report analyzes data from the New York Department of Financial Services (DFS) to shed light on denial and appeal processes spanning various types of health insurance throughout the state.

Throughout the report we introduce high level proposals based on our findings that may help improve access to necessary care and patient outcomes. Each high level proposal is made precise and discussed in more detail at the end of the report. Many of our proposals focus on concrete actions that can be taken by regulators and policy makers in New York.

¹ See e.g. [this lawsuit](#), [this lawsuit](#), and [this DOJ settlement](#) for just a few examples.

While there is much room to improve enforcement and policy, it is important to note that New York 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.

Regulatory bodies in the state also already monitor the data we analyze, and take critically important enforcement 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 data 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.

SECTION 2

New York Health Insurance Markets

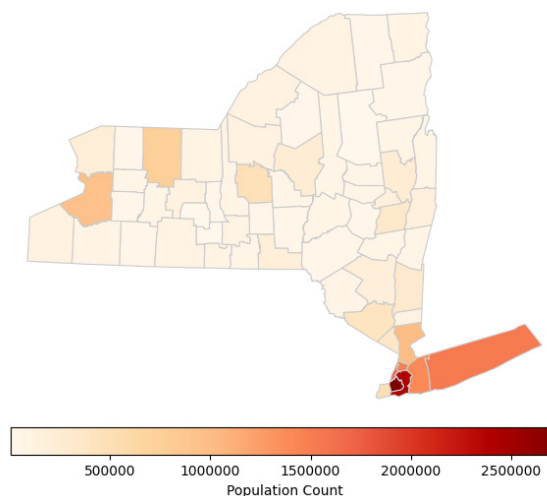
This report examines coverage denial and appeal patterns across New York state. Before presenting our findings, we briefly introduce the insurance markets relevant to the data we present. We additionally discuss enrollment and spending data across markets in [Appendix A](#).

Our analysis is necessarily influenced by New York's demographic characteristics; these include population density, health condition prevalence, racial and socioeconomic distributions, and age, sex, and gender distributions. These characteristics vary geographically throughout the state, and vary by health insurance delivery type. While comprehensive demographic adjustment is beyond our scope, it is important to keep in mind that all of these distributions affect our observed phenomenology. Figure 2.1 illustrates New York's geographic population distribution, providing one important piece of high level context for our findings.

Most of the data studied in this report comes from insurance markets primarily regulated by the state. Most notably, this means that data from self-funded employer sponsored plans, which are regulated by the federal government under [ERISA](#), and data from Medicare, is missing from most of our analyses.

We now outline the primary markets covered by the data we analyze.

Figure 2.1: New York's 2020 state population by county, according to the 2020 census.



Medicaid

Medicaid provides comprehensive coverage to lower income New Yorkers, and has no monthly premiums, and low copays for services. In general, states have numerous degrees of freedom in how exactly they implement Medicaid², and there are many details specific to New York's program that are beyond the scope of this article.

² See [this](#) for a brief primer.

Managed Long Term Care (MLTC)

Managed Long Term Care (MLTC) is a New York program that provides long term services and supports to people who are chronically ill or disabled and who want to stay in their own homes and communities while receiving care. The program covers things such as nursing, adult day care, home health aides, and physical therapists for those who are Medicaid eligible. Enrollment in the program is mandatory for some Medicaid beneficiaries who require long term care. Within the MLTC program, there are three models of plan administration: Partial Capitation³, Program of All-Inclusive Care for the Elderly Organizations, and Medicaid Advantage Plus.

Child Health Plus (CHP)

Child Health Plus is New York's implementation of the Children's Health Insurance Program. Children under the age of 19 who are residents of New York may qualify for [Child Health Plus](#), which is a zero or low premium plan with no copays for those whose families meet gross income eligibility requirements. The gross income requirements are less strict than those of Medicaid, and are similar to those of New York's Essential Plan. Any child whose family meets income eligibility requirements, who does not have other health insurance, and who does not qualify for coverage under the public employees' state health benefits plan qualifies for Child Health Plus.

Essential Plan

The [Essential Plan](#) is a zero premium New York state health plan offered to adults aged 19 to 64 who do not qualify for Medicaid, Child Health Plus, or employer sponsored plans,

and who additionally meet age and [income](#) requirements. It is New York's implementation of the [Basic Health Program](#) laid out in the Affordable Care Act, and New York specific provisions for the state's implementation are laid out in [state law](#).

Individual and Small Group Marketplace Plans

New York's Affordable Care Act state exchange (or 'marketplace') is called [New York State of Health](#). New Yorkers and small employers can purchase individual commercial Qualified Health Plans (QHPs) and small group qualified plans on the marketplace⁴.

Qualified Health Plan enrollment via New York State of Health is limited to those individuals who are not eligible for Medicaid, Child Health Plus, or the Essential Plan.

Self-Funded and Fully Insured Large Group Plans

There are also commercial, employer-sponsored plans made available to New Yorkers. These include both self-funded and fully insured plans. *Self-funded* plans are those in which an employer assumes financial risk for employee health care benefits and uses their own funds to pay for services⁵. *Fully insured* plans are those in which an employer pays premiums to a separate insuring entity to assume financial risk for employee health care benefits.

Market Comparisons

We highlight a few high level aspects of these markets, and how denials and appeals vary across them, in [Table 2.2](#).

³ More generally, capitated payment models are those in which an entity receives a fixed amount of money per patient to provide healthcare or cover the cost of healthcare services, regardless of the amount of services ultimately provided.

⁴ They can also use New York State of Health to enroll in the Essential Plan and Child Health Plus.

⁵ Note that self-funded plans typically contract with so-called Third Party Administrators to provide administrative services associated with managing health care claims. These services are typically provided by major commercial insurance carriers that also sell fully-insured.

Table 2.2: Key Characteristics of New York Insurance Programs

Program	Characteristic	Description
Medicaid	Funding Structure	Includes both Fee-for-Service and Medicaid Managed Care (MMC) delivery systems. A majority of enrollees (77.4%) are served by MMC [KFF23a] . Managed Care Organizations (MCOs) provide coverage in exchange for government-subsidized capitated payments funded by federal and state contributions.
	Population Demographics	Serves pregnant people and low income populations, and covers many demographics, including children, pregnant people, those with disabilities, those with complex health needs, and dual eligible elderly populations. There is a disproportionate representation of people of color compared to the state population (see Appendix A).
	Financial Responsibility for Denials	Providers typically absorb the cost or bear the responsibility for contesting post-service claim denials related to medical necessity, or services deemed not covered. Circumstances in which patients are billed for post-service denials are limited . Nonetheless, patients can face consequences for pre-service coverage denials, including delayed care and administrative burdens.
	Regulatory Framework	The program is jointly regulated by the Centers for Medicare and Medicaid Services (CMS) and state agencies such as the New York State Department of Health and the Department of Financial Services. There are federal restrictions on how Medicaid Managed Care Organizations are paid for the services they provide ⁶ , and there are limits on the fraction of capitated premiums they can retain as profit, in the form of Medical Loss Ratio (MLR) requirements ⁷ . New York's Medicaid Managed Care programs changed in April 2023, when managed care pharmacy benefits were 'carved out' of the program, having been relegated to NYRx [oH21] .
MLTC	Funding Structure	The MLTC programs in New York are funded by Medicaid for Medicaid eligible individuals, and partially by Medicare in limited contexts for dual eligible individuals. The different administration models vary in funding detail, but are generally paid for by fully or partially capitated payments to managed care organizations.
	Population Demographics	The demographics served are primarily disabled individuals, the elderly, and those with chronic conditions requiring continuous support services. Over 80% of enrollees are in New York City. As in the Medicaid population, there is a disproportionate representation of people of color compared to the overall state population demographics.
	Financial Responsibility for Denials	Providers typically absorb the cost or bear the responsibility for contesting post-service claim denials related to medical necessity, or services deemed not covered. Circumstances in which patients are billed for post-service denials are limited . Nonetheless, patients can face consequences for pre-service coverage denials, including delayed care and administrative burdens.
	Regulatory Framework	The program is jointly regulated by the Centers for Medicare and Medicaid Services (CMS) and state agencies such as the New York State Department of Health and the Department of Financial Services. Managed care organizations participating in MLTC must also meet Medical Loss Ratio (MLR) requirements .

⁶ For example, capitation rates must be deemed [actuarially sound](#) by CMS.

⁷ Note, however, that due to the technical definitions of medical loss ratios, there are ways to increase loss ratios without paying for more care. Quality improvement terms in loss ratios provide a mechanism to achieve compliance in questionable ways.

Child Health Plus (CHP)	Funding Structure	Combined state and federal funding with sliding-scale premiums based on family income. CMS determines how federal appropriations for the Children's Health Insurance Program are allocated among states. The funding is distinct from Medicaid funding, and insurers provide coverage in exchange for capitated payments and sliding scale premiums from eligible families.
	Population Demographics	Those served are children under 19 in lower-income families that do not qualify for Medicaid.
	Financial Responsibility for Denials	We were unable to determine any requirements legally prohibiting providers from billing patients for services for which coverage is denied post-service on the basis of medical necessity, or services deemed not covered. Whether or not such prohibitions exist, patients can face consequences for pre-service coverage denials, including delayed care and administrative burdens.
	Regulatory Framework	The program is jointly regulated by the Centers for Medicare and Medicaid Services (CMS) and state agencies such as the New York State Department of Health and the Department of Financial Services. Managed care organizations participating in Child Health Plus must also meet Medical Loss Ratio (MLR) requirements .
Essential Plan	Funding Structure	Federal funding through the Basic Health Program provisions of the Affordable Care Act provides most of the funding, with some supplemental state funds.
	Population Demographics	Working adults with lower incomes who do not qualify for Medicaid or employer-sponsored coverage.
	Financial Responsibility for Denials	We were unable to determine any requirements legally prohibiting providers from billing patients for services for which coverage is denied post-service on the basis of medical necessity, or services deemed not covered. Whether or not such prohibitions exist, patients can face consequences for pre-service coverage denials, including delayed care and administrative burdens.
	Regulatory Framework	The program is jointly regulated by the Centers for Medicare and Medicaid Services (CMS) and state agencies such as the New York State Department of Health and the Department of Financial Services. Insurers participating in the Essential Plan must also meet Medical Loss Ratio (MLR) requirements .
Individual and Small Group Marketplace	Funding Structure	The funding for these commercial plans is primarily premium based. There are also federally funded income based tax subsidies in the form of Premium Tax Credits (PTCs), and Cost Sharing Reductions (CSRs) for those who qualify.
	Population Demographics	The populations in these markets have higher average incomes, and higher income diversity, than the income restricted public programs. The population served includes self-employed individuals, small business employees, and others without employer-sponsored coverage.
	Financial Responsibility for Denials	Patients typically bear the responsibility for contesting post-service claim denials related to medical necessity, or services deemed not covered, and are responsible for any outstanding billed charges. Patients also face consequences for pre-service coverage denials, including delayed care and forgone care, and administrative burdens. Providers also bear some risk for denied claims, as they have to collect from patients, contest the denials, or absorb the costs. All three types of provider action occur regularly.
	Regulatory Framework	These plans are primarily regulated by state agencies such as the New York State Department of Health and the Department of Financial Services. Insurers selling these plans must also meet Medical Loss Ratio (MLR) requirements .

Large Group Plans	Funding Structure	Self-funded plans are funded by employers, with or without the use of premiums. They may also employ the use of external stop loss insurance. Fully-insured plans transfer risk, as well as administrative duties, to carriers through premium payments.
	Population Demographics	Employed individuals and dependents. Wide variation in incomes, demographics, and health status, though as with individual and small group marketplace plans, these markets have higher average incomes, and higher income diversity, than the income restricted public programs.
	Financial Responsibility for Denials	Patients typically bear the responsibility for contesting post-service claim denials related to medical necessity, or services deemed not covered, and are responsible for the billed charges. Patients also face consequences for pre-service coverage denials, including delayed care and forgone care, and administrative burdens. Providers also bear some risk for denied claims, as they have to collect from patients, contest the denials, or absorb the costs. All three types of provider action occur regularly.
	Regulatory Framework	Fully insured large group plans are primarily regulated by state agencies such as the Department of Health and the Department of Financial Services. Insurers must meet Medical Loss Ratio (MLR) requirements . Self funded group plans are primarily regulated by the Department of Labor under ERISA, and are not subject to the same state regulations as the fully insured plans.

Throughout this report, we analyze denial patterns within and across these markets, identifying concerning trends and potential drivers of inappropriate denials that affect health care access, patient outcomes, and system costs.

SECTION 3

New York Claims Data

3.1 Health Care Claims Reports

3.1.1 Background

In 2020, New York State enacted [legislation](#) requiring health insurers to report aggregate claims data to increase transparency in coverage decisions. Since 2022, the Department of Financial Services (DFS) has published quarterly spreadsheets with information about claims submitted, claims denied, claims appealed, and associated monetary values for state-regulated New York insurers across four market segments. The reports provide an unprecedented window into insurer adjudication behaviors, and the financial role played by appeals processes in the state.

There are a few key aspects of the data important to keep in mind:

1. Coverage Scope

The data only includes plans which are primarily state-regulated. As a result, the reports do not include data from two large segments of the insured New York population: those who are covered by self-funded employer sponsored plans, which are largely regulated by the Department of Labor under ERISA, and those covered solely by Medicare.

2. Denial Types

All denials recorded in the data correspond to post-service claims; prior authorization denials are not

included. As a result our analyses do not capture the full scope of coverage barriers, even within the insurance types considered.

3. Appeal Sources

The reported appeals include both appeals submitted directly by patients, and appeals submitted by providers on their behalf.

4. Timeframe

Our analysis focuses on the 2023 plan year – the most recent year for which there is complete data as of the time of writing.

More details about how the data are reported are included in the frequently asked questions for the data on the [DFS homepage](#).

3.1.2 Definitions and Methodology

Within this section we focus on denials, internal appeals, and internal appeal overturns. All of the data we analyze comes from the annual reports from insurers for 2023⁸. There are many inequivalent ways to calculate denial and appeal rates, and produce views of the raw data. In this subsection, we describe the methodology used to arrive at our numbers.

When we refer simply to **claims**, or to **claims adjudicated**, we are referring to claims which are recorded as denied in full, denied in part, or paid in full during the reporting period. Claims left pending are not included in such counts, unless specified otherwise.

Appeal Types

Throughout this report we will be concerned with appeals of health insurance denials. Appeals processes vary by insurance type, and typically include multiple stages. In most cases appeals processes include at least two types of appeal that may become available to patients: an internal appeal, and an external appeal. We define an *internal appeal* to be an appeal of a coverage denial made on behalf of an insured person to the same entity that adjudicated the initial denial. Internal appeal processes can themselves include multiple levels. They can be submitted by patients and by providers on behalf of patients. We define an *external appeal* or *independent medical review* to be an appeal of a coverage denial made on behalf of an insured person to a third party (often called an independent review entity) not involved in the adjudication of the original denial. External appeal processes are typically afforded to patients and their providers in only some contexts, such as those involving clinical determinations of medical necessity.

Rates

When we present denial rates, internal appeal rates, and internal appeal overturn rates, they represent the following calculations:

1. We define the **denial rate** to be the total number of claims denied *in full or in part* in the annual reporting period divided by the total number of claims adjudicated in the annual reporting period.
2. We define the **full denial rate** to be the total number of claims denied *in full* in the annual reporting period divided by the total number of claims adjudicated in the annual reporting period.
3. We define the **internal appeal rate** to be the total number of internal appeals adjudicated in the annual reporting period divided by the total number of claims denied in full or in part in the annual reporting period.
4. We define the **internal appeal overturn rate** to be the total number of internal appeals that are overturned *in full or in part* in the annual reporting period divided by the total number of internal appeals adjudicated in the annual reporting period.
5. We define the **full internal appeal overturn rate** to be the total number of internal appeals that are overturned *in full* in the annual reporting period divided by the total number of internal appeals adjudicated in the annual reporting period.

Insurer Aggregates

When reporting aggregate rate data, there are at least two distinct methodological approaches.

One method computes aggregate rates by summing total counts across all insurers and then calculating rates from these cumulative totals. This is the methodology we use to report aggregate rates.

A distinct approach is to first calculate individual rates for each insurer and then average those insurer rates. This calculation offers a different perspective, by giving equal weight to each insurer's claims adjudication practices, regardless of the insurer's total claim volume.

Validation Filtering

We perform a suite of basic validation checks on the spreadsheets in the health care claims reports to ensure they present data which at a minimum is not *clearly* inaccurate.

⁸ Note that the 2023 sheets have been substantively updated numerous times since they were originally released. We use a snapshot of the reports taken on November 20th, 2024, shortly after the most recent updates to the 2023 sheets of which we are aware.

In each validation check, figures denoted with *prior* subscripts indicate counts associated with the prior reporting period, while all other figures indicate counts associated with the target reporting period. The checks include:

1. Claims Conservation

We require that the total number of claims follows a conservation principle:

$$\begin{aligned} &(\text{Claims Left Pending}_{\text{prior}} + \text{Claims Received}) = \\ &(\text{Claims Denied Full} + \text{Claims Denied Partial} + \\ &\quad \text{Claims Paid} + \text{Claims Left Pending}) \end{aligned}$$

We require this conservation equation to be true both for each market segment in its entirety, but also for each provider category within each market segment. We allow this equation to be off by a small validation tolerance (± 1), to account for negligible inconsistencies in a few sheets. These inconsistencies may result from rounding errors associated with fields erroneously being stored as non-integral values in the raw cell data.

Any sheets which fail the validation are not included in our analyses.

2. Appeals Conservation

Similarly, we enforce a conservation principle for appeals:

$$\begin{aligned} &(\text{Appeals Left Pending}_{\text{prior}} + \text{Appeals Received}) = \\ &(\text{Appeals Overturned Full} + \text{Appeals Overturned Partial} \\ &\quad + \text{Appeals Upheld} + \text{Appeals Left Pending}) \end{aligned}$$

We require this to be true both for each market segment in a sheet in its entirety, but also for each provider category within each market segment. We allow this equation to be off by a small validation tolerance (± 1), to account for negligible inconsistencies in a few sheets. These inconsistencies may result from rounding errors associated with fields erroneously being stored as non-integral values in the raw cell data.

Any sheets which fail the validation are not included in our analyses.

3. Appeal Adjudication Ceiling

There are a handful of insurer reports in which the number of appeals adjudicated is reported to be larger than the sum of appeals received in the reporting period and appeals left pending in the prior reporting period. These reports still pass the appeals conservation validation check, by reporting the appeals left pending as a negative number. We discard reports for which this unexplained inconsistency

surpasses a validation tolerance.

Precisely, we discard reports for which the following two things are true:

$$\text{Appeals Left Pending} < 0$$

and

$$(|\text{Appeals Left Pending}| > .15 \cdot \text{Appeals Adjudicated})$$

Combined, these equations rule out cases where this unexplained discrepancy amounts to over 15% of all adjudicated appeals reported in the sheet. Any sheets which meet these two conditions are not included in our analyses. The choice of 15% is subjective. It results in exactly 4 *market segment sheets* (not insurers) being discarded.

Aside from these checks, we perform calculations using the data as it is reported. Throughout the report we highlight any data which passed the validation checks, but which raises questions about accuracy of the reported data that cannot be verified or debunked. It is worth noting that New York's Department of Financial Services collects reports from insurers, and posts them online, but at the time of writing explicitly notes they do not verify reported data for accuracy.

Billed and Allowed Amount Filtering

When we present aggregate data without qualification, it reflects a summary of all validated insurer sheets for insurers that reported 2023 annual reports. In other cases, we present analyses of subsets of the validated data focused on monetary values associated with claims. The reporting requirements grant insurers the flexibility to report monetary values via billed charges, allowed amounts, or both. Whenever we present monetary analyses, we specify whether we are presenting billed charges or allowed amounts. In such cases, we filter the collection of validated 2023 annual reports to retain only those insurers which report the monetary values via the relevant reporting standard. For example, any of our tables referencing 'billed charges' involves a calculation among only the subset of insurers which chose to report billed charges in their annual reports.

Pharmacy Claims

We exclude claims associated with the 'Pharmacy' provider category in all of our analyses in this section⁹, based on two methodological considerations.

First, as previously mentioned pharmacy benefits in New York's Medicaid Managed Care market underwent a notable change in 2023, and it's difficult to control for this

⁹ Pharmacy claims are however included in our analyses in the next section. The methodological considerations presented here do not apply to the external appeal data we explore in the next section. Furthermore, the two datasets do not correspond to a single cohort of claims, so no ability to merge the datasets is lost by including Pharmacy claims in one case but not the other.

change given the granularity of the data.

More critically, our research revealed substantial inconsistencies in pharmacy claim reporting across insurers. While claims counts, denial counts, and monetary values for pharmacy data appears meaningful on the surface, accompanying appeal rates suggest discrepancies in reporting methodologies. These discrepancies undermine the reliability of the data; while it is possible pharmacy values are accurately and consistently reported for each insurer, we were unable to develop enough trust in the data to incorporate pharmacy claims into our primary analysis. In the course of research, we did, however, conduct parallel computations for all of our analyses both with and without pharmacy claims. Most trends and fundamental findings remained qualitatively consistent across these analyses. The primary exceptions were the appeal rates and associated monetary values for pharmacy claims, which exhibited pronounced variability, and which altered overall appeal rates considerably when included.

It is important to note that because we omit pharmacy claims from the analyses presented in this section, the presented volumes and impact of denials and appeals are necessarily underestimates.

3.1.3 Analysis: Breakdown By Market Segment

We now begin analyzing the data in the Health Care Claims Reports. The 2023 health care claims reports contain information about 31 insurers, and include data for those insurers aggregated across four distinct market segments:

- Commercial¹⁰ (COM)
- Essential Plan (EP)
- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)

In this subsection, we consider how the health care claims report data varies across these market segments.

All Insurers

For each market segment we first report overall denial rates, internal appeal rates, and internal appeal overturn rates in Table 3.1.

Table 3.1: Aggregate New York Health Care Claims Report data broken down by market segment. For each market segment, the number of insurers whose data is aggregated is reported, and the aggregate denial rate, full denial rate, internal appeal rate, internal appeal overturn rate, and full internal appeal overturn rates are computed using the data for all insurers combined.

Seg	# Insurers	Denial Rate	Full Denial Rate	Appeal Rate	Overturn Rate	Full Overturn Rate
COM	26	24.81%	14.12%	0.65%	39.93%	30.55%
EP	10	32.11%	11.99%	2.25%	30.00%	21.10%
CHP	11	32.82%	12.93%	1.79%	17.08%	9.05%
MMC	10	28.09%	11.90%	2.02%	25.20%	16.42%

¹⁰ The data corresponds only to state-regulated commercial markets. The data is not recorded with granularity sufficient to isolate particular commercial sub markets, such as that of individual or small group plans sold on New York State of Health, or fully-insured large group employer sponsored plans.

The qualitative trends apparent in the findings are typical for those seen throughout U.S. health insurance in many different markets and states [\[PLWM23\]](#) [\[Dep23\]](#) [\[Gar23b\]](#).

Overall denial rates are over 20% across markets, and full denial rates are over 10% across markets.

While these rates are staggering, it is important to recall that there are many different contexts in which denials are administered – for example, denials resulting from duplicate claims submitted for the same service are included in this data. At the same time, many denials are blatantly inappropriate, and cause great harm to patients and providers. Ideally, we would isolate the rate at which denials are being inappropriately administered. This is not possible without detailed understanding of the individual claims that make up this aggregate data.

The next best thing would be to isolate the rate at which claims are denied (and appealed) for reasons that are more likely to be wrongful. For example, isolating the rate at which claims are denied for being purportedly ‘not medically necessary’, ‘experimental’, or ‘not covered’ would more meaningfully inform questions about the rate of inappropriate denials. In some markets, ‘not medically necessary’ denials are appealed at rates 10 to 50 times higher than denials administered for other rationales [\[Gar23b\]](#).

The health care claims reports require insurers to report rationale category counts for their denials, which allow for such isolation in principle. However, the categories include an ‘Other’ category, which accounts for much of the data, and whose intended scope of use is [specified](#) only as ‘Any denial reason that does not fit under the specifically designated categories would be in the “Other” category’. In each market segment, ‘Other’ is among the top two most commonly reported rationale categories. We explore the details of the rationale data in depth in [Appendix B](#).

The pervasive use of the “Other” category indicates a problem with the reporting schema, or the accuracy of reports; regardless of which problem explains the data, the use of this category should be addressed to make the rationale data more useful.



Policy Proposal

Regulators and lawmakers should investigate the underlying cause for pervasive use of the “Other” rationale category, and alter the reporting schema to ensure most denial rationales are more explicitly specified, and that insurers are reporting data consistently.

If most denials are denied for reasons that cannot be characterized with the existing rationale options, the reporting schema can be improved. By using a larger, but still mutually exclusive and completely exhaustive collection of categories, regulators can ensure explicit rationales for a majority of the data are reported. If instead the cause of the frequent use of the ‘Other’ category is that insurers are not consistently or accurately using the existing alternative categories, more comprehensive reporting guidelines, and validation and enforcement of accurate reporting, could resolve the issue.

Another feature that stands out in [Table 3.1](#) is that each rate for the commercial market takes on an extreme value relative to the government subsidized markets. This phenomenology may be explained by differences across these markets in incentive structures, patient advocacy resources, and regulatory rules and oversight. The difference in internal appeal rate between these market segments is most stark.

Internal appeal rates are roughly 3 times higher in government subsidized markets than in the commercial market. This may reflect more tightly regulated processes designed to support patient access to appeals, and greater access to patient advocacy resources for beneficiaries, in the government subsidized markets.

Appeals processes in government subsidized markets are more strictly regulated and prescribed than in commercial markets. For example, New York maintains [model denial notices](#) for its Medicaid Managed Care program, which helps standardize appeal right notices. Standardization makes it easier for patients and those who support them to understand and access their appeal rights. Commercial denial notices, on the other hand, vary widely in content and form. In addition, beneficiaries in government subsidized markets have access to more robust support systems than those in commercial markets. For example, the model notices (linked above) include contact information for free, effective advocacy services that can support patients

seeking appeals. Patients and providers may be more likely to seek appeals in government subsidized markets as a result of these systemic features which are absent in commercial markets. This possibility is consistent with observed trends.

The denial rate differences between the government subsidized markets and the commercial market have less clear origins. While it’s impossible to attribute the observed denial rate differences to specific market differences from this data alone, there are a few points that surely play some role in the observed trends.

One is that inappropriate denials (and coverage for inappropriate care) have historically had more severe consequences and faced greater scrutiny in government subsidized markets. Wrongful denials in New York’s Medicaid Managed Care program have led to [financial disincentives in the form of fines](#) for MCOs, and [federal scrutiny](#) from the Health and Human Services Office of the Inspector General. In addition to scrutiny and monetary penalties resulting from ad hoc actions, there are compliance related [quality incentive bonuses](#) built in to capitation payments to MCOs. These include a measure related to claims payment and denial issues. As a result, insurers in government subsidized markets may be more financially disincentivized than their peers in commercial markets from making initial and appeal review adjudication determinations in ways inconsistent with coverage rules specified in law, contracts, and medical policies. Note that these coverage rules specify both covered services and non-covered services, so more strict adherence to the rules in government subsidized markets could reasonably result in more or fewer denials. The data we have is insufficient to draw conclusions about the extent to which insurers in government subsidized markets are being motivated to follow coverage rules more strictly than their commercial peers, but increased adherence to rules may partially explain the differences in denial rates between these sectors.

Similarly, while commercial coverage rules vary considerably by insurer and plan, and insurers have leeway to develop and utilize bespoke clinical policies, the government subsidized markets have greater standardization and transparency for coverage rules. This makes it easier for non-insurer stakeholders, such as regulators, to measure insurer compliance with coverage rules in the government subsidized markets. It also means that software and processes used by insurance administrators to review and deny claims can be more streamlined, and standardized, in these markets. These sector differences could again reasonably result in more or fewer denials, and it’s impossible from the data presented here alone to deduce how these differences might be contributing to the observed trends. Nonetheless, it is likely that they are contributing to the observed differences in trends in some way.

All of these possibilities may contribute to the observed differences in overall denial rates, full denial rates, and internal appeal overturn rates.

Table 3.2 shows more fine-grained statistics explaining the

volumes and *billed* values of claims, denials, and appeals in the data, broken down by market segment. Table 3.3 shows the same information for *allowed* values, for those insurers that report allowed values.

Table 3.2: Aggregate market segment claims statistics for those insurers reporting billed charges. Note that the average billed value for claims typically increases in each step of the appeal funnel. For example, overturned appeals are more valuable on average than upheld appeals in every market.

Seg	# Insurers		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
COM	25	Tot. #:	100,907,717	25,052,231	14,252,383	161,255	64,404	49,209
		Tot. Billed:	\$187,627 M	\$48,704 M	\$36,906 M	\$2,309 M	\$973 M	Not Computable
		Avg. Billed:	\$1,859	\$1,944	\$2,589	\$14,320	\$15,106	Not Computable
EP	10	Tot. #:	15,405,775	4,946,966	1,846,472	111,071	33,322	23,439
		Tot. Billed:	\$20,364 M	\$5,854 M	\$3,367 M	\$1,059 M	\$368 M	Not Computable
		Avg. Billed:	\$1,322	\$1,183	\$1,824	\$9,535	\$11,046	Not Computable
CHP	10	Tot. #:	4,165,486	1,367,216	537,226	24,669	4,214	2,232
		Tot. Billed:	\$3,622 M	\$943 M	\$526 M	\$124 M	\$30 M	Not Computable
		Avg. Billed:	\$869	\$690	\$979	\$5,015	\$7,116	Not Computable
MMC	10	Tot. #:	99,398,615	27,917,824	11,829,173	564,695	142,282	92,746
		Tot. Billed:	\$122,803 M	\$33,942 M	\$18,412 M	\$4,966 M	\$1,745 M	Not Computable
		Avg. Billed:	\$1,235	\$1,216	\$1,556	\$8,794	\$12,266	Not Computable

Tables 3.2 and 3.3 show that the amount of money tied up in post-service claims denials, and in associated appeals processes, is massive. Across the markets represented, post-service denials account for over \$85 billion in billed charges, while internally appealed denials constitute over \$8 billion in disputed billed charges.

Table 3.3: Aggregate market segment claims statistics for those insurers reporting allowed charges. Note that insurers adhere to the standard to report \$0 worth of allowed amounts for denied claims, even for those denials which are ultimately overturned.

Seg	# Insurers		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
COM	17	Tot. #:	57,140,414	13,227,726	7,720,801	108,660	34,023	22,967
		Tot. Allowed:	\$48,774 M	\$28 M	\$0	\$366 M	\$210 M	Not Computable
		Avg. Allowed:	\$854	\$2	\$0	\$3,364	\$6,185	Not Computable
EP	5	Tot. #:	10,527,294	3,366,557	1,121,300	101,049	29,008	19,817
		Tot. Allowed:	\$2,421 M	\$102 M	\$0	\$192 M	\$69 M	Not Computable
		Avg. Allowed:	\$230	\$30	\$0	\$1,895	\$2,378	Not Computable
CHP	5	Tot. #:	2,801,786	889,430	317,948	23,329	3,574	1,705
		Tot. Allowed:	\$473 M	\$19 M	\$0	\$15 M	\$4 M	Not Computable
		Avg. Allowed:	\$169	\$21	\$0	\$661	\$1,165	Not Computable
MMC	8	Tot. #:	89,824,625	24,991,616	10,238,806	538,688	128,358	81,774
		Tot. Allowed:	\$18,557 M	\$454 M	\$0	\$617 M	\$255 M	Not Computable
		Avg. Allowed:	\$207	\$18	\$0	\$1,146	\$1,984	Not Computable

The appeals process is playing an outsized financial role in New York's health insurance markets. While the processes are intended to ensure access to necessary care in supposedly rare cases of wrongful denial, over \$8 billion in billed charges were disputed in 2023, with over \$3 billion covered as a result of internal appeal overturn. These costs would otherwise have been shouldered by patients and providers.

Combined with the low rate of appeal utilization, the data suggests that there may be a large, monetarily valuable volume of wrongfully denied claims that are never appealed. This has deeply troubling implications for patients, including the risk of physical harm caused by forgone care, and financial harm caused by medical debt.



Policy Proposal

Regulators should continue to monitor internal appeal overturns, and implement rules based on their measurements to disincentivize wrongful denials.

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.

If the data shows high rates and volumes of internal appeal overturn, the goal of all stakeholders should be to improve initial adjudication and thereby lower the need for appeals processes. There should be incentives and regulations in place to drive our systems toward this reality. A starting point is to require insurers to analyze and report on the details of denials which are overturned on internal appeal, and regularly implement measures to reduce the volume of wrongful denials leading to those overturns. Monitoring should then show a decrease in claims overturned on internal appeal, corresponding to a decrease in wrongful denials, all else equal. This would also improve understanding of wrongful denials necessary to address the broader problem.

On the other hand, the average allowed and billed value for a claim increases dramatically as one progresses through the appeal funnel.

In each market segment the total volume and total billed and allowed amounts decrease precipitously in each subsequent stage in the appeal funnel.

This phenomenon is apparent in [Tables 3.2](#) and [3.3](#), but is also demonstrated by visual scale in [Figures 3.4, 3.5, 3.6, 3.7](#) for each market segment.

The fact that the average billed value increases from submitted, to denied, to appealed claims is certainly not surprising. Insurers claim that denials help ensure health care is being delivered in cost effective and efficient ways, and use medical policies and contractual language to contain spending. For this reason, it makes sense that relatively expensive treatments are more frequently denied, driving up the average billed value for denied claims.

Figure 3.4: Appeal funnel volumes, and billed charges, among insurers reporting billed charges in the Commercial market segment.

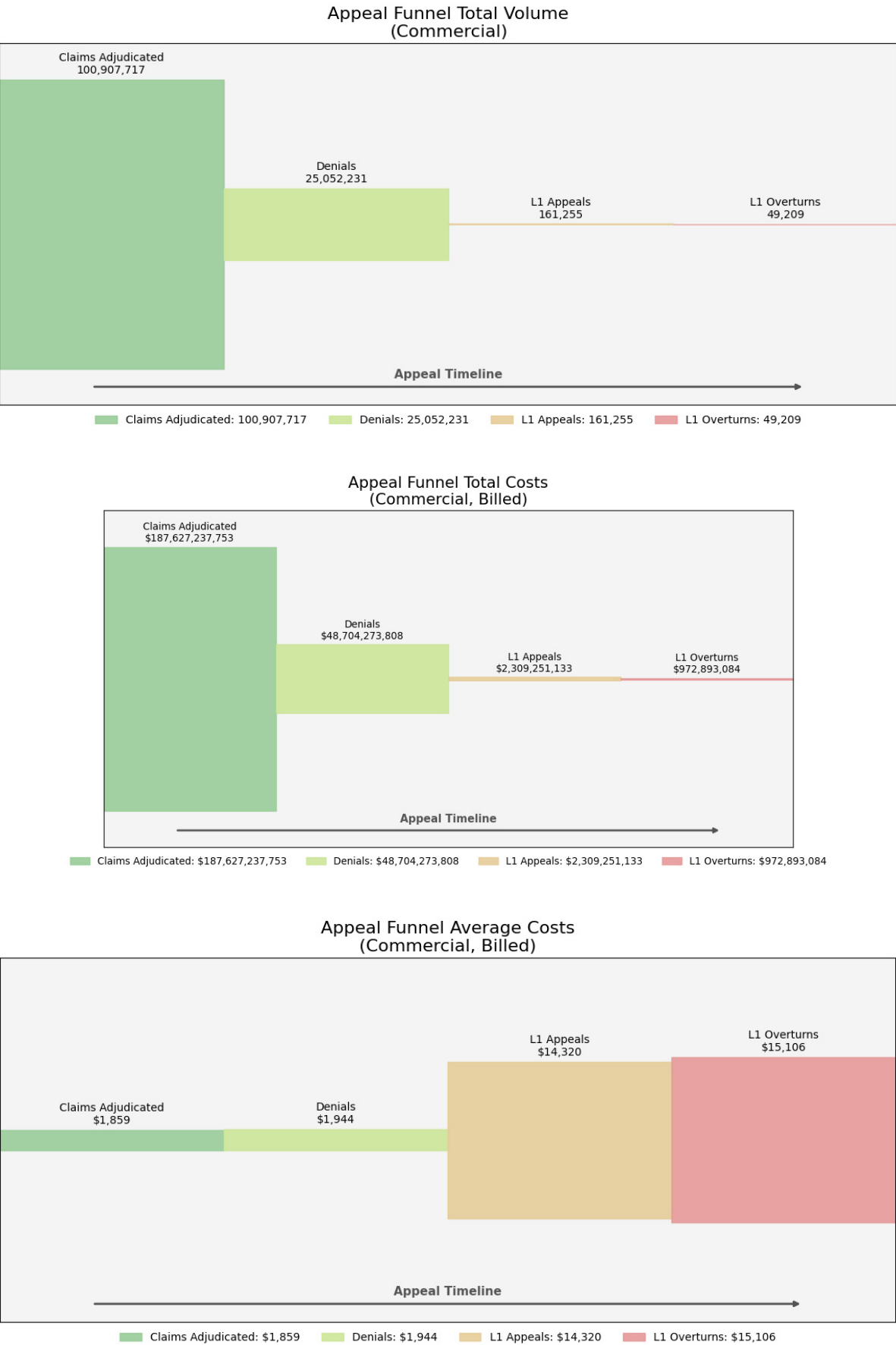


Figure 3.5: Appeal funnel volumes, and billed charges, among insurers reporting billed charges in the Essential Plan market segment.

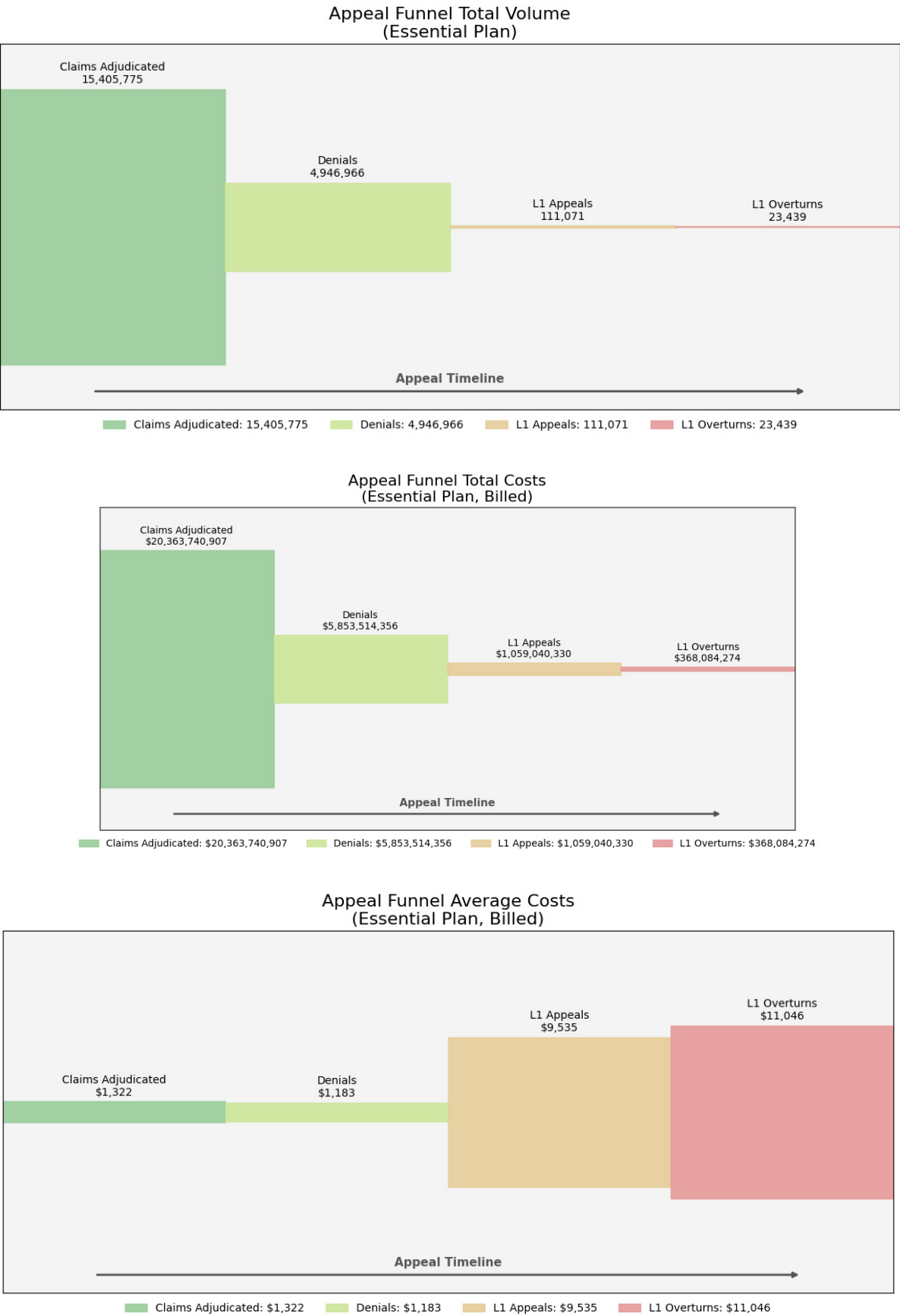
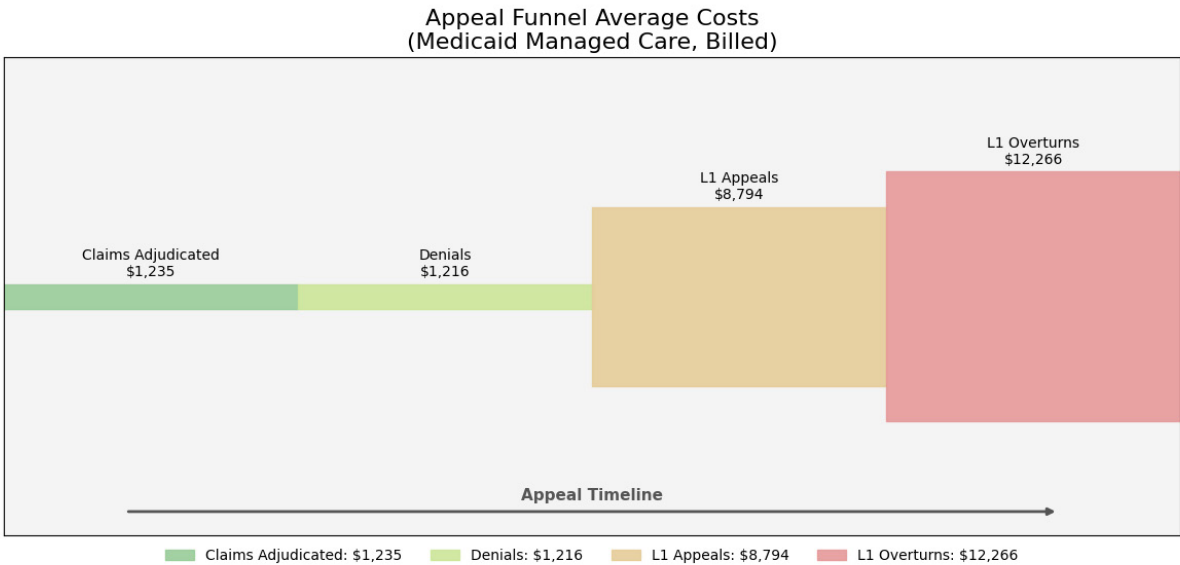
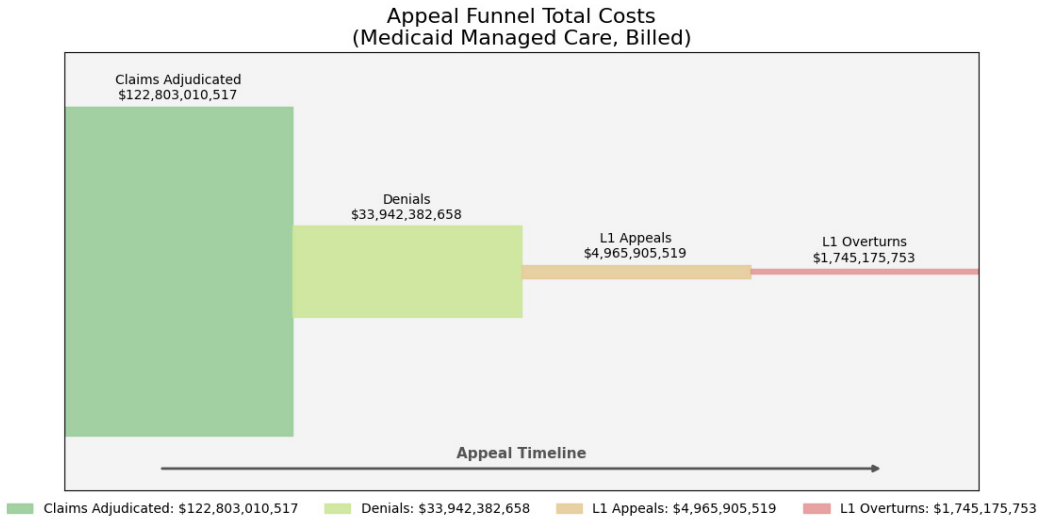
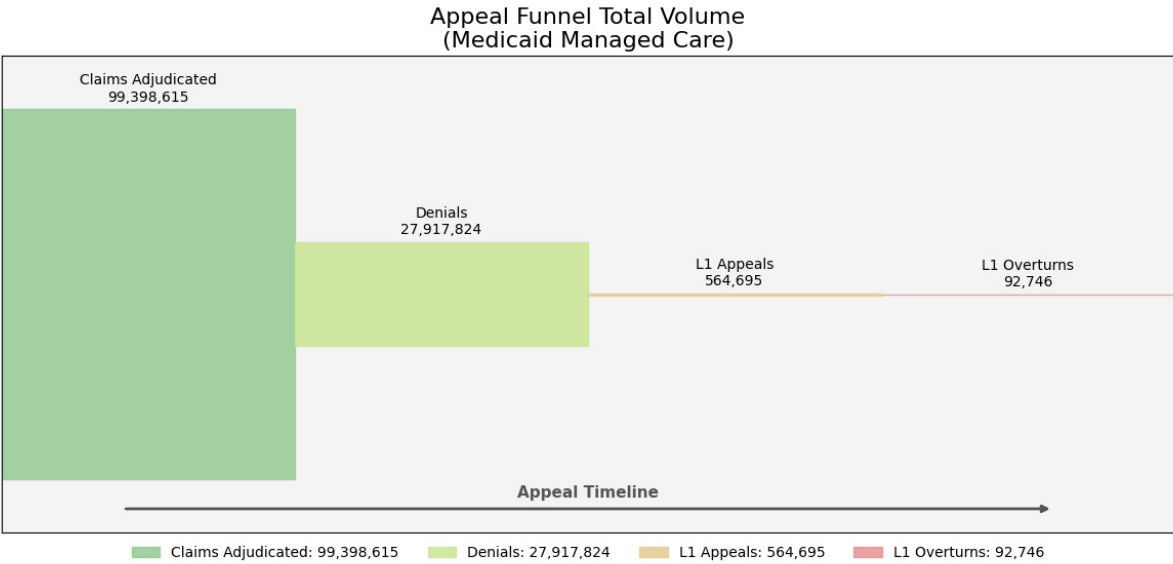


Figure 3.6: Appeal funnel volumes, and billed charges, among insurers reporting billed charges in the Child Health Plus market segment.



Figure 3.7: Appeal funnel volumes, and billed charges, among insurers reporting billed charges in the Medicaid Managed Care market segment.



Similarly, it is well known that few patients pursue appeals of coverage denials, that appeals processes are largely unfamiliar to patients, and that these processes are difficult to navigate even for those who are aware of them. For these reasons, it makes sense that expensive denials are appealed more often than inexpensive ones by patients. Similarly, providers have clear financial incentives to focus on appeals which are most cost effective to pursue. The more expensive a denial is, the higher the financial implications are for either the beneficiary or the provider, and the more likely at least one party is willing to spend considerable time, effort, and money trying to get a denial overturned.

It is the phenomenology in the last stage of the appeal funnel which is not well established via other data or literature known to the authors.

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.

Our analysis of the data reveals that among appealed denials, those that are overturned are more expensive on average than those that are upheld. This can be plainly seen even from the publicly available data in [Table 3.3](#), and is presumably made clear with more granularity in internal insurer analytics. Insurance companies also have the data necessary to understand that appeal utilization rates are low across markets. These facts suggest a troubling possibility: if similar adjudication errors occur among non-appealed denials (which vastly outnumber appealed denials), then a substantial volume of expensive, inappropriately denied care may remain unaddressed by appeals. This possibility is consistent with the observed trends, even without taking into account claims which, despite being denied inappropriately, are upheld at the level of internal appeal.¹¹

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.

Insurance companies could begin to address this situation by prioritizing improvement efforts for initial adjudication for the most expensive claims, to reduce the outsized financial

role of the appeals process. By systematically evaluating the types of denials that are frequently overturned on internal appeal, insurers could reduce error rates in initial decisions. Such error rate reduction would benefit both patients and providers, and reduce harm, administrative burdens, and costs resulting from wrongful denials. Such efforts might lower the average billed values for internal appeals and internal appeal overturns, and bring the value distribution between overturned and upheld appeals closer together.

The question becomes, why do wrongful denials of expensive care persist at large scale, when insurers have the data they need to systematically identify them, begin to address them, 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 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.

3.1.4 Analysis: Breakdown By Provider Category

The data in the health care claims reports comes equipped with further breakdowns which show how the claims, denials, appeals, and associated values are distributed among a group of high level provider categories. The categories laid out in the dataset are:

- Hospital Inpatient
- Hospital Outpatient¹²
- Other Facilities
- Physicians
- Other Health Care Professionals
- Pharmacy
- Other/Unknown

In this subsection, we consider how the health care claims report data associated with each market segment is distributed among these provider categories. As we have done in all analyses thus far, we disregard the data associated with the Pharmacy Provider category, as discussed in the methodology section.

¹¹ External appeal rates suggest such claims constitute a considerable fraction of upheld internal appeals. See Section 3.2

¹² Insurers are [instructed](#) to record emergency department visits within the hospital outpatient provider category.

All Insurers

For each market segment we first report overall denial rates, internal appeal rates, and internal appeal overturn rates for each provider category in Tables 3.8, 3.9, 3.10, and 3.11. These numbers correspond to aggregate counts for all payers in the data that passed our validation checks.

Table 3.8: Commercial market segment denial, internal appeal, and internal appeal overturn rates by provider category, for all insurers in the data.

Provider Category	Denial Rate	Full Denial Rate	Appeal Rate	Overturn Rate	Full Overturn Rate
Hospital - Inpatient	35.92%	24.91%	3.84%	30.15%	26.24%
Hospital - Outpatient	31.43%	15.21%	0.88%	32.80%	26.42%
Other Facilities	21.94%	13.46%	1.41%	27.92%	25.64%
Physicians	22.66%	12.32%	0.61%	43.43%	37.63%
Other Health Care Professionals	24.97%	16.27%	0.44%	51.31%	24.68%
Other / Unknown	28.90%	15.91%	0.51%	24.32%	20.93%

Table 3.9: Essential Plan market segment denial, internal appeal, and internal appeal overturn rates by provider category, for all insurers in the data.

Provider Category	Denial Rate	Full Denial Rate	Appeal Rate	Overturn Rate	Full Overturn Rate
Hospital - Inpatient	39.22%	20.15%	19.50%	25.53%	24.29%
Hospital - Outpatient	41.63%	11.32%	2.49%	22.83%	8.02%
Other Facilities	25.78%	11.03%	0.94%	11.10%	9.15%
Physicians	31.68%	10.31%	1.91%	29.45%	20.31%
Other Health Care Professionals	29.72%	13.44%	1.89%	41.81%	33.57%
Other / Unknown	31.04%	14.94%	3.06%	26.47%	19.90%

Table 3.10: Child Health Plus market segment denial, internal appeal, and internal appeal overturn rates by provider category, for all insurers in the data.

Provider Category	Denial Rate	Full Denial Rate	Appeal Rate	Overturn Rate	Full Overturn Rate
Hospital - Inpatient	49.09%	21.97%	12.43%	24.69%	23.90%
Hospital - Outpatient	40.74%	11.09%	1.41%	20.34%	14.15%
Other Facilities	20.91%	13.33%	0.35%	13.48%	12.92%
Physicians	34.80%	10.55%	1.51%	27.27%	10.81%
Other Health Care Professionals	28.24%	12.58%	2.15%	8.80%	4.61%
Other / Unknown	39.17%	24.56%	2.20%	10.57%	8.47%

Table 3.11: Medicaid Managed Care market segment denial, internal appeal, and internal appeal overturn rates by provider category, for all insurers in the data.

Provider Category	Denial Rate	Full Denial Rate	Appeal Rate	Overturn Rate	Full Overturn Rate
Hospital - Inpatient	42.26%	16.67%	11.20%	30.36%	28.79%
Hospital - Outpatient	30.18%	8.93%	1.51%	26.25%	15.88%
Other Facilities	14.63%	9.23%	0.62%	18.73%	16.81%
Physicians	29.48%	11.78%	2.14%	31.03%	17.26%
Other Health Care Professionals	27.16%	12.59%	1.82%	15.03%	11.85%
Other / Unknown	31.72%	17.78%	2.49%	21.44%	15.04%

Across insurance types, denial rates and appeal rates for inpatient hospital care are among the highest of all provider categories.

While we cannot say conclusively what leads to this trend from this data alone, one factor which clearly contributes to it is the fact that inpatient hospital care is among the most expensive types of care. This means that insurers, providers, and patients alike have more at stake financially when they are wrongly held responsible for the bills for this category of care. For this reason, it is not surprising that denial rates and appeal rates are among the highest in this provider category.

Although inpatient hospital care is denied and appealed at high rates compared to other types of care in all markets, the appeal rate for inpatient hospital care is lower in the commercial market than in the government subsidized markets. In fact, this is another manifestation of a phenomenon already observed: appeal rates are lower in general in the commercial market than in the government subsidized markets. Here we see that the appeal rate being lower is true across provider categories. This may be a result of regulatory oversight, patient support resources, and mandated appeal right disclosures in subsidized markets.

Lower appeal rates in commercial markets merit further investigation, especially if the rate of inappropriate denials is similar to the government subsidized markets. The cost burden of claim denials in commercial markets often gets passed on to patients when providers forgo appeal support, or fail to win appeals, which leads to medical debt.



Policy Proposal

Regulators should prioritize audits of high cost claims denials, such as those associated with hospital inpatient denials, to identify patterns of inappropriate denials and reduce medical debt burden.

Tables [3.12](#), [3.13](#), [3.14](#), and [3.15](#) again show the aggregate claim volume and billed value statistics for all insurers, but broken down by both provider category and market segment. Tables [3.16](#), [3.17](#), [3.18](#), and [3.19](#) show the same breakdowns for allowed amounts among insurers reporting such data.

Table 3.12: Breakdown by provider category among Commercial plans, for insurers reporting billed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	759,892	273,556	189,656	10,478	3,159	2,747
	Tot. Billed:	\$53,100 M	\$17,483 M	\$14,249 M	\$1,155 M	\$478 M	Not Computable
	Avg. Billed:	\$69,879	\$63,911	\$75,131	\$0.110 M	\$0.151 M	Not Computable
Hospital – Outpatient	Tot. #:	11,355,883	3,570,332	1,727,912	31,221	10,234	8,236
	Tot. Billed:	\$60,428 M	\$15,214 M	\$9,737 M	\$631 M	\$292 M	Not Computable
	Avg. Billed:	\$5,321	\$4,261	\$5,635	\$20,212	\$28,517	Not Computable
Other Facilities	Tot. #:	2,667,169	587,725	360,492	8,104	2,250	2,060
	Tot. Billed:	\$5,354 M	\$1,729 M	\$1,524 M	\$86 M	\$36 M	Not Computable
	Avg. Billed:	\$2,007	\$2,943	\$4,226	\$10,613	\$15,822	Not Computable
Physicians	Tot. #:	51,092,520	11,582,999	6,298,616	70,223	30,501	26,414
	Tot. Billed:	\$39,644 M	\$7,499 M	\$6,044 M	\$328 M	\$127 M	Not Computable
	Avg. Billed:	\$776	\$647	\$960	\$4,664	\$4,176	Not Computable
Other Professionals	Tot. #:	27,749,332	6,933,013	4,517,676	30,493	15,655	7,514
	Tot. Billed:	\$17,410 M	\$4,181 M	\$3,471 M	\$74 M	\$28 M	Not Computable
	Avg. Billed:	\$627	\$603	\$768	\$2,434	\$1,800	Not Computable
Other/ Unknown	Tot. #:	7,282,921	2,104,606	1,158,031	10,736	2,605	2,238
	Tot. Billed:	\$11,690 M	\$2,597 M	\$1,882 M	\$36 M	\$12 M	Not Computable
	Avg. Billed:	\$1,605	\$1,234	\$1,625	\$3,325	\$4,576	Not Computable

Table 3.13: Breakdown by provider category among Essential Plan plans, for insurers reporting billed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	98,250	38,529	19,797	7,514	1,918	1,825
	Tot. Billed:	\$5,279 M	\$2,041 M	\$1,210 M	\$625 M	\$232 M	Not Computable
	Avg. Billed:	\$53,728	\$52,972	\$61,097	\$83,203	\$0.121 M	Not Computable
Hospital – Outpatient	Tot. #:	1,896,897	789,672	214,715	19,649	4,485	1,575
	Tot. Billed:	\$5,690 M	\$1,958 M	\$858 M	\$259 M	\$71 M	Not Computable
	Avg. Billed:	\$2,999	\$2,480	\$3,996	\$13,167	\$15,829	Not Computable
Other Facilities	Tot. #:	549,709	141,713	60,637	1,333	148	122
	Tot. Billed:	\$1,239 M	\$346 M	\$182 M	\$5 M	\$0.872 M	Not Computable
	Avg. Billed:	\$2,254	\$2,443	\$3,001	\$3,742	\$5,892	Not Computable
Physicians	Tot. #:	6,588,304	2,086,956	679,058	39,778	11,713	8,078
	Tot. Billed:	\$4,104 M	\$662 M	\$456 M	\$71 M	\$26 M	Not Computable
	Avg. Billed:	\$623	\$317	\$672	\$1,775	\$2,204	Not Computable
Other Professionals	Tot. #:	4,326,701	1,286,050	581,513	24,311	10,164	8,160
	Tot. Billed:	\$2,629 M	\$531 M	\$428 M	\$61 M	\$30 M	Not Computable
	Avg. Billed:	\$608	\$413	\$735	\$2,513	\$2,920	Not Computable
Other/ Unknown	Tot. #:	1,945,914	604,046	290,752	18,486	4,894	3,679
	Tot. Billed:	\$1,424 M	\$314 M	\$234 M	\$38 M	\$9 M	Not Computable
	Avg. Billed:	\$732	\$521	\$803	\$2,079	\$1,879	Not Computable

Table 3.14: Breakdown by provider category among Child Health Plans plus, for insurers reporting billed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	14,376	7,092	3,155	887	219	212
	Tot. Billed:	\$804 M	\$266 M	\$151 M	\$85 M	\$21 M	Not Computable
	Avg. Billed:	\$55,934	\$37,562	\$47,713	\$95,650	\$96,644	Not Computable
Hospital – Outpatient	Tot. #:	470,972	191,595	52,080	2,728	555	386
	Tot. Billed:	\$918 M	\$270 M	\$110 M	\$19 M	\$5 M	Not Computable
	Avg. Billed:	\$1,948	\$1,409	\$2,115	\$7,019	\$8,933	Not Computable
Other Facilities	Tot. #:	242,696	50,919	32,380	178	24	23
	Tot. Billed:	\$184 M	\$70 M	\$27 M	\$0.488 M	\$0.175 M	Not Computable
	Avg. Billed:	\$757	\$1,369	\$827	\$2,743	\$7,309	Not Computable
Physicians	Tot. #:	1,551,253	540,105	164,026	8,203	2,237	887
	Tot. Billed:	\$685 M	\$137 M	\$77 M	\$7 M	\$2 M	Not Computable
	Avg. Billed:	\$442	\$254	\$467	\$870	\$862	Not Computable
Other Professionals	Tot. #:	1,467,982	413,883	183,036	9,059	797	418
	Tot. Billed:	\$805 M	\$135 M	\$109 M	\$8 M	\$1 M	Not Computable
	Avg. Billed:	\$548	\$325	\$593	\$873	\$1,462	Not Computable
Other/ Unknown	Tot. #:	418,207	163,622	102,549	3,614	382	306
	Tot. Billed:	\$226 M	\$65 M	\$53 M	\$4 M	\$0.595 M	Not Computable
	Avg. Billed:	\$541	\$399	\$517	\$1,159	\$1,557	Not Computable

Table 3.15: Breakdown by provider category among Medicaid Managed Care plans, for insurers reporting billed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	893,070	377,383	148,905	42,249	12,827	12,165
	Tot. Billed:	\$42,103 M	\$13,820 M	\$7,650 M	\$3,389 M	\$1,349 M	Not Computable
	Avg. Billed:	\$47,144	\$36,621	\$51,377	\$80,203	\$0.105 M	Not Computable
Hospital – Outpatient	Tot. #:	20,132,004	6,076,350	1,798,558	91,504	24,016	14,528
	Tot. Billed:	\$32,727 M	\$10,267 M	\$3,890 M	\$741 M	\$185 M	Not Computable
	Avg. Billed:	\$1,626	\$1,690	\$2,163	\$8,093	\$7,710	Not Compatible
Other Facilities	Tot. #:	9,117,018	1,334,125	841,937	8,220	1,540	1,382
	Tot. Billed:	\$9,211 M	\$2,348 M	\$1,305 M	\$40 M	\$8 M	Not Computable
	Avg. Billed:	\$1,010	\$1,760	\$1,550	\$4,823	\$4,879	Not Computable
Physicians	Tot. #:	34,289,617	10,110,188	4,040,710	215,908	66,994	37,276
	Tot. Billed:	\$19,215 M	\$3,425 M	\$2,443 M	\$338 M	\$107 M	Not Computable
	Avg. Billed:	\$560	\$339	\$605	\$1,565	\$1,602	Not Computable
Other Professionals	Tot. #:	23,490,961	6,379,421	2,958,624	116,057	17,448	13,748
	Tot. Billed:	\$12,045 M	\$2,141 M	\$1,689 M	\$159 M	\$33 M	Not Computable
	Avg. Billed:	\$513	\$336	\$571	\$1,372	\$1,892	Not Computable
Other/ Unknown	Tot. #:	11,475,945	3,640,357	2,040,439	90,757	19,457	13,647
	Tot. Billed:	\$7,502 M	\$1,942 M	\$1,435 M	\$300 M	\$63 M	Not Computable
	Avg. Billed:	\$654	\$533	\$703	\$3,305	\$3,238	Not Computable

Table 3.16: Breakdown by provider category among Commercial plans, for insurers reporting allowed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	590,142	172,230	130,671	8,949	2,300	2,207
	Tot. Allowed:	\$17,495 M	\$5 M	\$0	\$188 M	\$177 M	Not Computable
	Avg.Allowed:	\$29,646	\$28	\$0	\$20,975	\$50,839	Not Computable
Hospital – Outpatient	Tot. #:	8,243,404	2,421,006	1,110,678	27,074	7,884	6,684
	Tot. Allowed:	\$17,608 M	\$10 M	\$0	\$130 M	\$71 M	Not Computable
	Avg.Allowed:	\$2,136	\$4	\$0	\$4,788	\$9,034	Not Computable
Other Facilities	Tot. #:	1,884,664	384,205	203,899	4,305	695	625
	Tot. Allowed:	\$1,237 M	\$1 M	\$0	\$6 M	\$4 M	Not Computable
	Avg.Allowed:	\$656	\$3	\$0	\$1,479	\$5,284	Not Computable
Physicians	Tot. #:	29,470,749	6,248,241	3,613,249	37,938	9,855	8,346
	Tot. Allowed:	\$7,610 M	\$7 M	\$0	\$26 M	\$13 M	Not Computable
	Avg.Allowed:	\$258	\$1	\$0	\$691	\$1,282	Not Computable
Other Professionals	Tot. #:	14,770,648	3,360,275	2,227,315	20,760	11,361	3,425
	Tot. Allowed:	\$2,169 M	\$3 M	\$0	\$10 M	\$4 M	Not Computable
	Avg.Allowed:	\$147	\$1	\$0	\$469	\$319	Not Computable
Other/ Unknown	Tot. #:	2,180,807	641,769	434,989	9,634	1,928	1,680
	Tot. Allowed:	\$2,655 M	\$1 M	\$0	\$6 M	\$2 M	Not Computable
	Avg.Allowed:	\$1,217	\$2	\$0	\$611	\$1,224	Not Computable

Table 3.17: Breakdown by provider category among Essential Plan plans, for insurers reporting allowed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	73,664	30,760	13,308	4,607	1,107	1,089
	Tot. Allowed:	\$636 M	\$12 M	\$0	\$112 M	\$47 M	Not Computable
	Avg.Allowed:	\$8,635	\$374	\$0	\$24,388	\$42,718	Not Computable
Hospital – Outpatient	Tot. #:	1,264,479	541,108	127,553	18,169	3,670	1,037
	Tot. Allowed:	\$519 M	\$34 M	\$0	\$47 M	\$12 M	Not Computable
	Avg.Allowed:	\$410	\$64	\$0	\$2,560	\$3,240	Not Computable
Other Facilities	Tot. #:	370,514	91,533	33,765	630	13	8
	Tot. Allowed:	\$116 M	\$1 M	\$0	\$0.170 M	\$52,504	Not Computable
	Avg.Allowed:	\$314	\$12	\$0	\$270	\$4,039	Not Computable
Physicians	Tot. #:	4,384,669	1,418,910	375,776	35,463	9,370	6,036
	Tot. Allowed:	\$670 M	\$35 M	\$0	\$11 M	\$4 M	Not Computable
	Avg.Allowed:	\$153	\$24	\$0	\$315	\$387	Not Computable
Other Professionals	Tot. #:	2,654,542	746,886	317,010	23,772	9,980	7,994
	Tot. Allowed:	\$284 M	\$12 M	\$0	\$14 M	\$4 M	Not Computable
	Avg.Allowed:	\$107	\$16	\$0	\$603	\$398	Not Computable
Other/ Unknown	Tot. #:	1,779,426	537,360	253,888	18,408	4,868	3,653
	Tot. Allowed:	\$195 M	\$8 M	\$0	\$7 M	\$2 M	Not Computable
	Avg.Allowed:	\$110	\$15	\$0	\$379	\$440	Not Computable

Table 3.18: Breakdown by provider category among Child Health plans, for insurers reporting allowed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	9,870	4,901	1,859	566	118	117
	Tot. Allowed:	\$94 M	\$59,704	\$0	\$9 M	\$3 M	Not Computable
	Avg.Allowed:	\$9,476	\$12	\$0	\$16,783	\$21,765	Not Computable
Hospital – Outpatient	Tot. #:	316,278	127,082	30,710	2,522	444	285
	Tot. Allowed:	\$79 M	\$5 M	\$0	\$2 M	\$0.586 M	Not Computable
	Avg.Allowed:	\$249	\$38	\$0	\$840	\$1,319	Not Computable
Other Facilities	Tot. #:	178,094	38,206	25,864	85	3	2
	Tot. Allowed:	\$29 M	\$0.733 M	\$0	\$21,767	\$21,679	Not Computable
	Avg.Allowed:	\$164	\$19	\$0	\$256	\$7,226	Not Computable
Physicians	Tot. #:	1,092,008	370,671	96,066	7,644	1,878	622
	Tot. Allowed:	\$132 M	\$12 M	\$0	\$1 M	\$0.521 M	Not Computable
	Avg.Allowed:	\$121	\$31	\$0	\$182	\$277	Not Computable
Other Professionals	Tot. #:	867,244	228,165	87,586	8,909	755	378
	Tot. Allowed:	\$107 M	\$0.784 M	\$0	\$1 M	\$0.118 M	Not Computable
	Avg.Allowed:	\$123	\$3	\$0	\$155	\$156	Not Computable
Other/ Unknown	Tot. #:	338,292	120,405	75,863	3,603	376	301
	Tot. Allowed:	\$33 M	\$0.798 M	\$0	\$0.999 M	\$0.351 M	Not Computable
	Avg.Allowed:	\$97	\$7	\$0	\$277	\$934	Not Computable

Table 3.19: Breakdown by provider category among Medicaid Managed Care plans, for insurers reporting allowed charges.

Provider Category		Claims	Denials	Full Denials	Appeals	Overturns	Full Overturns
Hospital – Inpatient	Tot. #:	824,659	365,088	137,751	36,507	11,076	10,831
	Tot. Allowed:	\$5,156 M	\$22 M	\$0	\$401 M	\$183 M	Not Computable
	Avg.Allowed:	\$6,252	\$60	\$0	\$10,973	\$16,503	Not Computable
Hospital – Outpatient	Tot. #:	18,676,234	5,622,912	1,612,005	86,077	20,203	12,100
	Tot. Allowed:	\$3,559 M	\$187 M	\$0	\$88 M	\$25 M	Not Computable
	Avg.Allowed:	\$191	\$33	\$0	\$1,022	\$1,255	Not Computable
Other Facilities	Tot. #:	8,074,049	1,188,864	737,612	4,739	288	191
	Tot. Allowed:	\$2,347 M	\$8 M	\$0	\$2 M	\$0.976 M	Not Computable
	Avg.Allowed:	\$291	\$7	\$0	\$387	\$3,387	Not Computable
Physicians	Tot. #:	31,029,388	8,984,930	3,379,737	206,062	60,716	31,930
	Tot. Allowed:	\$3,453 M	\$167 M	\$0	\$52 M	\$20 M	Not Computable
	Avg.Allowed:	\$111	\$19	\$0	\$253	\$327	Not Computable
Other Professionals	Tot. #:	19,961,364	5,263,047	2,386,828	114,895	16,932	13,306
	Tot. Allowed:	\$2,359 M	\$30 M	\$0	\$23 M	\$6 M	Not Computable
	Avg.Allowed:	\$118	\$6	\$0	\$197	\$355	Not Computable
Other/ Unknown	Tot. #:	11,258,931	3,566,775	1,984,873	90,408	19,143	13,416
	Tot. Allowed:	\$1,683 M	\$40 M	\$0	\$52 M	\$20 M	Not Computable
	Avg.Allowed:	\$149	\$11	\$0	\$576	\$1,031	Not Computable

There are a few observations worth highlighting in these detailed breakdowns.

1. The billed value¹³ associated with denials is large in every market segment, and in every provider category. Billed denial values range from tens of millions of dollars to tens of billions of dollars for services associated with each individual provider category within a single market. In 2023 the total billed value of denials was 48.7 billion in the Commercial market, 5.8 billion in the Essential Plan market, 0.9 billion in the Child Health Plus market, and 34 billion in the Medicaid Managed Care market.
2. The appeals process is playing a critical role in allowing insured beneficiaries to access coverage to which they are entitled. This is true in spite of the fact that appeal rates are low. Even modest improvements to appeal access and success would likely result in significant financial returns to insured beneficiaries or their providers. In 2023 the internal appeals process allowed insured beneficiaries and their providers to collectively avoid costs they would otherwise have had to pay worth at least 973 million in the Commercial market, 368 million in the Essential Plan market, 30 million in the Child Health Plus market, and 1.7 billion in the Medicaid Managed Care market, via overturned post-service denials. The overturns instead resulted in allowed costs to insurers amounting to at least 210 million in the Commercial market, 69 million in the Essential Plan market, 4 million in the Child Health Plus Market, and 255 million in the Medicaid Managed Care market.

The appeals process is playing an inappropriately outsized role in New York. In 2023 it led to a shift in payment responsibility for bills totaling billions of dollars for patients or their providers, to bills totaling hundreds of millions of dollars for insurers. 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.

3.2 External Appeal Database

3.2.1 Background

The New York Department of Financial Services maintains an external appeal database documenting individual independent medical reviews (IMRs), or *external appeals*, within the state. This database contains records from various insurance types, including Medicaid Managed Care, fully insured commercial plans (categorized by type: HMO, PPO, EPO), Essential Plan, Child Health Plus, and Managed Long Term Care. Each appeal record includes data about the appeal outcome, the diagnosis associated with the denial, the service or treatment denied, and sometimes additional reviewer notes. Unlike the health care claims reports, this data includes appeals of both post-service denials, and of prior authorizations. Data from 2019 to present is available on the [DFS website](#). The following analysis examines this New York external appeal data.

External appeals serve a unique and critical role in ensuring access to justice for patients facing inappropriate denials. They provide a relatively unbiased, low-barrier pathway for patients to contest denials. In contrast, internal appeals lack a conceptual basis for impartiality. As we will demonstrate, external appeal overturn rates suggest that insurers may act on their clear financial incentive for biased internal appeal adjudication. What we can state definitively is that the disagreement between internal and external reviews—among claims processed through both stages—is significant across many U.S. insurance markets [[Gar23b](#)]. Internal and external review processes yield inconsistent outcomes for the same set of coverage denials¹⁴.

External appeal overturn represents an assessment from a relatively unbiased party that an insurer has made the wrong coverage decision. High volumes and rates of external appeal overturn indicate problems in initial adjudication and internal appeal review.

First level appeals for denials administered by private companies are typically adjudicated internally by those same companies. They often have a clear financial incentive to favor one decision over another (regardless of whether they act on that incentive). In external appeal processes, independent entities are contracted to review the appeals. While these review entities may also have potential conflicts of interest, such conflicts are less direct. As a result, external appeal outcomes function as a relatively unique proxy for measuring both the prevalence of inappropriate denials and the quality of internal appeal review.

¹³ This is the only monetary value we can associate with denials from this data. One way to estimate the actual costs insurers avoid by not paying these claims is to multiply the total billed value by the typical fraction of billed charges that are allowed in each market.

¹⁴ In some cases, the evidence reviewed during appeals processes, such as medical records, changes from one level of appeal to another as additional supporting documentation is provided. In others, the evidence presented remains the same. In either case, the underlying, original coverage denial remains consistent across different stages of the appeal process.

3.2.2 Analysis: Breakdown By Market Segment

The external appeal database contains information about the following types of insurance:

- Medicaid Managed Care (MMC)
- CHIP
- Essential Plan
- Managed Long Term Care (MLTC)
- Fully Insured HMO (FI HMO)
- Fully Insured PPO (FI PPO)
- Fully Insured EPO (FI EPO)
- Self Funded Employer Sponsored (Self Funded)
- Indemnity

In this subsection, we consider how the external appeal data varies at a high level across these insurance types. Throughout, we discard records from 2024, since the year is incomplete at the time of writing¹⁷. Inclusion of the incomplete data would lead to a misleading view of the statistics inconsistent with the methodology used for complete years.

All Insurers

Table 3.20 shows a high level breakdown of the external appeals database records, and the associated external appeal overturn rates, from 2019 to 2023.

Table 3.20: Aggregate external appeal statistics broken down by insurance type, from 2019 to 2023 (inclusive). Overturns and overturn rates represent full overturn counts only. The counts and rates are higher when including partial overturns.

Insurance Type	# Insurers	Total Appeals	Overturns	Overturn Rate
MLTC	30	2,891	2,085	72.12%
CHIP	12	249	149	59.84%
Self Funded	16	1,241	600	48.35%
FI EPO	20	1,488	623	41.87%
FI PPO	34	2,589	1,077	41.60%
MMC	47	14,998	5,956	39.71%
Indemnity	25	3,967	1,566	39.48%
FI HMO	25	5,040	1,858	36.87%
Essential Plan	21	715	247	34.55%
Total	90	33,259	14,200	42.70%

¹⁵ Medicare has a multi-level appeal process with five levels. Level two appeals are the closest analog to external appeals in the markets considered here.

¹⁶ A Medicare star rating measure reflects this penalty. See e.g. measure C29 of the [2024 technical notes](#).

¹⁷ Note that the external appeal database is substantively updated on a rolling basis. Our analysis uses a snapshot of the database downloaded on November 20th, 2024.

Utilization of external appeals is low across insurance types in New York, but the processes serve a valuable role for those who pursue them. External appeals are overturned at rates above 30% across insurance types. The rate at which external appeals are overturned in Managed Long Term Care and CHIP, insurance markets with relatively vulnerable populations, is particularly troubling.

This data raises questions about how many upheld internal appeals merit overturn, but are never externally appealed.



Policy Proposal

Regulators should implement automatic forwarding of upheld internal appeals (or make internal processes optional), and add a financial incentive for insurers to get internal appeal adjudication right.

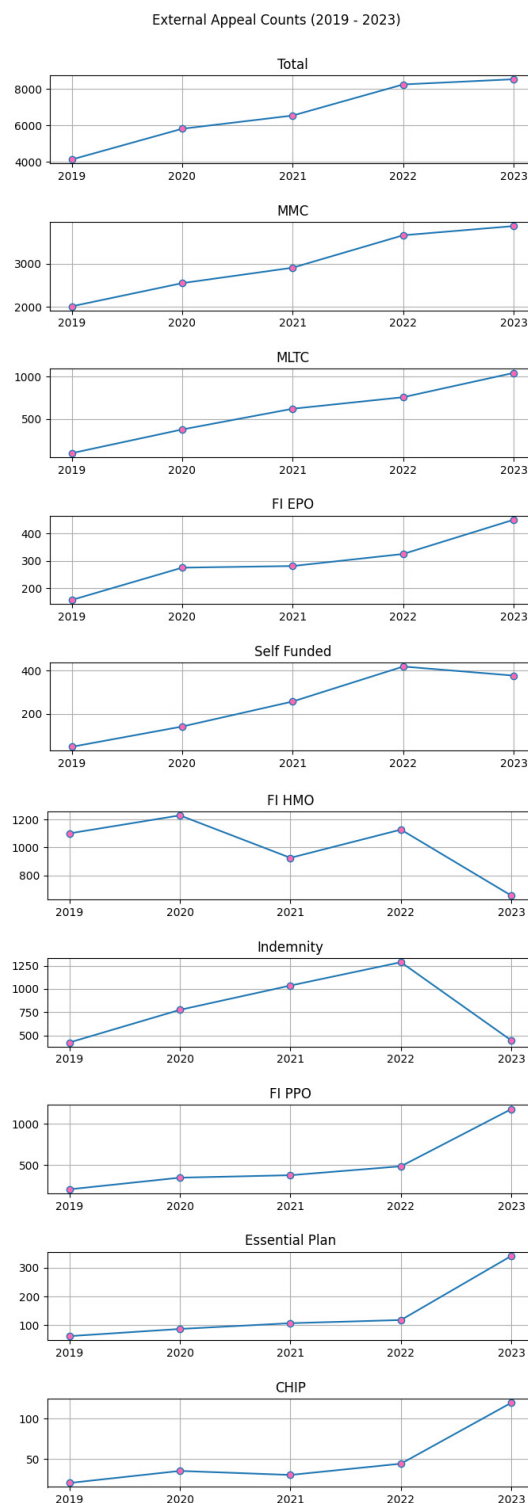
A lesson can be drawn here from an approach taken in Medicare to protect beneficiaries' access to covered care. Medicare Advantage insurers are incentivized to adjudicate first level appeals correctly by a combination of [automatic forwarding](#) of upheld internal appeals, and a financial bonus paid to Medicare Advantage Organizations which attain an external appeal overturn rate that is sufficiently low¹⁸. Combined, these measures ensure that inappropriate internal appeal adjudication will be measured, and will cost insurers. The result, causal or not, is that external appeal overturn rates in Medicare Advantage are much lower than those seen in this data, hovering around 5% on average [Gar23a].

Figures 3.21 and 3.22 show the trends in external appeal counts and full overturn rates over time. In most insurance types, external appeal utilization increased steadily from 2019 to 2023. In the same period, external appeal overturn rates for different insurance types changed in various ways. Despite this, rates remained above 30% in all markets, and much higher than 30% in some.

This data shows that more external reviews are being submitted and reviewed every year. This has cost implications, because appeal review is laborious and costly. It may also indicate that appeals are playing an increasingly large role in accessing covered care. Appeals should serve to fix rare problems, rather than serve as increasingly

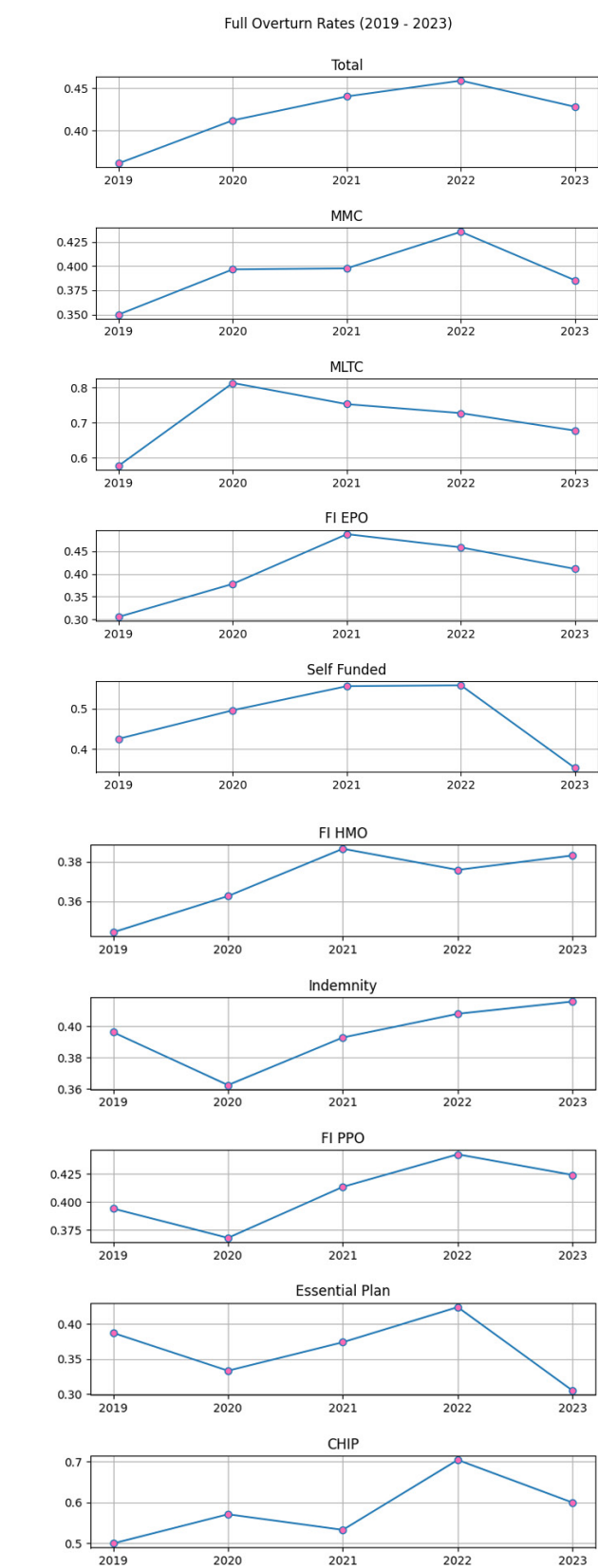
common hoops that patients and providers must jump through to access care to which they are contractually entitled.

Figure 3.21: External appeal volume trends from 2019 to 2023, split across insurance types. For most insurance types, external appeal volumes increased between 2019 and 2023.



¹⁸ A Medicare star rating measure reflects this incentive. See e.g. measure C29 of the [2024 technical notes](#).

Figure 3.22: External appeal overturn rate trends from 2019 to 2023, split across insurance types.



3.2.3 Analysis: Breakdown By Diagnosis

Diagnosis Categories

Each record in the external appeal database has a *diagnosis category* associated with it¹⁹. These categories provide a high level partition for the types of care sought in the individual cases making up the database. They are formatted as comma-separated lists of plain-text category descriptors, with individual categories typically denoted by multiple, related, slash-separated characterizations.

For example, the 5 most prevalent categories in the data are:

- [Digestive System/ Gastrointestinal]
- [Cardiac/ Circulatory Problems]
- [Central Nervous System/ Neuromuscular Disorder]
- [Orthopedic/ Musculoskeletal]
- [Dental Problems]

Even in cases where external appeals are overturned, patients incur costs and face harms resulting from the complexity of the processes. External appeals processes are laborious, and have costs for patients arising from time spent, and from access to care delayed. When appeals are not sought or not overturned, the original denials can lead to forgone care or bills. Harmful consequences for patients are often severe, and inequitably distributed among the general population of patients.

Understanding how external appeal volumes and overturn rates vary by patient diagnoses sheds light on the extent to which some patient populations are shouldering disproportionate risks and costs from inappropriate denials.

All Insurers

Figures 3.23, 3.24, and 3.25 show the diagnosis categories with the largest volume of external appeals, as well as the categories which are overturned at the highest and lowest rates. This data is presented for all records in the external appeal database in aggregate, and also broken down by insurance type.

There are a few things that stand out in these breakdowns, in addition to the most appealed categories (listed above). One is that certain categories of diagnoses are among the most appealed categories across *insurance types*, while others play an important role *unique to a particular market*.

¹⁹ The exact origin of the individual categorizations, and how if at all they are associated with ICD-10 codes associated with the medical records, is not specified in any public database documentation, as far as we are aware.

Diagnoses related to the Digestive System, Cardiac issues, and Central Nervous System issues were among the most frequently externally appealed across insurance types.

They uniformly lead to relatively high volumes of external appeals. It is impossible from this data alone to determine whether this is due to higher volumes of submitted claims, higher volumes of denials, higher volumes of internal appeal upholds, or some combination of these factors for these diagnoses. Regardless of the cause, the external appeal processes afforded to New Yorkers have larger scale implications for these diagnosis categories than others.

In other cases, there are categories of diagnosis which result in relatively high volumes of external appeal overturns only for some insurance types.

Central Nervous System issues make up an outsized fraction of Managed Long Term Care external appeals.

This suggests a serious need for further investigation by regulators given the overturn rates, which show that 74% of these appeals result in overturn.

External appeals related to Dental Problems make up an outsized portion of CHIP appeals.

This again suggests a need for further investigation given the overturn rates, which show that 67% of these appeals result in overturn. However, in this case the denominators are much smaller (roughly a factor of 10 smaller), and it is possible the result is an artifact of a small dataset.

Finally, [Figure 3.24](#) suggests that certain subpopulations of patients, with particular types of diagnoses and medical situations, may be facing inappropriate denials administered at disproportionately high rates. For example, patients with diagnoses relating to substance use disorder in Medicaid Managed Care plans in New York are having their external appeals overturned 64% of the time, which is 24% higher than the average overturn rate in Medicaid Managed Care. Similarly, 85% of external appeals from patients with diagnoses related to cancer in Managed Long Term Care plans are overturned, which is 13% higher than the MLTC average. The differences between the diagnosis categories with the highest overturn rates and the average overturn rates is staggering for each insurance type. This suggests inappropriate denials may be heavily skewed towards certain diagnosis demographics. The data supports this possibility in every market, though the affected demographics vary by market.

An important takeaway is that some patient populations are bearing the brunt of the harms caused by wrongful denials, and these patient populations are often already facing dire circumstances, accumulating harms from denials over long time spans, or particularly vulnerable.

This data shows that while wrongful denials have broad impact and most people have some connection to them,

their effects can be more pronounced and have particularly grave consequences for certain demographics of patients.

Figure 3.23: Top externally appealed diagnosis categories, broken down by insurance type.

Top Externally Appealed Diagnosis Categories (2019 - 2023)

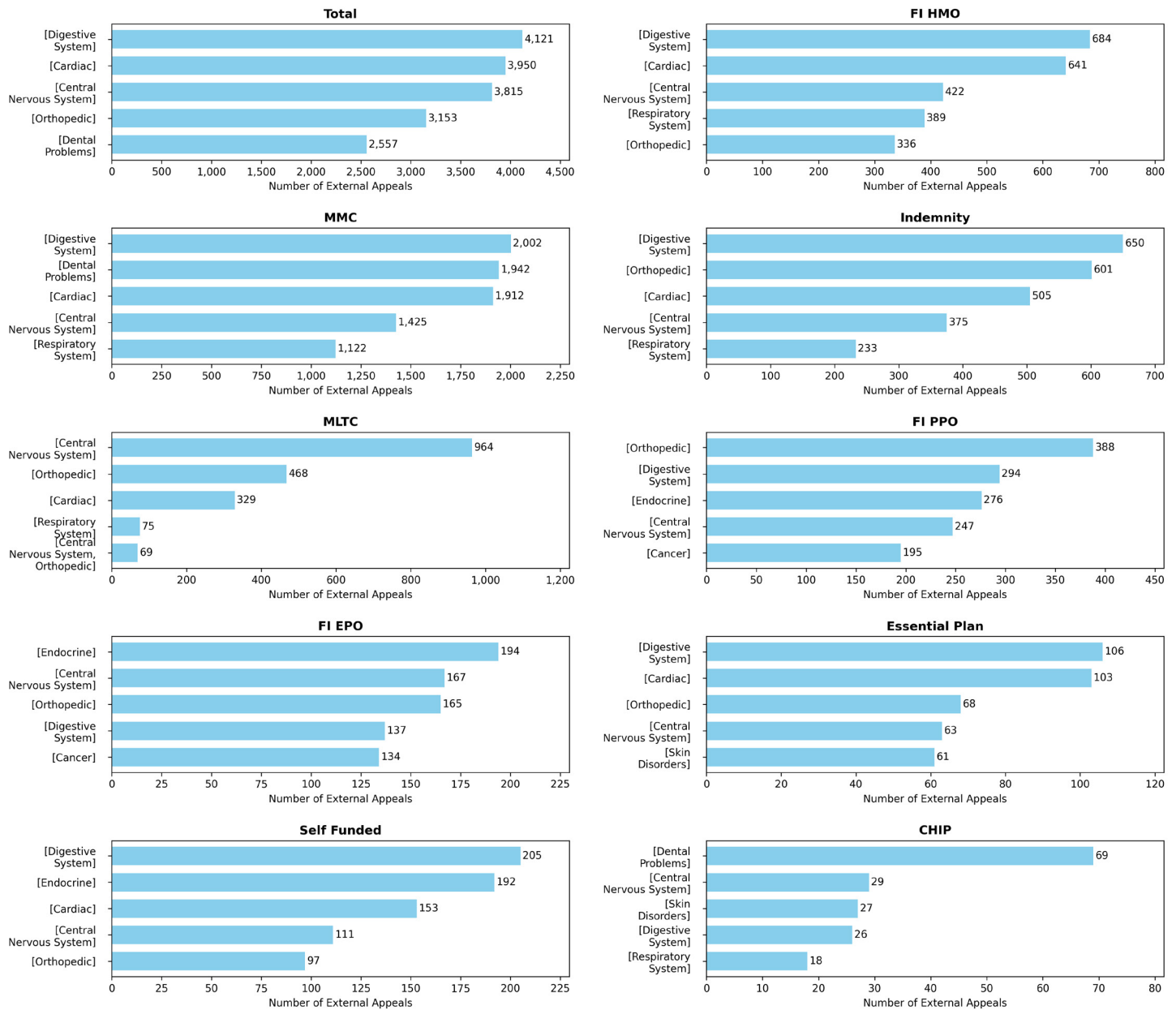


Figure 3.24: Diagnosis categories with the highest overturn rates, broken down by insurance type. Only categories which have at least 25 records were considered for the rate comparison.

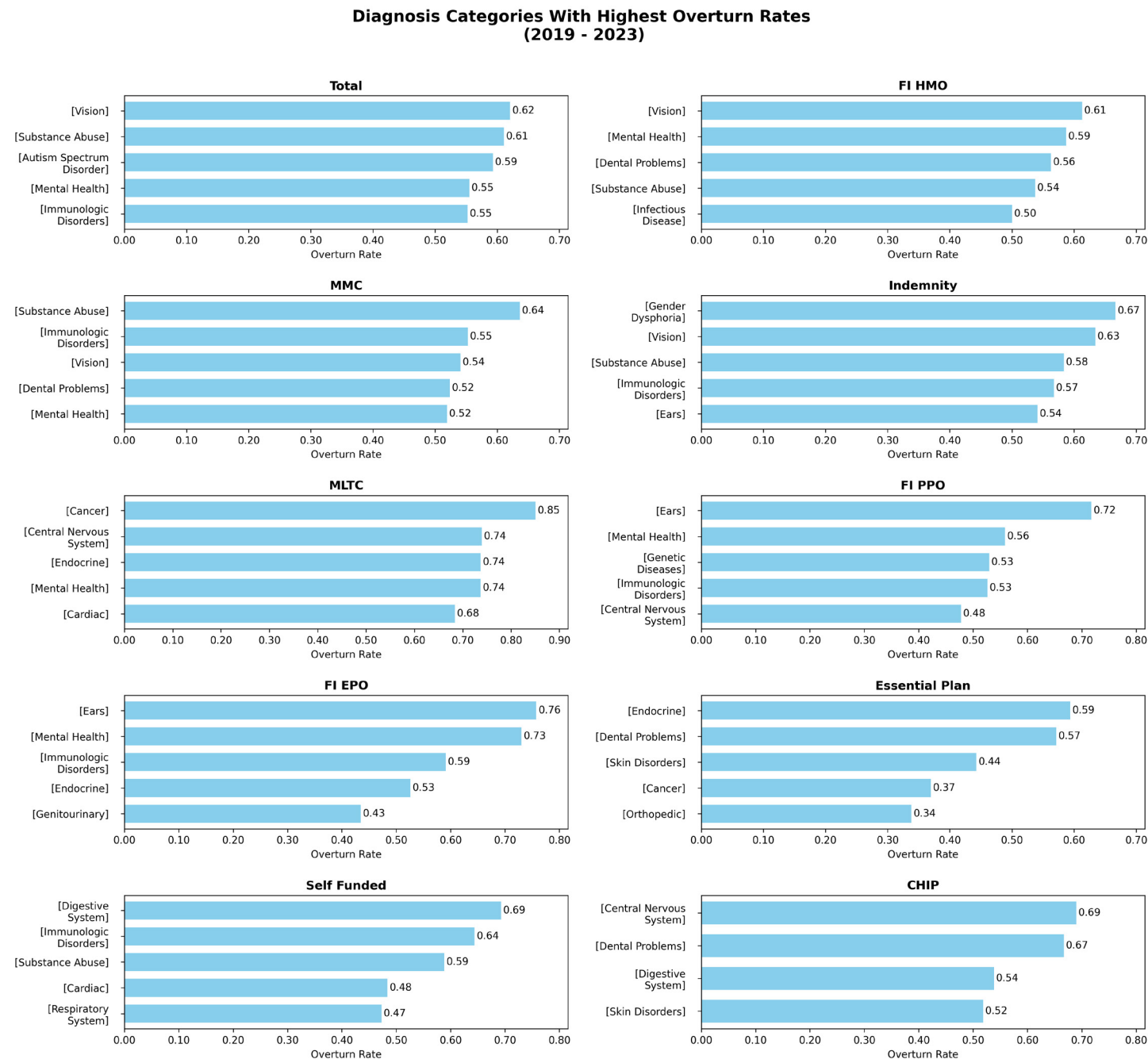
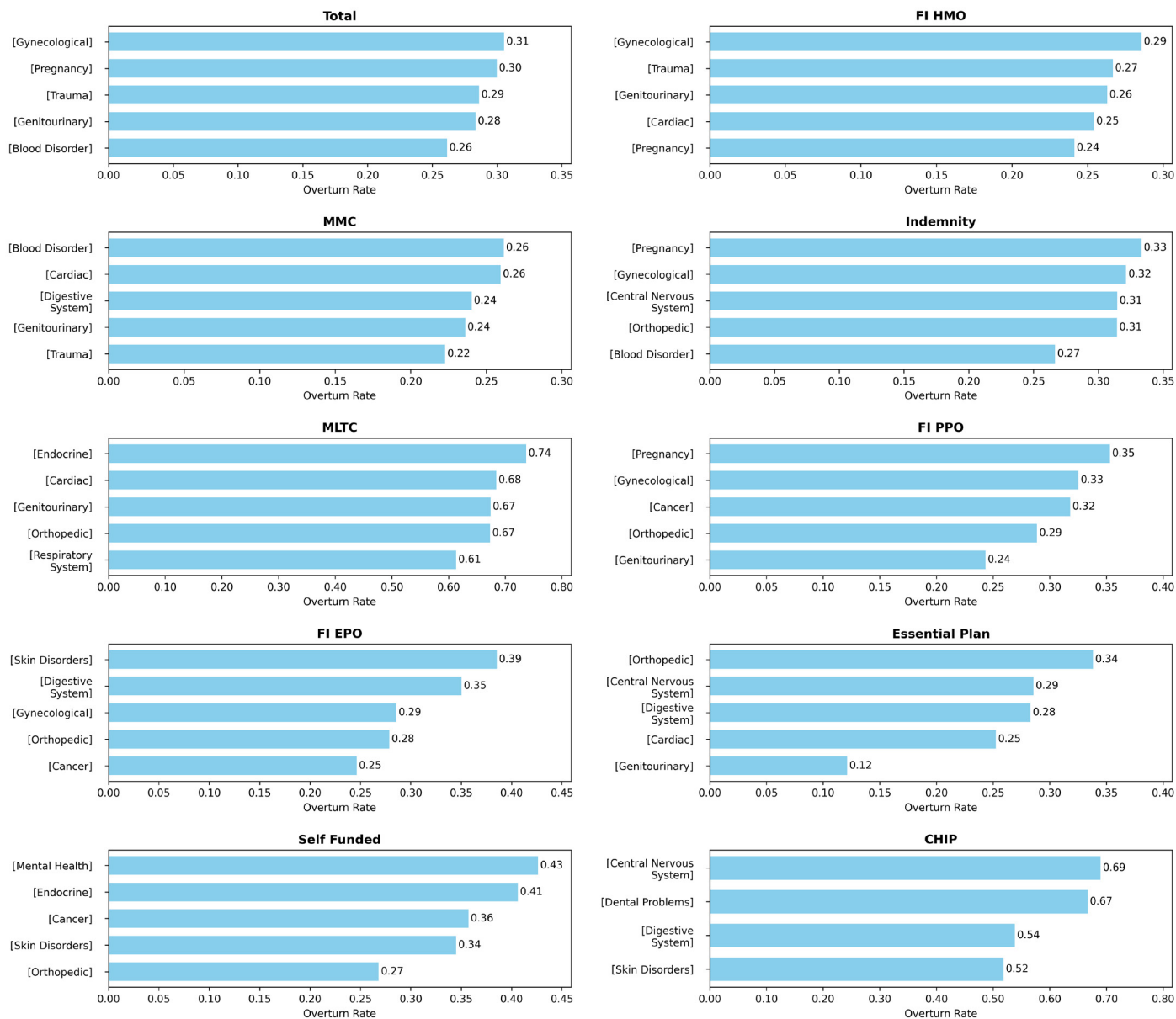


Figure 3.25: Diagnosis categories with the lowest overturn rates, broken down by insurance type. Only categories which have at least 25 records were considered for the rate comparison.

Diagnosis Categories With Lowest Overturn Rates (2019 - 2023)



3.2.4 Analysis: Breakdown By Treatment

Treatment Categories

Each record in the external appeal database also has a *treatment category* associated with it²⁰. These categories provide a high level partition for the types of services sought or received in the individual cases making up the database. They are formatted as comma-separated lists of plain-text category descriptors, with individual categories typically denoted by multiple, related, slash-separated characterizations. For example, the 5 most prevalent treatment categories in the data are:

- [Inpatient Hospital]
- [Pharmacy/ Prescription Drugs]
- [Home Health Care]
- [Dental/ Orthodontic Procedure]
- [Surgical Services]

Understanding how external appeal volumes and overturn rates vary by treatment or service is important because it sheds light on the extent to which inappropriate denials and internal appeal decisions may be distributed among different types of care.

All Insurers

Figures 3.26, 3.27, and 3.28 show the treatment categories that receive the largest volume of external appeals, as well as the categories which are overturned at the highest and lowest rates. This data is presented for all records in the external appeal database in aggregate, and also broken down by insurance type.

There are a few things that stand out in these breakdowns, in addition to the most appealed categories (listed above). One is that, as with diagnosis categories, certain categories of treatment are among the most appealed categories *across insurance types*, while others play an important role unique to a *particular market*.

Inpatient Hospital Admission and Pharmacy related services were among the most frequently externally appealed service categories across many types of insurance.

They represent categories of service which nearly uniformly lead to relatively high volumes of external appeals. It is impossible from this data alone to determine whether this is due to higher levels of submitted claims, higher volumes of denials, higher volumes of appeal upholds, or some combination of these factors for these services. Regardless of the cause, the external appeal processes afforded to

New Yorkers have larger scale implications for these service categories than others.

In other cases, there are categories of treatment which result in high volumes of external appeal overturns for only some insurance types.

Home Health Care related services make up an outsized fraction of Managed Long Term Care external appeals.

This again suggests the same serious need for further investigation by regulators given the overturn rates, which show that 73% of appeals of this type result in overturn.

External appeals related to Dental services make up an outsized portion of MMC and CHIP appeals.

This again suggests a need for further investigation related to dental services in CHIP, but also for dental services in MMC (given the overturn rate for appeals of this type).

Finally, Figure 3.27 suggests that certain subpopulations of patients, with particular types of medical situations and required treatments, may be facing a disproportionately high rate of inappropriate denials. For example, across insurance types patients seeking treatment related to Autism have their appeals overturned up to 74% of the time.

Our findings suggest that insurers may be targeting specific patient populations via inappropriate denial practices.

These findings are consistent with alleged targeted inappropriate denial practices advocates have long been raising alarms about. For example, allegations of systemic wrongful denial patterns for Applied Behavioral Analysis for those with Autism were recently considered in an investigative report [Wal24].



Policy Proposal

Regulators should continue to measure and begin financially penalizing high rates of external appeal overturn, both in aggregate, and at the level of individual types of care.

²⁰ The exact origin of individual categorizations, and how if at all they are associated with CPT codes associated with the medical records, is not specified in any public data-base documentation, as far as we are aware.

There are many similarly concerning trends apparent in these graphs; there are too many to list explicitly, so we point out just a few. Patients seeking services related to advanced imaging in Medicaid Managed Care plans have their external appeals overturned 49% of the time, which is 9% higher than the average overturn rate in Medicaid Managed Care. Similarly, 59% of external appeals from

patients seeking pain management related services in Essential Plans are overturned, which is 24% higher than the Essential Plan average. This is, among many of the statistics drawn from this data, cause for concern. It merits investigation by regulators, as it has serious repercussions for patients.

Figure 3.26: Top externally appealed treatment categories, broken down by insurance type.

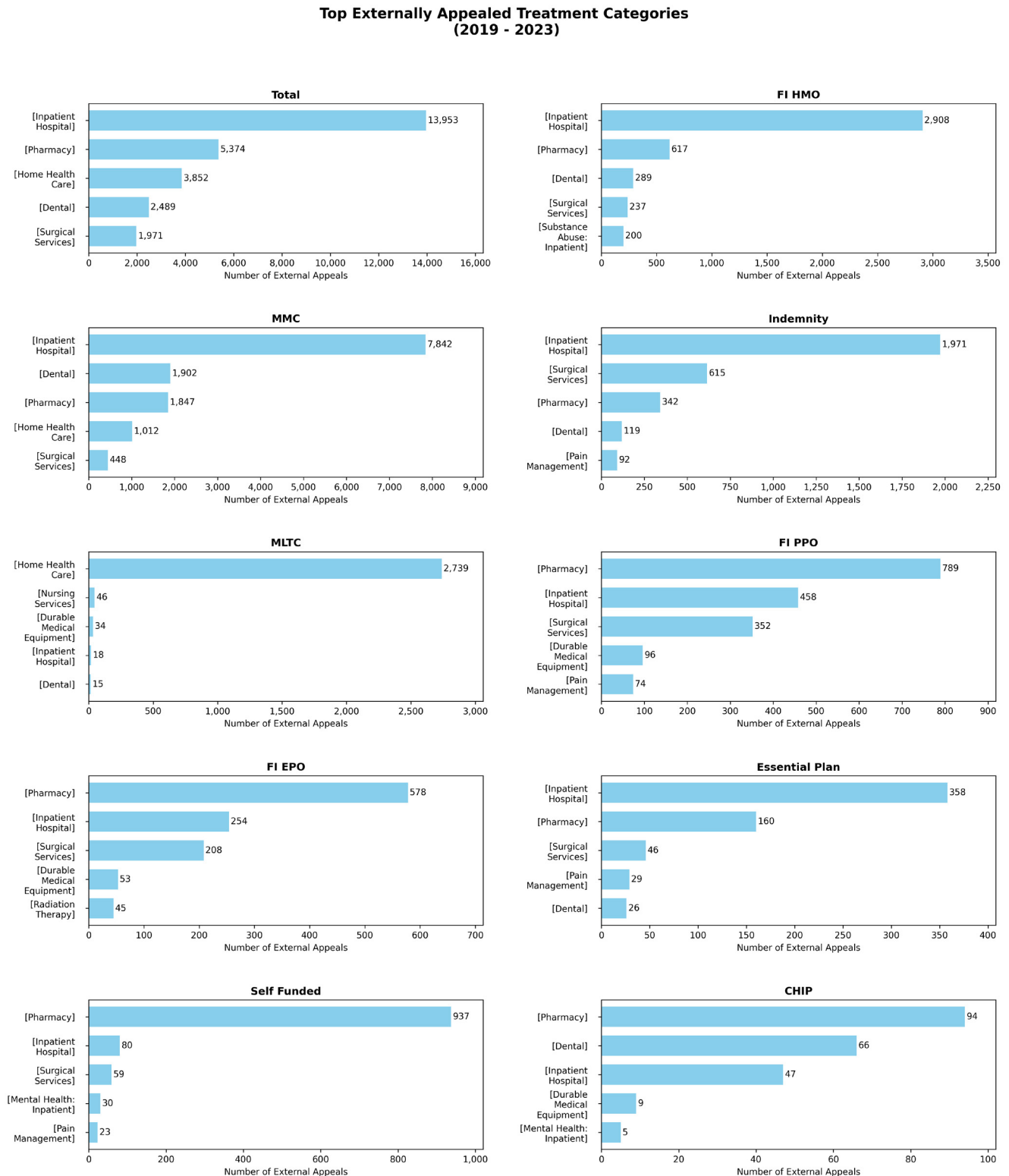


Figure 3.27: Treatment categories with the highest overturn rates, broken down by insurance type. Only categories which have at least 25 records were considered for the rate comparison.

Treatment Categories With Highest Overturn Rates (2019 - 2023)

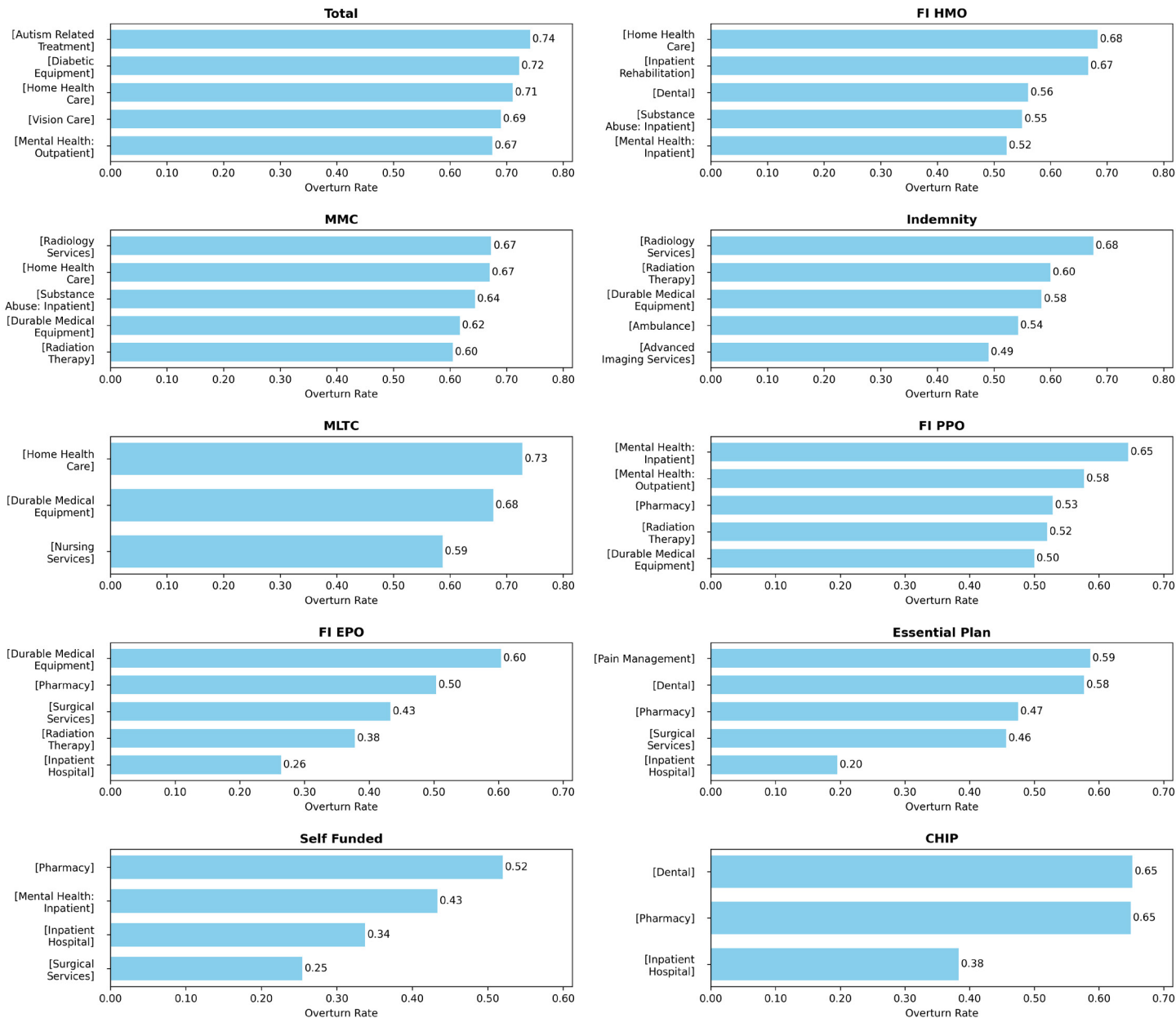
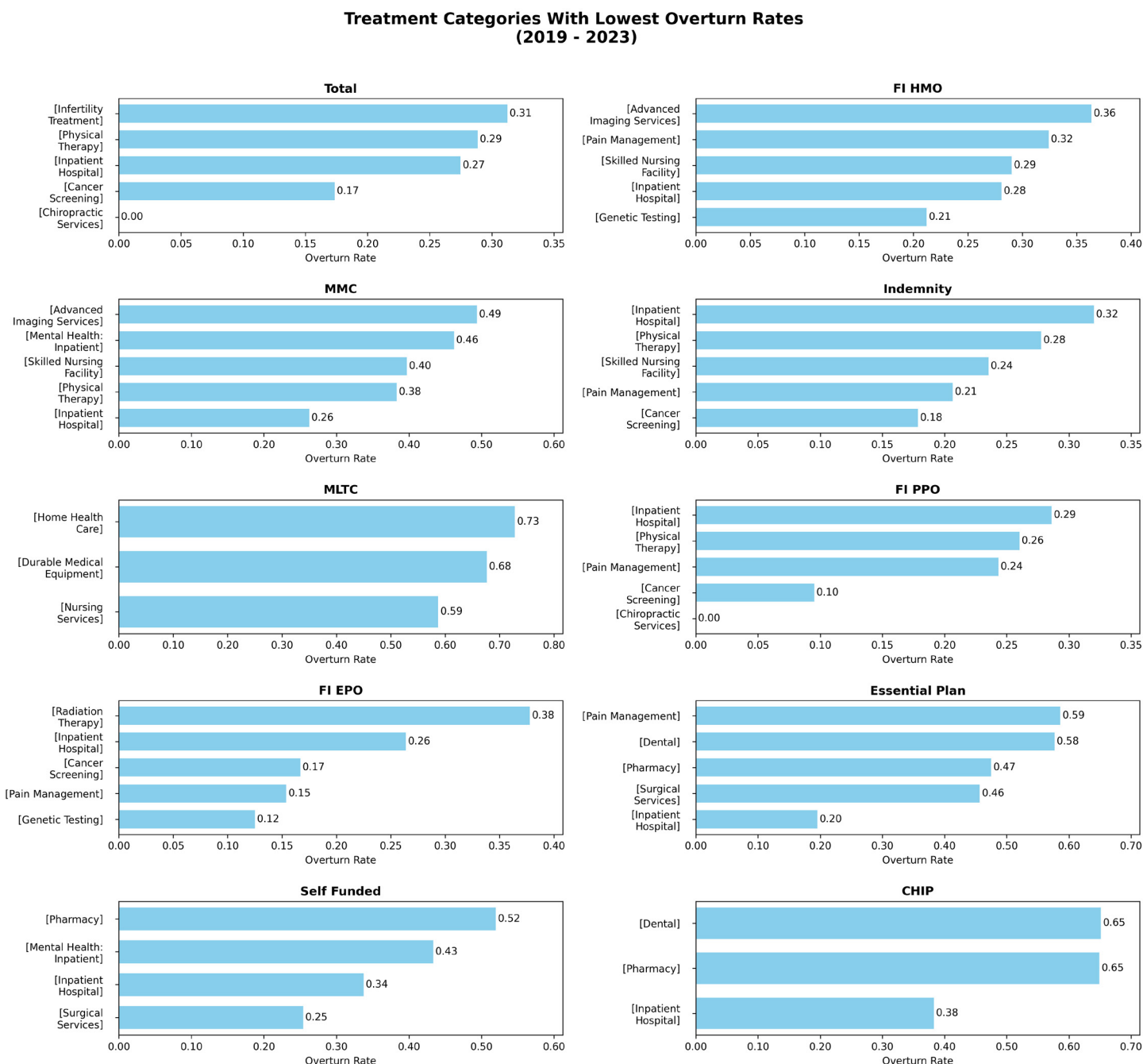


Figure 3.28: Treatment categories with the lowest overturn rates, broken down by insurance type. Only categories which have at least 25 records were considered for the rate comparison.



Medical Loss Ratios

A *Medical Loss Ratio* (MLR) is a general term for a ratio roughly representing the fraction of premium revenue (or capitation revenue) that is spent paying medical claims (as opposed to spent on administrative costs, quality improvement initiatives, or retained as profit). The exact calculations employed to produce such ratios vary by market segment and insurance type, and are typically defined in state and federal regulation. In many contexts there are minimum MLRs that plans must meet. Those that do not meet the minimum thresholds can be subject to

corrective actions, or be forced to issue refunds to policy holders.

Medical Loss Ratios can provide a useful, if superficial, understanding of the extent to which plans are financially prioritizing covering care and improving patient outcomes over retaining profit or growing organizationally. The New York Department of Financial Services notes on their [webpage](#), “The MLR is important because it is used as a measure of the reasonableness of premiums. The MLR is also important because if, at the end of the year, the MLR is below the minimum (i.e. the premium was excessive), the

Department has the authority to order corrective action, including refunds to policyholders.”

While they can inform high level understanding of financial performance, it is important to note that the precise definitions of MLRs in different markets can be subtle. For example, in New York’s Medicaid Managed Care program, the numerator of the MLRs includes both covered claims costs, but also quality improvement expenditures, and fraud prevention expenditures. Each term in this numerator can in principle hide costs that are not necessarily supportive of the “reasonableness of premiums”.

We investigate here whether Medical Loss Ratios are correlated with the administration of inappropriate denials. While we have no mechanism to directly measure inappropriate denials in the data we analyze, we use external appeal overturns as an imperfect proxy for the relative rate of inappropriate denials in different contexts.

Medicaid Managed Care

States are not required to enforce minimum MLRs for Medicaid MCOs, but they must proactively aim to achieve MLRs of at least 85% via their capitation rate schemes. Furthermore, states have the option to require remittances from plans when MLRs fall below their minimum target thresholds. New York both enforced a minimum MLR of 86% on Medicaid MCO plans for the years under consideration, and requires remittances for MLRs that do not meet the threshold [HRG23]. Data on plan MLRs and remittances must be reported to CMS per 42 CFR 438.74.

In Figures 3.29 and 3.30 we show the external appeal overturn rate as a function of medical loss ratio for Medicaid Managed Care MCOs without MLTC benefits, and separately for partially capitated MLTC only plans for the 2020 report year.

The Medicaid Managed Care data shows a clear correlation between external appeal overturn rates and medical loss ratios.

There is a trend of decreasing external appeal overturn rates as an insurer’s adjusted MLR increases.

The data suggests that medical loss ratio may be correlated with the occurrence of inappropriate denials in New York’s Medicaid Managed Care Program.

The Partial Managed Long Term Care data exhibits similar but higher variance behavior. It appears that there could be a bifurcation driving the variance, though we have not yet determined whether the apparent bifurcation is just a coincidental artifact, or really driven by some as-yet undefined phenomenology.

Figure 3.29: External appeal overturn rate as a function of adjusted medical loss ratio for New York Medicaid Managed Care Organizations in the 2020 MLR reporting period. Sources: Adjusted Medical Loss Ratios (MLRs) were obtained from MLR Summary Reports. The corresponding external appeal overturn rates for the MLR reporting period were calculated from the external appeal database. We consider here only plans which occur in both the MLR data and the external appeal database.

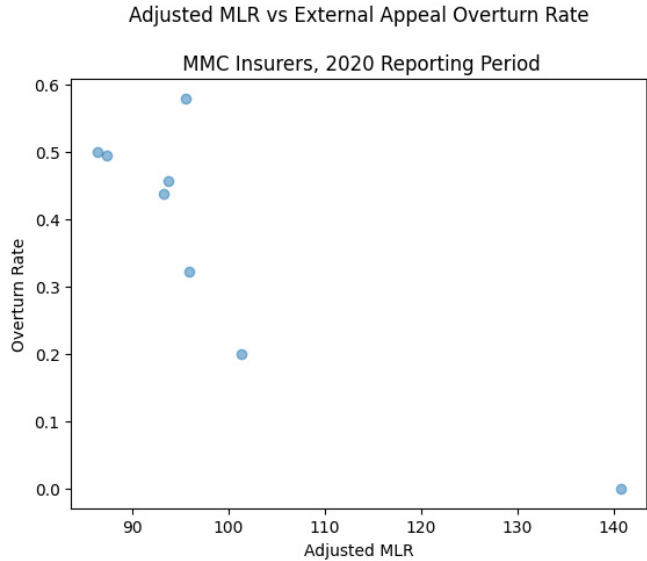
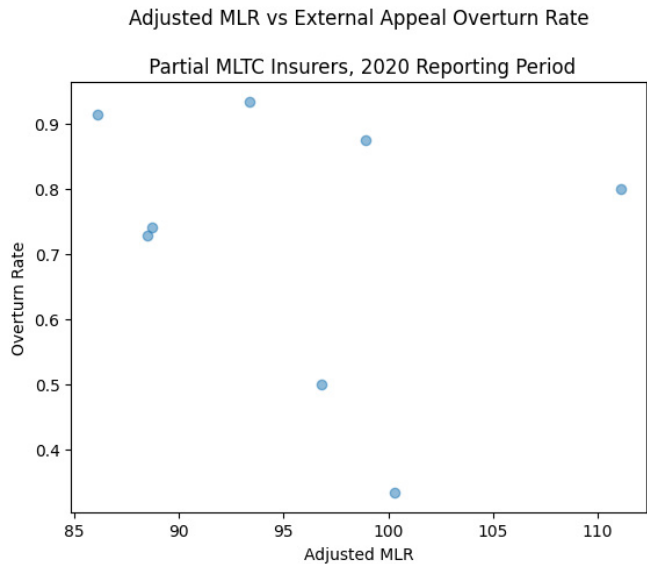


Figure 3.30: External appeal overturn rate as a function of adjusted medical loss ratio for New York Partial Managed Long Term Care in the 2020 MLR reporting period. Sources: Adjusted Medical Loss Ratios (MLRs) were obtained from MLR Summary Reports. The corresponding external appeal overturn rates for the MLR reporting period were calculated from the external appeal database. We consider here only plans which occur in both the MLR data and the external appeal database.



Policy Recommendations

This section summarizes our key policy recommendations made throughout the text, based on the analysis of denial and appeal patterns across New York State's health insurance markets. Our recommendations are prioritized based on potential impact and feasibility.

Automatic Appeal Forwarding

Recommendation

Require all state-regulated health plans in New York to automatically forward eligible upheld internal appeals for external review.

Rationale

Data reveals that few denied claims reach external review despite high overturn rates at this level. The multi-stage appeals process effectively blocks access to unbiased review, disadvantaging those unable to navigate its complexities. This burden falls heaviest on vulnerable populations with fewer resources.

Implementation

Establish a forwarding protocol requiring upheld internal appeals to automatically advance to external review in all state-regulated markets. This requires no other appeal process changes, though it would increase costs to fund additional external reviews. These costs may eventually be offset by a reduction in inappropriate denials.

Expected Impact

This reform would reduce medical debt and ease provider revenue strain by correcting more inappropriate denials without requiring further action from patients or providers. For prior authorization denials, it would prevent physical harm by overturning some wrongful denials that would otherwise remain in place.

Financial Penalties for High External Appeal Overturn Rates

Recommendation

Financially penalize insurers with high external appeal overturn rates to incentivize accurate internal appeal adjudication. Assess problematic overturn rates both in aggregate and stratified by type of care, ensuring that wrongful denials that disproportionately affect some populations are detected and mitigated.

Rationale

High external appeal overturn rates suggest systemic errors that delay necessary care, increase patient medical debt, create unnecessary costs, and burden patients administratively and emotionally. Insurers lack sufficient incentives to improve internal reviews without more financial consequences. Historical data suggests that some patient populations face inequitable harm.

Implementation

- Establish baseline expected overturn rates in aggregate, and for specific types of care, using historical data and reasonable standards.
- Create a sliding scale of penalties for overturn rates that are high in aggregate or for specific types of care. Make penalties increase with higher overturn rates.
- Assess quarterly or annually with public reporting.
- Direct penalty funds to consumer protection or premium reduction.
- Require insurers with high overturn rates to develop and implement improvement plans.
- Phase in penalties to allow insurers time to improve processes.

Expected Impact

Penalties will drive insurers to improve internal appeals processes, leading to more accurate determinations, reduced administrative costs for all stakeholders, timely patient care approvals, and enhanced public trust in health insurance.

High Internal Appeal Overturn Rate Disincentives

Recommendation

Disincentivize wrongful denials through rules targeting high internal appeal overturn rates. **Note:** This recommendation depends on the first two recommendations.

Rationale

High internal appeal overturn rates indicate systematically flawed initial claim denials or inadequate provider-insurer communication. These unnecessary denials create barriers to care, increase costs, and burden patients. Just as insurers need incentives for accurate *internal appeal* adjudication, they also need incentives for correct *initial* adjudication. If the first two recommendations for automatic forwarding and penalties for external appeal overturns are implemented, then wrongful internal appeal upholds will typically be caught and penalized. This recommendation guards against the possibility that insurers knowingly administer wrongful denials, but reverse them whenever they are appealed (effectively skirting the external overturn penalties).

Implementation

- Require tracking and reporting of internal appeal overturn rates by denial category and service type.
- Mandate public reporting of root cause analysis for categories with consistently high overturn rates.
- Establish threshold overturn rates for denials unrelated to provider mistakes that trigger regulatory action.
- Implement a tiered response system:
 - Tier 1 (Moderate rates): Require process improvement plans.
 - Tier 2 (High rates): Apply financial penalties and enhanced monitoring.
 - Tier 3 (Very high rates): Limit market participation.

Expected Impact

This policy will improve initial claim review accuracy, reduce administrative waste, decrease care delays, enhance insurer-provider communication, and increase system efficiency by ensuring legitimate claims are promptly approved without appeals.

Prioritized Audits for High Risk and High Value Denials

Recommendation

Audit denials of coverage that risk physical harm (e.g. urgent prior authorization) and involve expensive care (e.g. hospital inpatient denials). Identify patterns of inappropriate denials causing the greatest harm, and incentivize reductions.

Rationale

Inappropriate denials restricting access to care worsen health outcomes. Expensive denials create significant financial risk, contributing to medical debt and provider revenue strain. Targeted oversight of high-impact denials is an efficient way to use limited regulatory resources to protect patients.

Implementation

- Establish criteria for high risk and high value denials (e.g. prior authorization denials in life-threatening situations, and claim denials for hospital inpatient care and complex procedures).
- Conduct targeted audits of these high-impact denials.
- Require insurers to submit detailed justification for audited denials.
- Analyze data to identify inappropriate denial patterns and assess root causes.
- Implement severe financial penalties for failure to address identified patterns.
- Publish findings and hold public hearings on systemic issues.

Expected Impact

Prioritized audits will reduce inappropriate high-impact claim denials, decrease patient medical debt, improve insurer compliance for costly services, create more predictable coverage, and enable efficient use of regulatory resources by focusing on the most impactful problems.

Racial Data Collection and Reporting

Recommendation

Collect racial demographic data and report it publicly with health care claims reports and external appeal data to inform questions about racial equity in the administration of health insurance coverage adjudication.

Rationale

Without data, it is difficult to identify and address potential racial disparities in health insurance claim denials and appeals. Historical patterns of inequity in health care access and outcomes suggest such disparities likely exist in claims processing. Transparent reporting of demographic data is essential for identifying problems, developing targeted solutions, and measuring progress toward equitable health insurance administration.

Implementation

- Implement reporting requirements for denials and appeals stratified by demographic categories in the Health Care Claims Reports.
- Include racial data in the external appeal database.

Expected Impact

Racial data reporting will reveal previously invisible disparities, enhance accountability, and guide targeted interventions. Ultimately, this could help reduce health disparities by ensuring more equitable access to covered services across all populations

Improved Denial Rationale Reporting

Recommendation

Investigate 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.

Rationale

The New York Health Care Claims Reports show that current denial rationale reporting fails to provide meaningful insight into denial distributions. This obscures the true scale of wrongful denials. More explicit reporting is necessary to identify systemic issues, enhance public understanding, and strengthen oversight.

Implementation

- Conduct a comprehensive audit of denials whose rationale is currently categorized as 'Other' to identify common themes.
- Audit denials currently classified as 'Other' to identify common patterns.
- Expand rationale categories based on audit findings.
- Restrict use of 'Other' category to no more than 10% of denials.

Expected Impact

Enhanced transparency in denial reporting will improve understanding of publicly reported claim denial data, enable more effective regulatory oversight, and help identify problematic denial patterns.

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Appendix A: Insurance Market Enrollment And Spending Data

Medicaid

In 2022 there were a total of 5,633,689 beneficiaries enrolled in comprehensive risk-based²¹ Medicaid Managed Care Organization (MCO) plans in New York [CMS23]. In the same year spending on Medicaid MCO capitated premiums in New York accounted for 60.6% of the state's total Medicaid spending (accounting for 59.3 billion dollars of 97.9 billion spent on New York's program overall) [KFF23c]. New York's Medicaid MCO spending accounted for roughly 6.3% of the 804 billion dollars of governmental spending on Medicaid across all states in 2022 [KFF23b].

Demographic Breakdowns

It is useful to note a few things about the Medicaid Managed Care population in New York, as that population is the subject of much of the data we analyze. Figure 1 shows the per capita Medicaid Managed Care enrollment in each county in New York – that is, the fraction of that county's population enrolled in Medicaid Managed Care – as of June 2023. Figure 2 shows the total Medicaid Managed Care population in New York broken down by race.

Figure 1: Overall Medicaid Managed Care per capita enrollment across New York by county. For each county, the fraction of the total county population enrolled in the specified Medicaid Managed Care plan set is displayed. We refer to this fraction as the Medicaid Managed Care per capita enrollment. Source: [Medicaid Managed Care Enrollment Reports](#), June 2023.

MMC Enrollment Per Capita

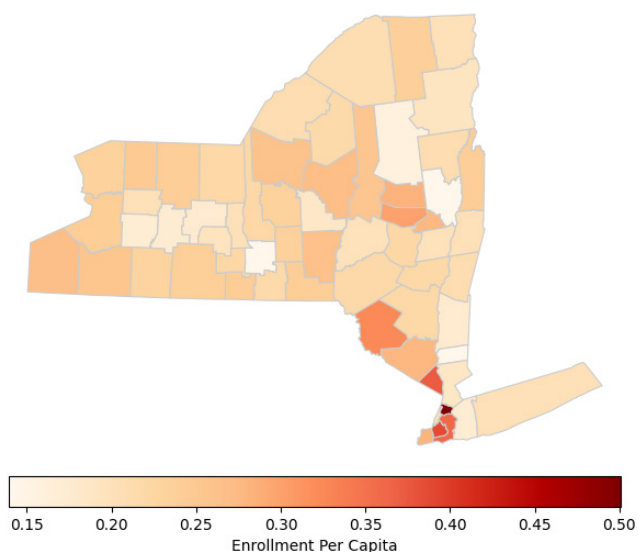
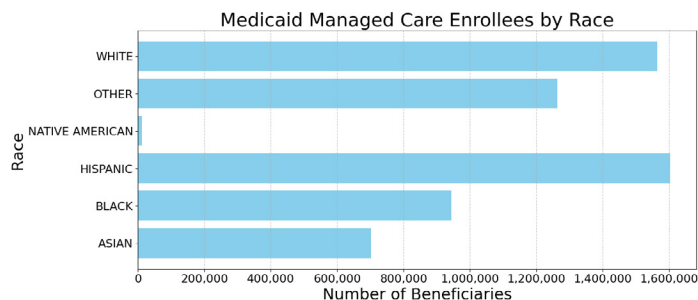


Figure 2: Medicaid Managed Care enrollment in New York broken down by race. Source: [Medicaid Program Enrollment by Month](#), June 2023.



Managed Long Term Care

As of December 2022, enrollment in New York MLTC plans was 300,026, with New York City residents accounting for 81% of that enrollment.

Child Health Plus

As of December 2022, the total enrollment in Child Health Plus in New York was 375,572.

Essential Plan

As of December 2023, the total enrollment in New York's Essential Plan was 1,215,135.

Individual and Small Group Marketplace Plans

In 2022, enrollment in Qualified Health Plans was 225,843.

Self Funded and Fully Insured Large Group Plans

In 2022, enrollment in all employer-sponsored plans totaled 9,045,200. We were unable to determine the fraction of this enrollment corresponding to fully insured large group plans.

²¹ This is a type of capitated plan arrangement with specific coverage requirements. See [this](#) MACPAC primer for more information.

Appendix B: Denial Rationale Reporting

In this appendix we analyze the denial rationale data reported with the Health Care Claims Reports. As discussed in relation to our policy proposal for rationale reporting requirements, the current reporting standard allows insurers to report rationales for many of their denials using the poorly specified 'Other' category. This possibility

allowed by the reporting requirement is occurring in practice, and renders the rationale data far less useful than it could be. Figures 3, 4, 5, and 6 show the aggregate distribution of denial rationales in each market segment, which illustrate the problem.

Figure 3: Aggregate denial rationale distribution among insurers in the Commercial market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

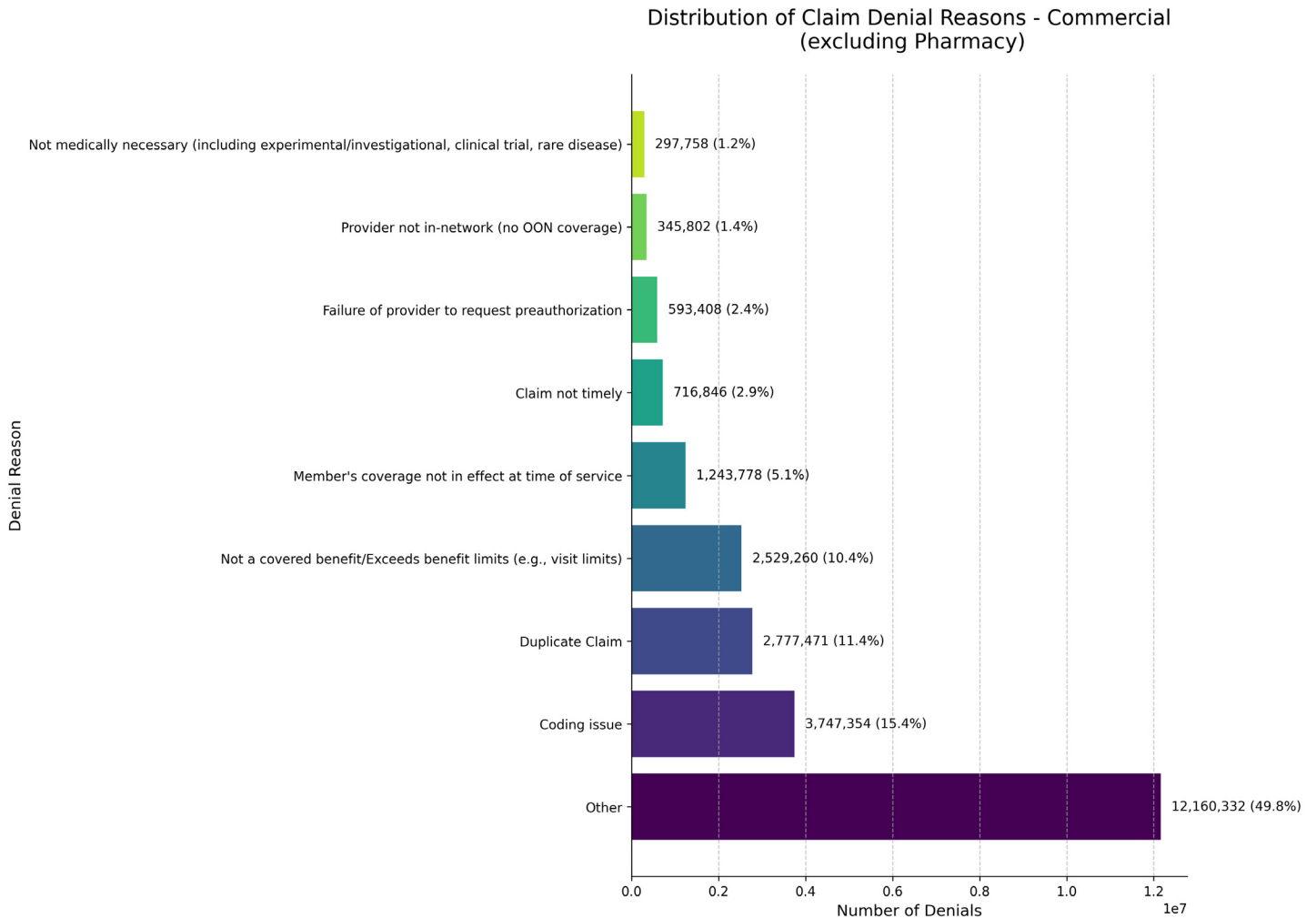


Figure 4: Aggregate denial rationale distribution among insurers in the Essential Plan market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

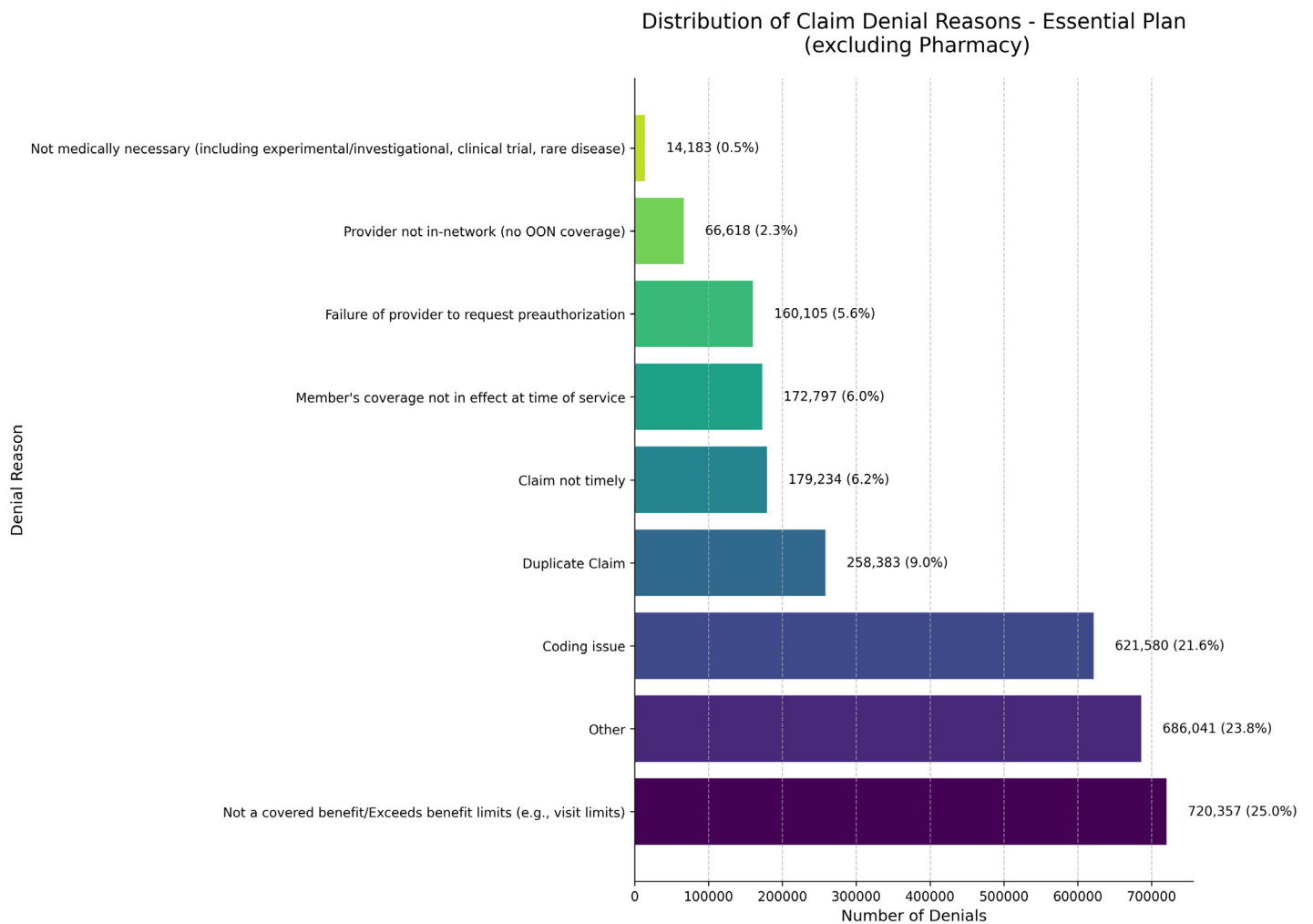


Figure 5: Aggregate denial rationale distribution among insurers in the Child Health Plus market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

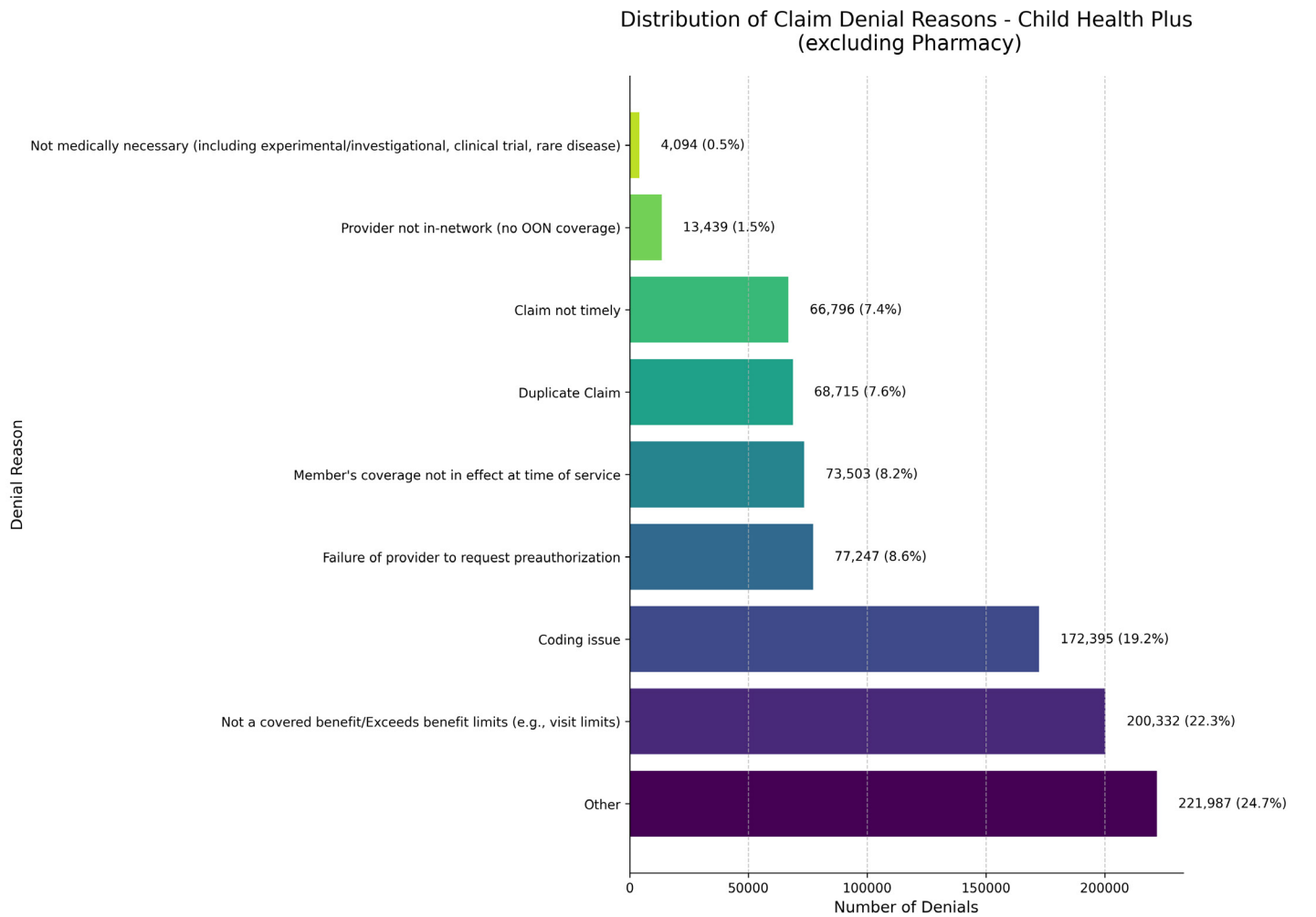
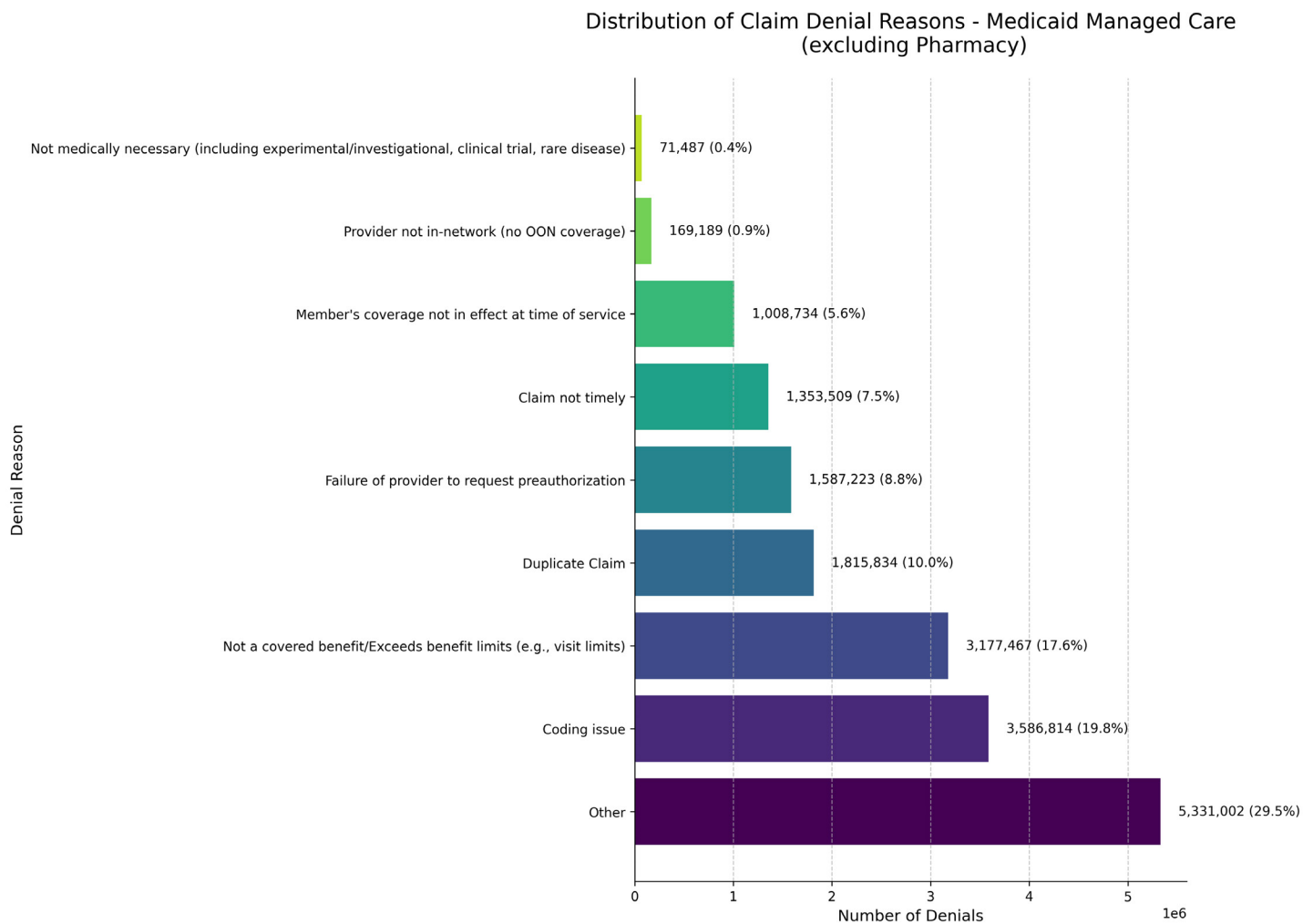


Figure 6: Aggregate denial rationale distribution among insurers in the Medicaid Managed Care market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.



Insurer reporting requirements in many markets across the U.S. require some minimal reporting of denial rationale distributions, and typically allow for use of an ‘Other’ category with underspecified reporting requirements and lack of validation or enforcement. Almost universally, this category is used for a large fraction of reported data, rendering the rationale reporting opaque and limited in utility [\[PLWM23\]](#) [\[Gar23b\]](#).

In the case of the New York Health Care Claim Reports, there is some variation in the use of the ‘Other’ category by market segment, and pronounced variation in the use of the category by insurer. While some insurers use the category sparingly, assigning explicit rationales to the vast majority of their denials, others use the ‘Other’ category for the vast majority of their denials. Figures [7](#), [8](#), [9](#), and [10](#) show the distribution of ‘Other’ category usage by insurer in each market segment.

Figure 7: Distribution of 'Other' denial rationale category usage by insurer in the Commercial market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

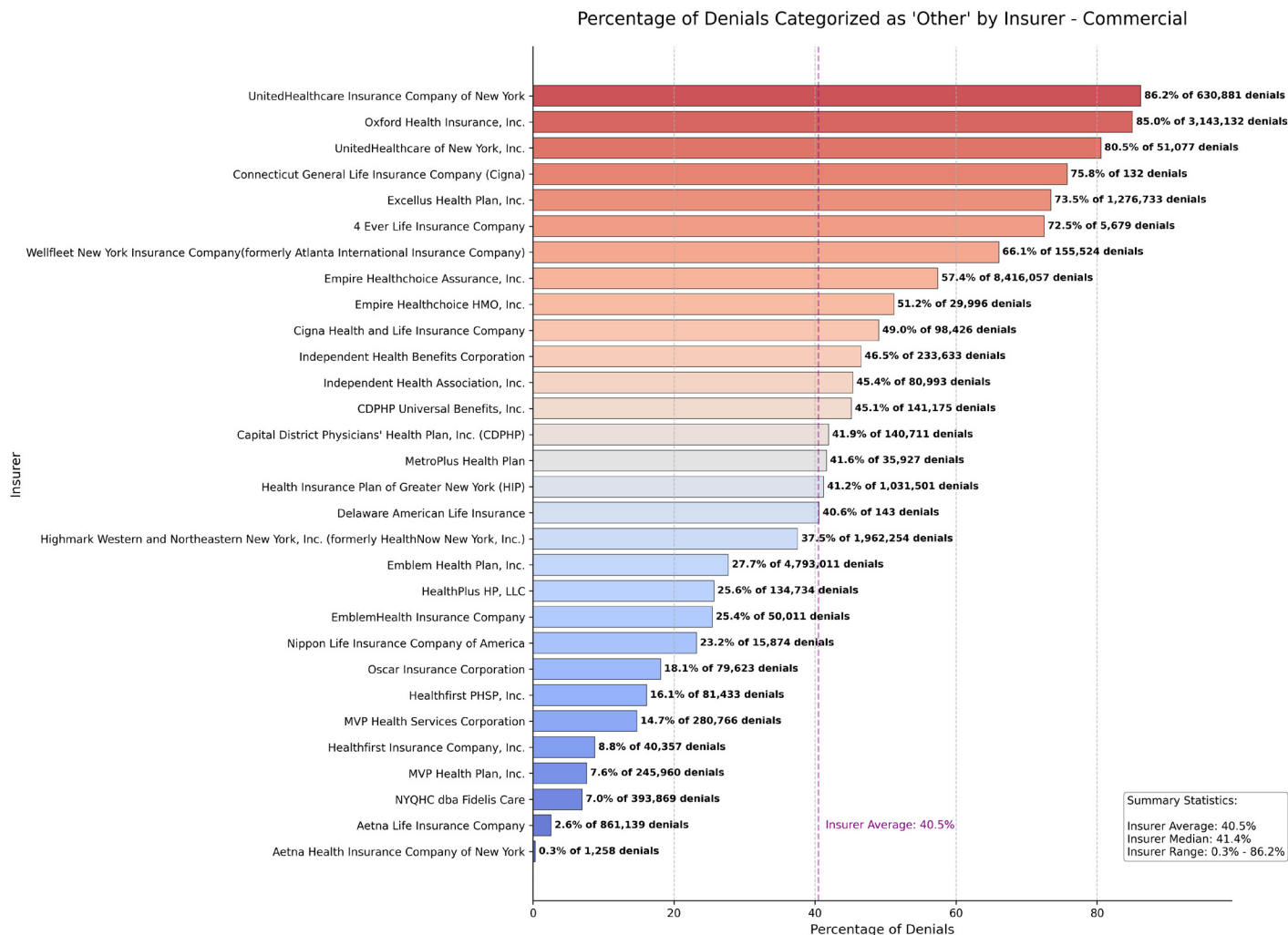


Figure 8: Distribution of 'Other' denial rationale category usage by insurer in the Essential Plan market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

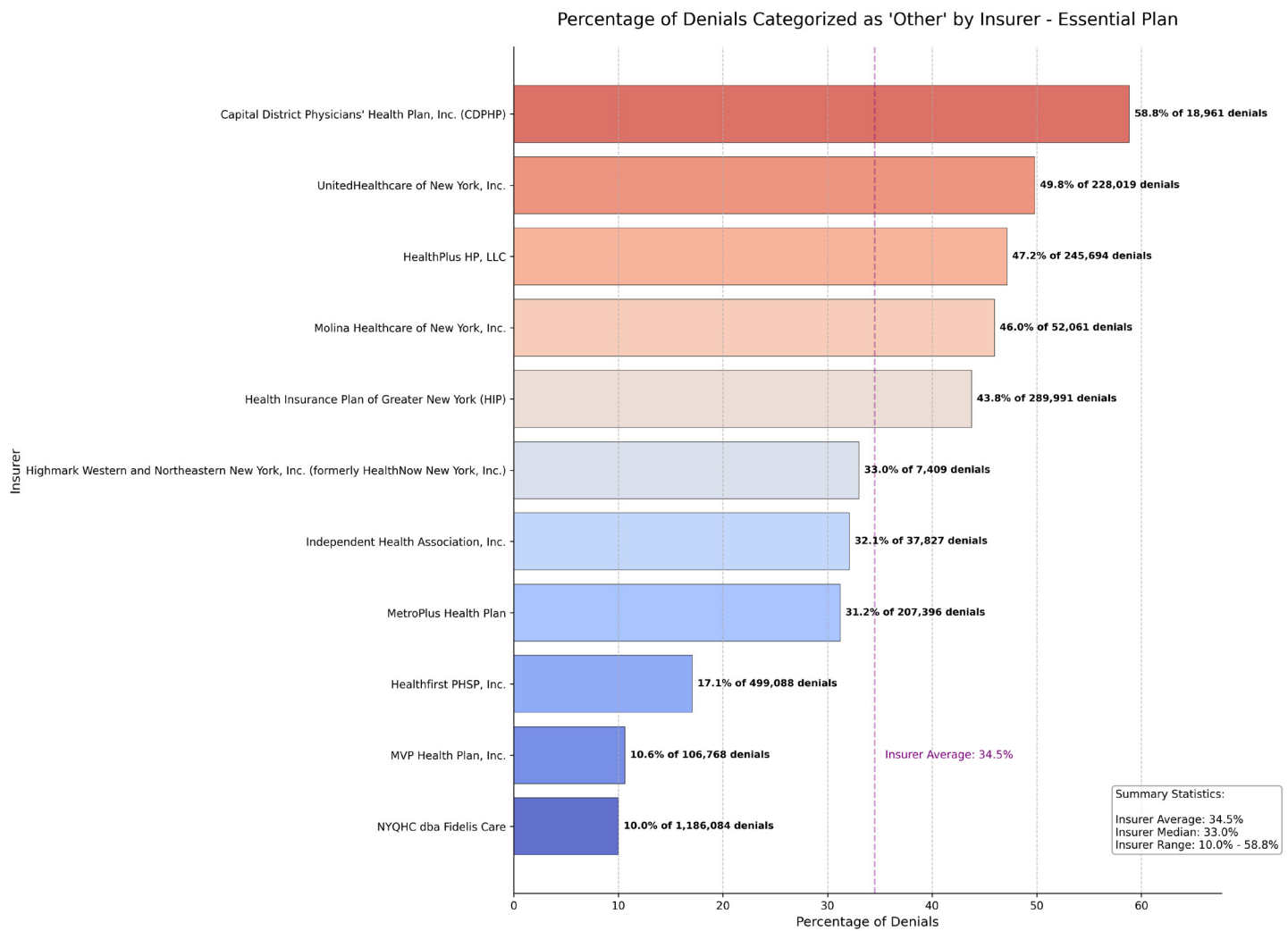


Figure 9: Distribution of 'Other' denial rationale category usage by insurer in the Child Health Plus market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.

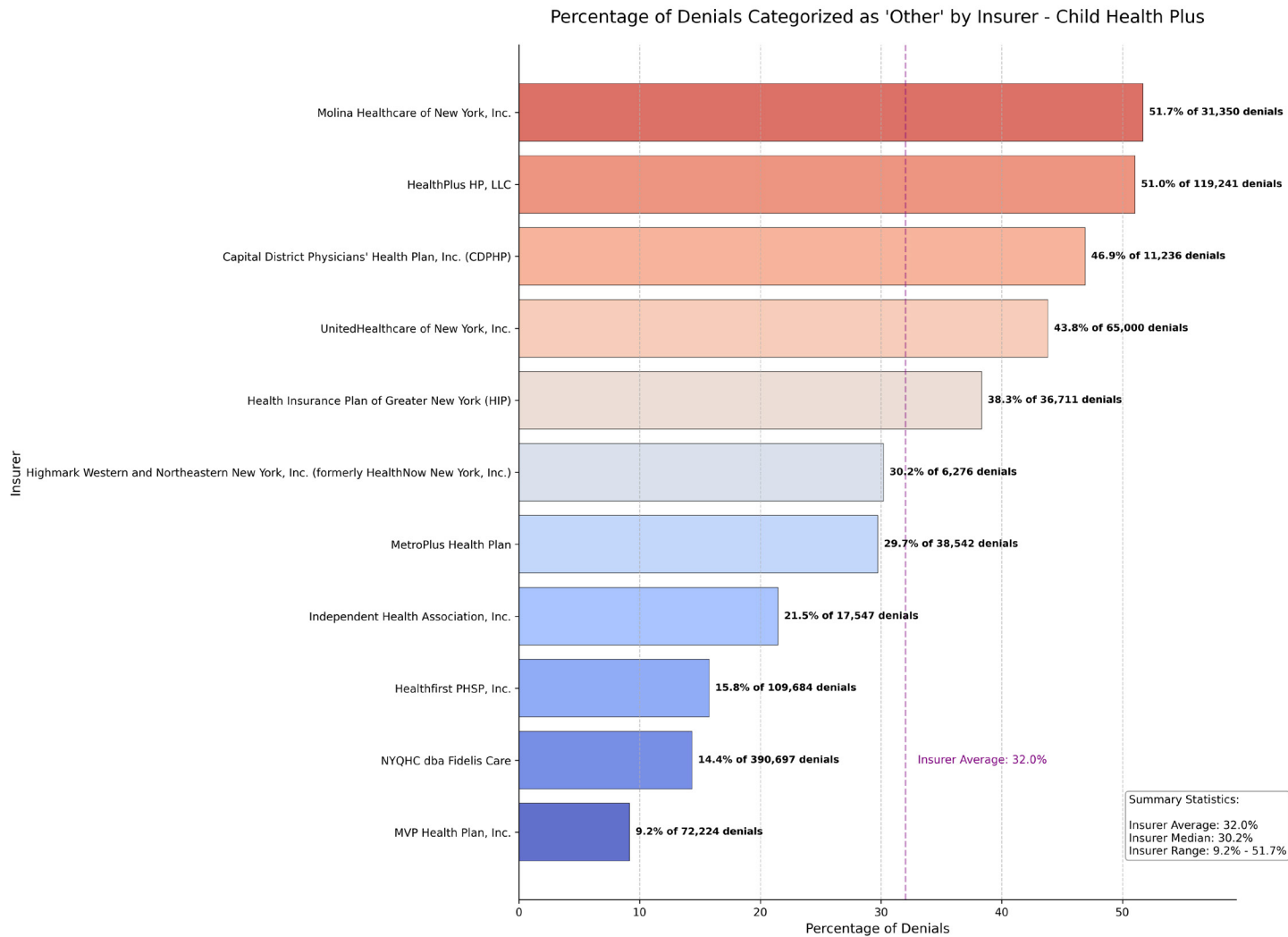
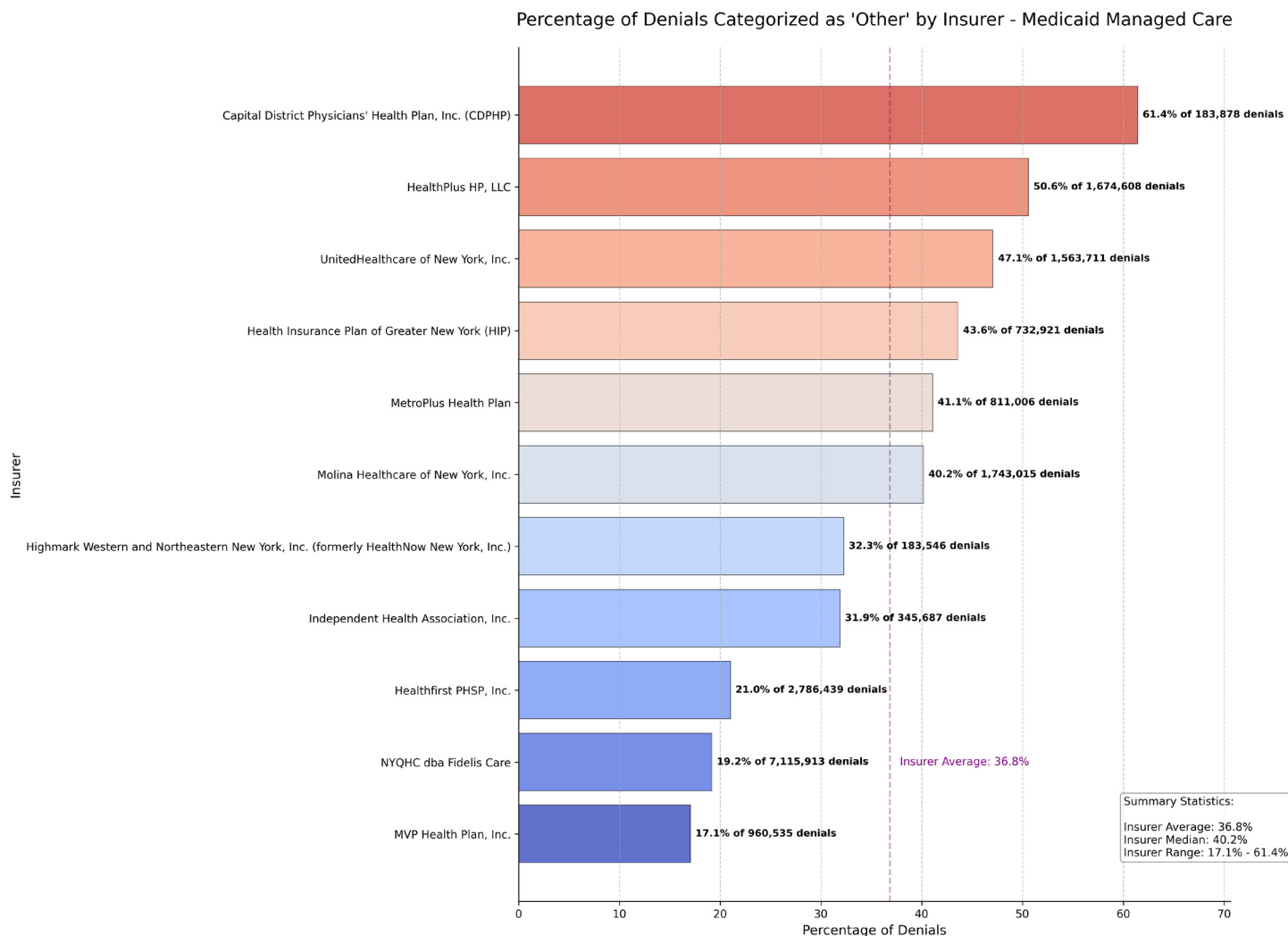


Figure 10: Distribution of ‘Other’ denial rationale category usage by insurer in the Medicaid Managed Care market segment. Note that the total count of reported denial rationales does not exactly match the total count of reported denials, despite the fact that reporting instructions suggest each denial should be associated with exactly one rationale.



The data shows that the ‘Other’ category is being used far too often, and hindering the ability of the public to understand the true underlying distribution of denial rationales. For example,

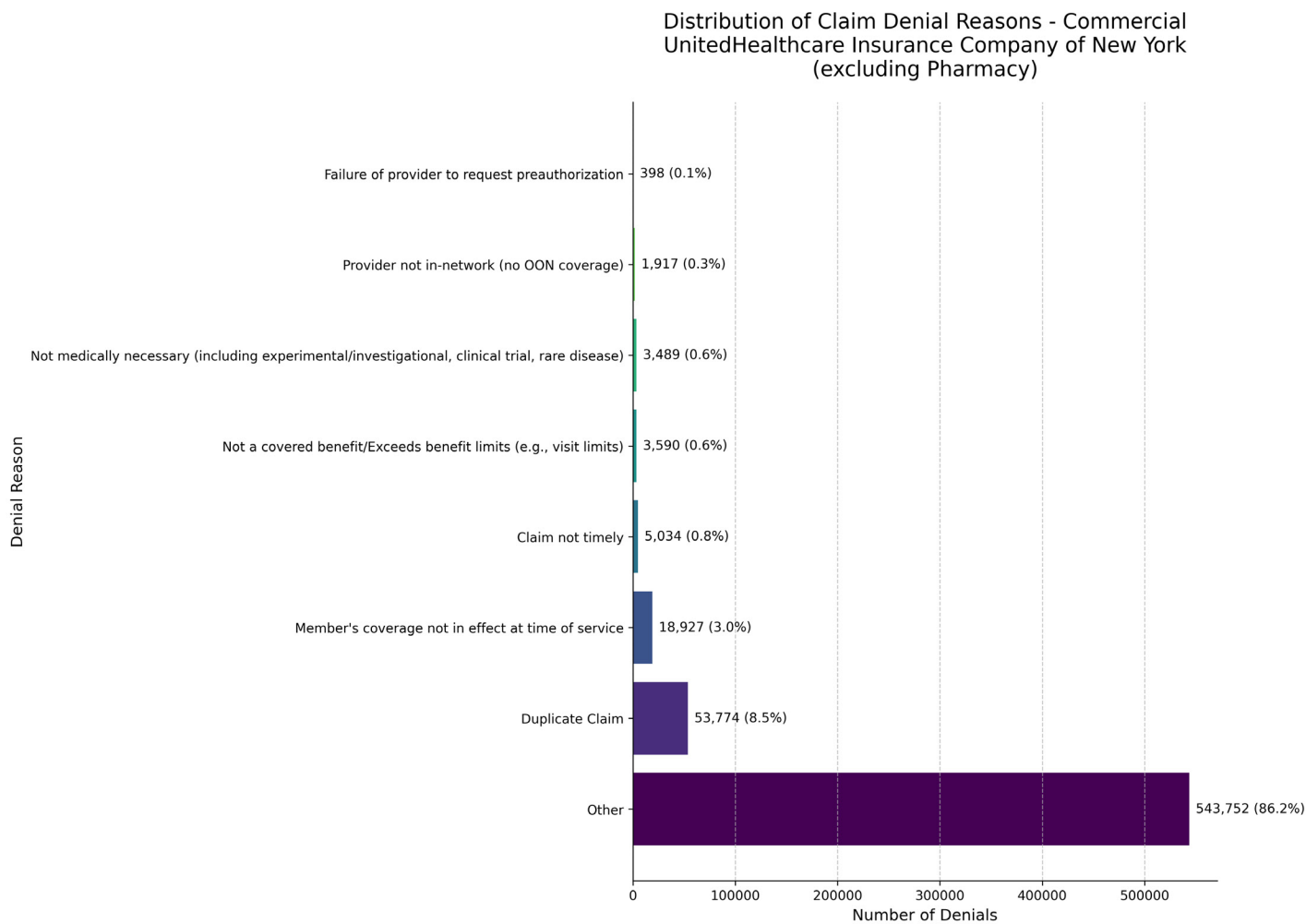
A majority of commercial insurers in New York report over 40% of denial rationales using the ‘Other’ category. Absent strict reporting requirements and validation, this scheme effectively allows insurers to withhold denial rationales at will (whether or not they do that), and greatly reduces the utility of the rationale data.

The frequent use of the ‘Other’ category may be a problem with the accuracy of the reported data, rather than a problem with the reporting schema. Though both

problems may exist, the fact that some insurers report explicit rationales for the vast majority of their denials suggests that the existing reporting schema does not necessarily lead to frequent use of the ‘Other’ category. Moreover, comparison of the denial rationale distributions for insurers that use the ‘Other’ category sparingly with those that use it often suggests insurers may be following different reporting practices.

For example, some insurers use the ‘Other’ category for a large fraction of their denials, but the ‘not medically necessary’ category for a miniscule fraction. Other insurers use the ‘Other’ category sparingly, but report a larger fraction of denials using the ‘not medically necessary’ category. Figures 11 and 12 show an example of this difference, using the commercial denial rationale distributions for two insurers: UnitedHealthcare Insurance Company of New York and Aetna Life Insurance Company, respectively.

Figure 11: Distribution of denial rationale categories in the commercial market for UnitedHealthcare Insurance Company of New York.



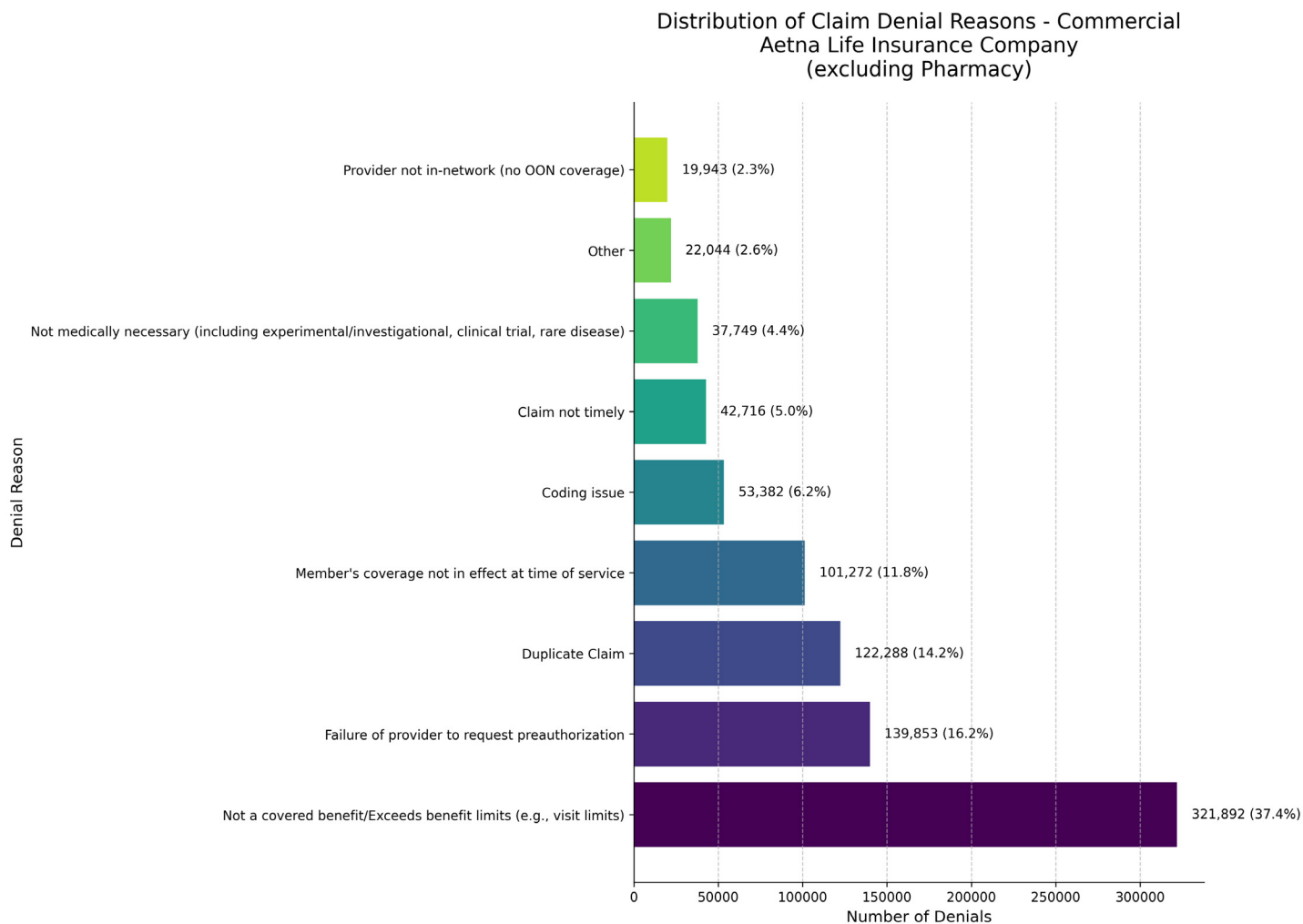
UnitedHealthcare Insurance Company of New York reports 86.2% of denial rationales using the ‘Other’ category, and 0.6% of denial rationales using the ‘Not Medically Necessary’ category. On the other hand, Aetna Life Insurance Company reports only 2.6% of denial rationales using the ‘Other’ category, but 4.4% of denial rationales using the ‘Not Medically Necessary’ category.

While it is possible that Aetna Life Insurance Company administers denials on the basis of lack of medical necessity at a rate 7 times higher than UnitedHealthcare Insurance Company of New York, it is also possible that the ‘Other’

category is being used by UnitedHealthcare Insurance Company of New York to report medical necessity denials, or that the ‘Not Medically Necessary’ category is being used by Aetna Life Insurance Company to report denials that ought to be reported under the ‘Other’ category.

On this subject, reporting instructions provided by the NY DFS [state](#) that when claims have more than one denial reason, ‘If any one of the denial reasons is “not medically necessary,” the claim should be counted there.’ It may be the case that some insurers are failing to follow this directive.

Figure 12: Distribution of denial rationale categories in the commercial market for Aetna Life Insurance Company.



The primary takeaway that is clear from the reported data is that the use of the ‘Other’ category is pervasive, and that lack of visibility into the content of the ‘Other’ category hinders the utility of the rationale data. Among all of the problems presented in this report, this is one of easiest problems to fix.