MASSACHUSETTS
HEALTH POLICY COMMISSION

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HPC DATAPOINTS

Evidence of Administrative Complexity: Health Insurance Claim Denials in Massachusetts

BACKGROUND

Administrative costs are a driver of high health care spending, accounting for 15 to 30% of total health care spending.[1] Both insurers and providers incur administrative costs, and most of these non-clinical costs are billing- and insurance-related expenditures.[2] Submitting and adjudicating claims (along with other administrative tasks) are necessary components of the complex system of delivering and paying for health care that functions between insurers, providers, and patients. However, not all administrative costs add value to the system as studies estimate that at least half of all administrative spending is wasteful or ineffective in impacting health outcomes.[3]

Administrative costs can be difficult to identify and quantify as the costs are borne by multiple parties and comprise a wide range of tasks within the health care system. In addition to member coverage and benefit limits applicable to each claim, each insurer establishes requirements for how providers must submit claims for payment, including necessary codes, documentation, and timelines. Analyzing health care claims data, specifically claim denials, is one way to gain greater insight into the administrative costs related to provider-insurer claims processing.

In this issue of the Datapoints series, the Massachusetts Health Policy Commission (HPC) examines claim denial data from commercial health insurers, focusing on administrative denials, and publishes results for the first time.

This is a printable version of DataPoints. The online version features interactive graphics that show additional information, and is available on the HPC's website at masshpc.gov/publications/datapoints

DATA AND METHODS

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Each year, fully-insured commercial health insurers report on claim denials to the HPC's Office of Patient Protection (OPP) and the Massachusetts Division of Insurance (DOI).[4] [5] The insurers report annual data by claim type: professional claims; institutional claims (outpatient); institutional claims (inpatient); and lab claims.[6] The insurers then further break down those claim types into three clinical categories: medical surgical claims, mental health claims, and substance use disorder (SUD) claims. The insurers report total number of claims for each of those 12 categories, both paid and denied, and the reasons for denial. For this reporting, insurers do not submit data on prior authorization requests or pharmacy claims.

Providers submit claims to insurers, and insurers use codes to communicate to the providers how the claim is being processed. In the adjudication process, insurers may (1) pay the claim in full, (2) adjust the claim and issue partial payment, or (3) deny the claim. In the case of adjustments and denials, insurers utilize Claim Adjustment Reason Codes (CARCs) to communicate these denials. The insurers are given detailed instructions by OPP and the DOI as to how to categorize every CARC into 11 identified categories for this reporting.[7] Exhibit 1 shows the 11 claim denial categories, labeled A through I. For purposes of this analysis, similar reasons were consolidated to create six broader catego-

Throughout this analysis, categories F, G, H, and I are categorized broadly as "administrative denials" because there are no clinical decisions being made, and the denials are largely based on errors in submission.

ries of claim denials, shown on the right-hand side of Exhibit 1. Throughout this analysis, categories F, G, H, and I are categorized broadly as "administrative denials" because there are no clinical decisions being made, and the denials are largely based on errors in submission.

Exhibit 1: Categorization of Denial Reasons Reported by Insurers

REASONS REPORTED	CONSOLIDATED REASONS
(A) No prior authorization or referral by insured	Denial Reason A
(B) Medical Necessity	Denial Reasons B + C
(C) Experimental or investigational	Denial Reasons B + C
(D) Member not covered or eligible at the time services were rendered	Denial Reasons D + E1 + E2 + E3
(E1) Service not covered–benefit limit	Denial Reasons D + E1 + E2 + E3
(E2) Service not covered–benefit exclusion	Denial Reasons D + E1 + E2 + E3
(E3) Provider not covered / out-of-network	Denial Reasons D + E1 + E2 + E3
(F) Duplicate claim or coverage	Denial Reason F
(G) Incomplete claim	Denial Reasons G + H
(H) Coding error	Denial Reasons G + H
(I) Other administrative denial	Denial Reason I

The data reflect fully adjudicated claims with a calendar year 2022-2024 service date. Multiple claims may pertain to the same service. For example, a claim that was fully adjudicated and denied for any reason may have subsequently been resubmitted, successfully processed, and paid. In such case, two data points would be reported in the data: one denied and one paid claim, which are not linked in any manner.

As such, the reported data does not indicate how many of the reported denials resulted in a patient not receiving coverage for the services. Therefore, this analysis reports on the backend administrative communication between plans and providers, rather than the patient impact.

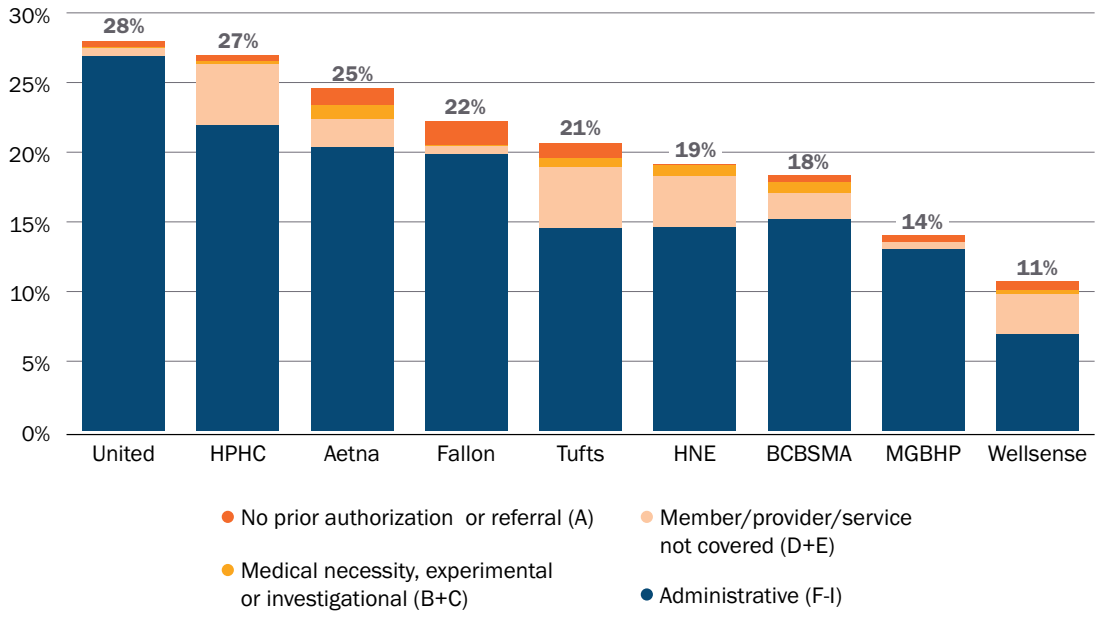
FINDINGS

The average overall denial rate by insurers was 20.4%, meaning that approximately one out of every five claims submitted to a fully-insured health insurer in Massachusetts was denied.

In 2024, health insurers reported 45.9 million total claims. **The average overall denial rate by insurers was 20.4%,** meaning that **approximately one out of every five claims submitted to a fully-insured health insurer in Massachusetts was denied.** This 20.4% figure is consistent with other publicly reported data on claim denials by Federal Marketplace plans and insurers in other states.[8] **There is significant variation in the share of claims denied by insurers in Massachusetts,** ranging from 28% for United Healthcare to 11% for Wellsense (Exhibit 2).

Across insurers, a large percentage of the claims were denied for administrative reasons: duplicate claim or coverage, incomplete claim, coding error, or other administrative denial. **Strictly clinical reasons for denying coverage, including medical necessity or experimental/investigational denials, made up at most 1% of denials for any insurer.**

Exhibit 2: Percentage of Total Claims Denied by Insurer and Denial Reason, 2024



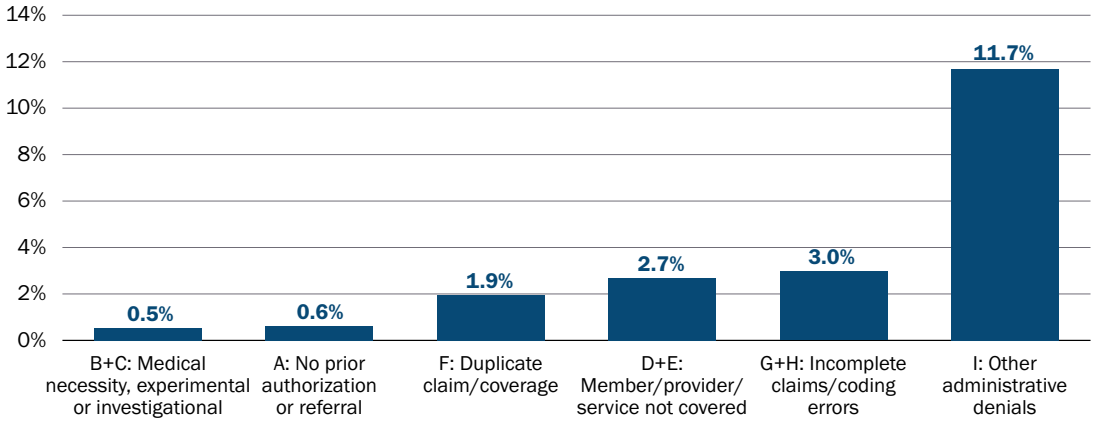
NOTES: The denominator is total reported claim lines (both paid and denied). Total claims combines all categories of claims reported at the claim line level, including a few small claim categories: institutional (MH), institutional (SUD), labs (MH) and labs (SUD). Insurers reported approximately 45.9 million total claims. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

The denial reason "other administrative denials" was the most common reason for denial by a significant margin: 11.7% of all claims were denied for that reason.

This pattern of high rates of administrative denials continues when examining claims denied by denial reason. **The denial reason "other administrative denials" was the most common reason for denial by a significant margin: 11.7% of all claims were denied for that reason.** "Other administrative denials" primarily include claims denied for not meeting the insurers' rules and procedures, including timely filing, inclusion of correct documentation, and services that should be billed separately.[9] Notably, another **4.9% of all claims were denied for an incomplete claim, coding error, or duplicate claim or coverage.**

Exhibit 3: Percent of total claims denied by denial reason, 2024



NOTES: The denominator is total reported claim lines (both paid and denied, approximately 45.9 million). Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.

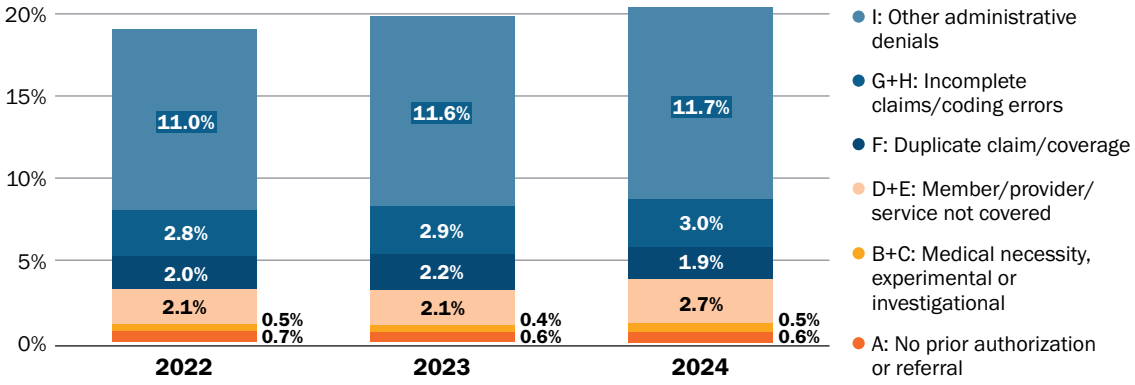
SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Notably, another 4.9% of all claims were denied for an incomplete claim, coding error, or duplicate claim or coverage.

Although the overall share of claims denied increased slightly from 2022 to 2024, the reasons for denial remained consistent during this time. Administrative denials, categories F, G, H, and I, made up 15.8% of claims in 2022, 16.7% in 2023, and 16.6% in 2024 (Exhibit 4).

Although the overall share of claims denied increased slightly from 2022 to 2024, the reasons for denial remained consistent during this time.

Exhibit 4: Percent of total claims denied by denial reason, 2022-2024



NOTES: The denominator is total reported claim lines (both paid and denied) in each calendar year. Results include all categories of claims reported at the claim line level and all payers that reported data. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Other administrative denials were the most common denial reason in all but one claim category shown in Exhibit 5. Professional medical/surgical claims, including office visits with primary care providers and specialists, and institutional outpatient claims, services received in hospital outpatient departments, have the highest volume of any claim category. The high volume of claims may be why administrative denials are more prevalent in those two claim categories. Denials by claim category remained consistent from 2022 to 2024.

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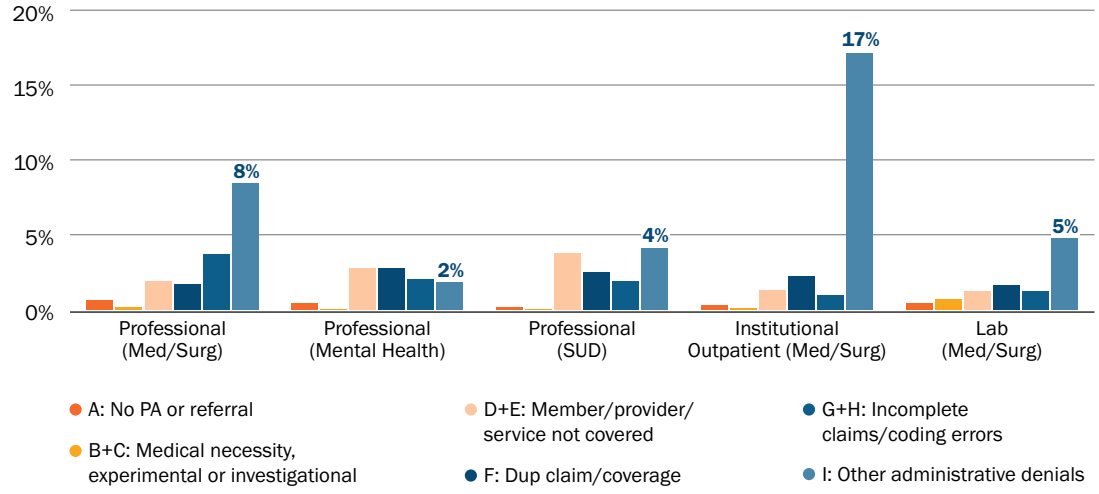
Exhibit 5: Median denial rate among insurers by denial reason and claim category, 2024



NOTES: Denominator is total reported claim lines (both paid and denied). Results for several smaller claim categories are not shown: institutional (MH), institutional (SUD), labs (MH) and labs (SUD). Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume. N for each claim category: professional medical/surgical = 24.3M; professional mental health = 3.8M; professional SUD = 446K; institutional outpatient medical/surgical = 12.9M; labs medical/surgical = 4.1M.

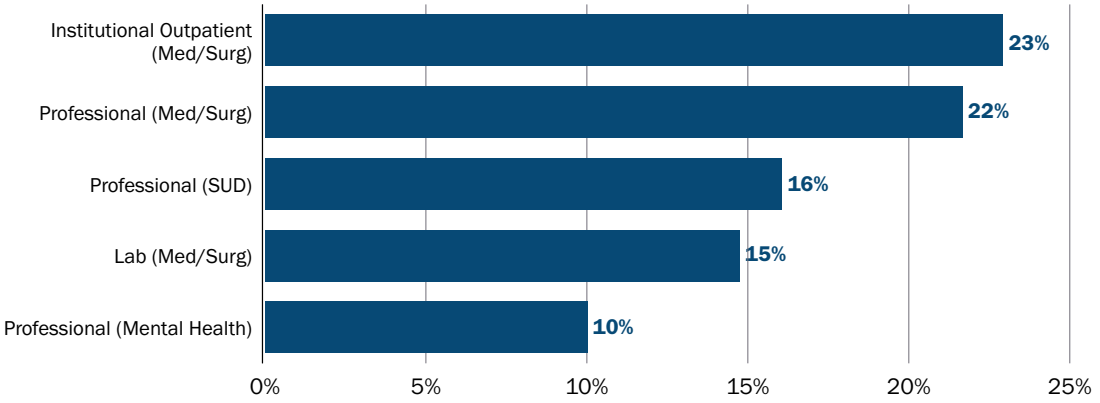
SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Institutional outpatient claims had the highest denial rate at 23%.

Exhibit 6 examines the claim denials data only by claim category, without the cross-section of denial reasons. This reveals that **institutional outpatient claims – which include services such as outpatient same day surgeries, radiology performed by hospital outpatient departments, and care received in emergency departments – had the highest denial rate at 23%.** This is more than double the 10% denial rate of professional mental health claims.

Professional medical/surgical claims and institutional outpatient medical/surgical claims are the categories with the highest volume of claims, at 24.3 million and 12.9 million, respectively, and also have the highest denial rates. By contrast, for the category with the lowest rate of denial, professional mental health, there were only 3.8 million claims reported for 2024.

Exhibit 6: Percent of total claims denied by claim category, 2024



NOTES: The denominator is total claims (both paid and denied) within each claim category. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume. Results by the following small claim categories are not shown: institutional (MH), institutional (SUD), labs (MH) and labs (SUD).

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Exhibits 7 and 8 focus on the professional medical/surgical claim category, the largest claim category with 24.3 million claims exchanged between providers and insurers in 2024. When comparing the total claims denied by denial reason, there is significant payer variation, but an overall predominance of denials for administrative reasons.

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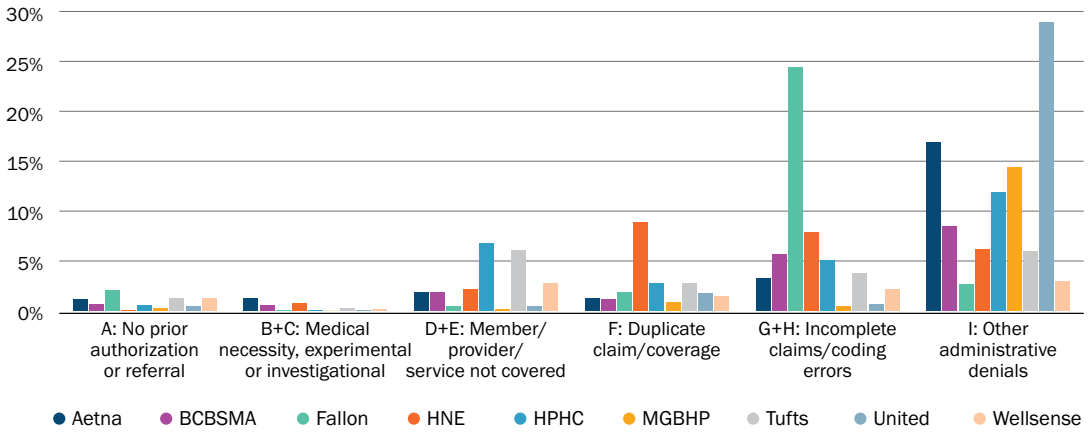
Exhibit 7: Percent of total claims denied by denial reason and insurer for professional medical/surgical claims, 2024



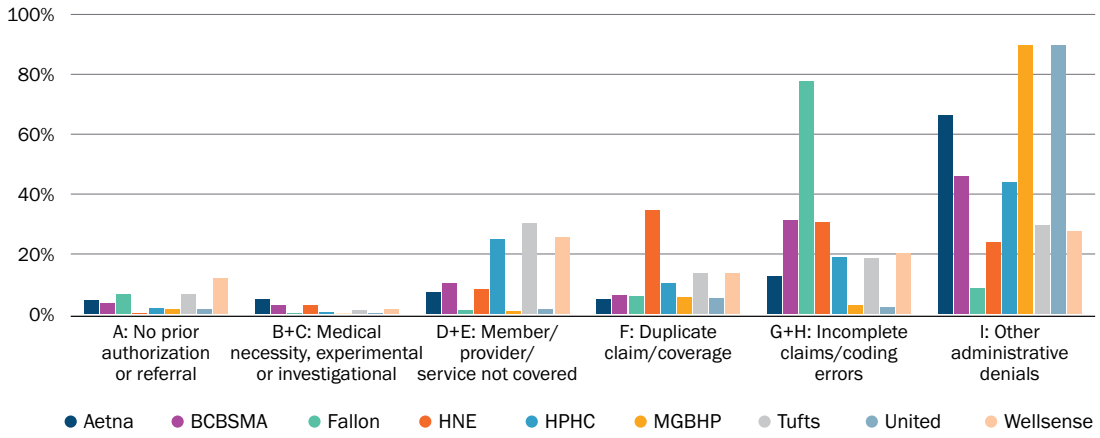
NOTES: Denominator is total reported professional medical/surgical claim lines (both paid and denied), thus the bars attributed to an individual insurer will sum to the percent of reported claims that were denied for that insurer. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume.

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Six out of nine insurers reported "other administrative denials" as the largest claim denial reason for professional medical/surgical claims.

Six out of nine insurers reported "other administrative denials" as the largest claim denial reason for professional medical/surgical claims. Exhibit 8 contains the same data as Exhibit 7 but the categories of denials are displayed as a percentage of denied claims rather than a percentage of all claims. While the share of total claims denied provides an overall landscape of 2024 claims, the share of denied claims by reason emphasizes administrative reasons for denials for many payers. As a percentage of denied claims, around 90% of United Healthcare's and MGBHP's claims were denied for reasons categorized as other administrative denials. Almost 80% of Fallon's denied claims were denied for incomplete claims or coding errors.

Exhibit 8: Percent of denied claims by denial reason and insurer for professional medical/surgical claims, 2024



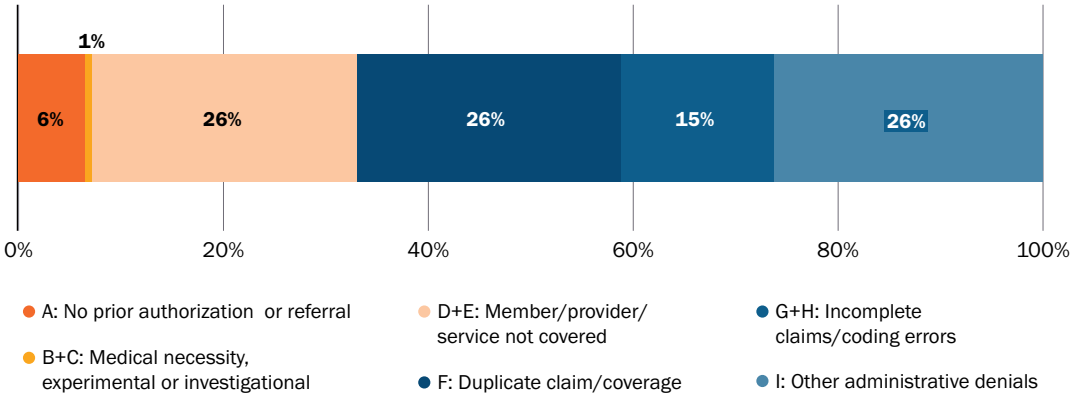
NOTES: Denominator is reported professional medical/surgical claim lines that were denied, thus the bars attributed to an individual insurer will sum to 100% of their denials for this claim category. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume. Insurers reported approximately 5.3 million professional medical/surgical denials.

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

Across all insurers, 80% of professional medical/surgical claims that were denied were denied for administrative reasons.

Across all insurers, 80% of professional medical/surgical claims that were denied were denied for administrative reasons: incomplete claim, coding error, duplicate claim or coverage, or other administrative denial. Exhibit 9 shows that denial reasons were more variable for professional mental health claims, with **67% of professional mental health claims denied for these same administrative reasons.**

Exhibit 9: Percent of total claims denied by denial reason for professional mental health claims, 2024



Denial reasons were more variable for professional mental health claims, with 67% of professional mental health claims denied for these same administrative reasons.

NOTES: Bar represents total reported professional mental health claim lines that were denied. Cigna data were excluded due to data quality issues. Connecticare and Wellfleet data are not included in this analysis due to relatively small claim volume. Insurers reported approximately 377K professional mental health denials.

SOURCES: OPP (Health Policy Commission) analysis of CY 2024 carrier reports, submitted pursuant to Chapter 52 of the Acts of 2016 and 958 CMR 3.000.

The **Massachusetts Health Policy Commission (HPC)** is an independent state agency charged with monitoring health care cost trends and making policy recommendations to improve the affordability of health care for all residents of the Commonwealth. Through data-driven analysis, actionable policy insights, public accountability, and innovative investments, the HPC seeks to improve health care delivery, lower costs, and reduce health disparities.

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CONCLUSION

In 2024, fully-insured health insurers reported 45.9 million total claims, over 9 million of which were denied, an average overall denial rate by insurers of 20.4%. 5.4 million claims were denied because providers did not meet insurer rules and procedures (identified in reporting as "other administrative denials") and another 2.2 million were denied for being incomplete, containing errors, or due to duplicate claims or coverage. These findings were consistent from 2022 to 2024. Each of those 7.6 million claims denied for administrative reasons represents an interaction between a provider and insurer and administrative resources spent by each to submit and adjudicate claims, potentially multiple times.

Six out of nine insurers reported other administrative denials as the largest claim denial reason for professional medical surgical claims, with two insurers reporting as much as 90% of their denied claims falling within this category. Across all insurers, 80% of denied professional medical/surgical claims were denied for administrative reasons: incomplete claims, coding error, duplicate claim or coverage, or other administrative denials.

Results from this analysis highlight claims processing as an area of opportunity to address administrative inefficiencies in the health care system. Insurers could benefit from performing additional internal analyses to identify areas of high denial rates by claim type, denial reason, or by provider. Insurers should seek to expand upon their outreach and education to providers, with the use of additional targeted data analysis, to better clarify instructions as to how to submit claims. Insurers should also take advantage of proposed regulatory changes, which, when finalized, would allow insurers to promote financial incentives to providers to reduce the submission of inappropriate and duplicate claims.

Standardizing and streamlining the process for submitting claims among insurers would be a more comprehensive action to reduce inefficiencies across the health care system. **Studies estimate that standardization of billing could save 27% of billing- and insurance-related costs.**[10] Although there have been efforts in Massachusetts to standardize certain aspects of insurer and provider interactions, claims processing remains complex. Each insurer has its own technology for submitting claims, as well as documentation requirements, which adds to the complexity of the system. Previous work by the HPC detailed the complexity of submission requirements for preventive services as well as the variation in requirements between insurers. This differentiation by insurer makes it more difficult and time-consuming for providers to submit claims and may lead to the large percentage of administrative claim denials, particularly in high volume claim categories like professional medical/surgical claims and institutional outpatient medical/surgical claims.

Any effort to reduce inefficiencies in claims processing should be a concerted effort involving both insurers and providers. It is consumers and employers who should ultimately benefit from any administrative costs saved through lower premiums and cost-sharing.

APPENDIX

- Table of CARC codes with mapping to the 11 denial reasons listed in the reporting found in Excel tab labeled "ASC X12 EDI 835 Crosswalk" in the Chapter 52 Reporting Template.
- Reporting template found in Excel tab labeled "Reporting Dashboard" in the Chapter 52 Reporting Template.

Endnotes

1 Health Affairs (2022). "The Role Of Administrative Waste In Excess US Health Spending." (October 6, 2022); Health Affairs Council on Health Care Spending and Value (2023). "A road map for action: recommendations of the Health Affairs Council on Health Care Spending and Value." (February 2023).

2 Cutler (2020). "Reducing Administrative Costs in U.S. Health Care." The Hamilton Project (March 2020).

3 Health Affairs (2022). "The Role Of Administrative Waste In Excess US Health Spending." (October 6, 2022);

4 Insurers submit claims denial reporting pursuant to Chapter 52 of the acts of 2016, codified at M.G.L. c. 1760, § 7(b)(5)and 958 CMR 3.600(1)(e).

5 Cigna data were excluded due to data quality issues. Wellfleet and Connecticare data were excluded due to relatively small claim volume. Certain insurers under the same corporate umbrella were consolidated: Aetna Health and Aetna Life Insurance; Harvard Pilgrim Health Plan and HPHC Insurance Company; and Tufts Associated Health Maintenance, Tufts Health Public Plans Direct, and Tufts Insurance Co.

6 This analysis excludes all inpatient institutional claims, as those claims are recorded at the header level rather than the line level, such that reporting on inpatient institutional claims with the other categories of claims is not feasible.

7 Category A reflects claims for services received that have been processed and denied because there was no prior authorization or referral in place prior to the patient receiving the service. This is different than denials of prior authorization requests for prospective services, which take place prior to the patient receiving the service. Prior authorization requests are not reflected in this reporting.

8 Lo et al. (2025). "Claims Denials and Appeals in ACA Marketplace Plans in 2023." KFF (January 27, 2025).

9 See Appendix for assignment of each CARC to one of the 11 claim denial categories for this reporting.

10 Health Affairs Council on Health Care Spending and Value (2023). "A road map for action: recommendations of the Health Affairs Council on Health Care Spending and Value." (February 2023).