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ISSUE BRIEFS / AUGUST 1, 2024

Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.

Photo: Andrew Lichtenstein/Corbis via Getty Images

TOPLINES

Many insured, working-age Americans face unexpected medical bills and coverage denials for doctor-recommended care

Challenging coverage denials and medical bills often works, but significant numbers of people are unaware of their right to do so

AUTHORS

Avni Gupta, Sara R. Collins, Shreya Roy, Relebohile Masitha

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Americans are increasingly struggling to get their health insurance to work for them. High deductibles and copayments are causing nearly two of five working-age adults to delay visiting the doctor and filling prescriptions.[1] Those who do get care can become burdened by medical or dental debt, something almost one-third of working-age adults report experiencing.[2] Billing errors and denials of coverage by insurance companies may contribute to this problem. Media investigations have found that insurers are becoming increasingly adept in using technology to deny payment of medical claims and pressure their company physicians to deny care during prior authorization reviews.[3] Doctors also report spending increasing amounts of time on the phone with insurance company physicians over denials of care for their patients.[4]

In this brief, we report findings from a Commonwealth Fund survey on the extent to which working-age adults say their insurance provider charged for a health service they thought should have been free or covered or denied coverage for care recommended by their doctors. We examined whether people challenged such errors or coverage denials, the reasons why they didn't, and the implications for their health and well-being. People were grouped by the coverage source they reported at the time of the survey, such as employer or individual market or marketplace, though it should be noted that some may have switched insurance plans during the year.

The survey was conducted by SSRS with a nationally representative sample of 7,873 adults age 19 and older from April 18 through July 31, 2023. Our analysis focuses on the 5,602 working-age respondents — under age 65 — who were insured at the time of the survey. Analysis of billing issues was further limited to the 4,803 individuals who were insured for the entire year (see "How We Conducted This Survey" for more information).

Highlights

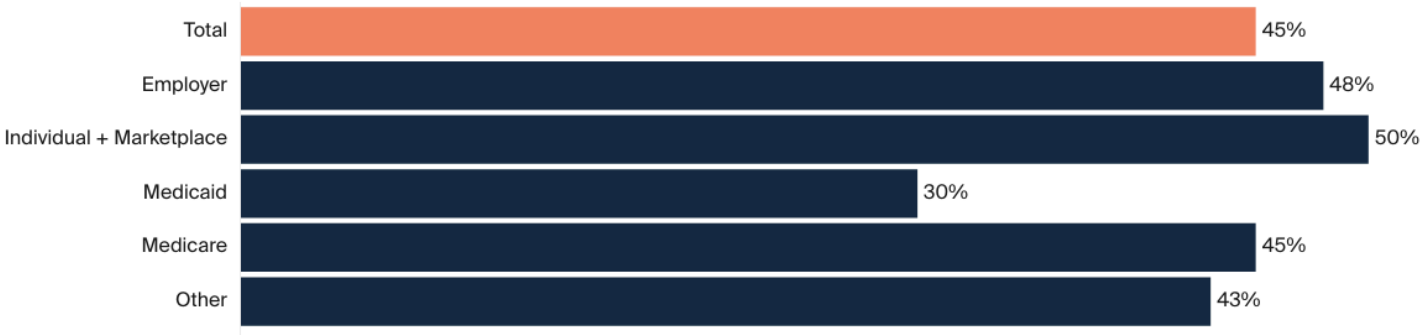
- Forty-five percent of insured, working-age adults reported receiving a medical bill or being charged a copayment in the past year for a service they thought should have been free or covered by their insurance.
- Less than half of those reporting billing errors said they challenged them. Lack of awareness about their right to challenge a bill was the most common reason, particularly among younger people and those with low income.
- Nearly two of five respondents who challenged their bill said that it was ultimately reduced or eliminated by their insurer.
- Seventeen percent of respondents said that their insurer denied coverage for care that was recommended by their doctor; more than half said that neither they nor their doctor challenged the denial.
- Nearly six of 10 adults who experienced a coverage denial said their care was delayed as a result.

Findings

More than two of five working-age adults report being charged for a health service that they thought was free or covered by insurance.

Percentage of insured adults ages 19–64 who reported receiving a bill or being charged a copayment for a health care service that they thought was free or covered, by type of insurance coverage

In the past 12 months have you or a family member received a bill or been charged a copayment for a health care service that you thought should have been free or covered by your insurance?



Download data

Base: Adults ages 19–64 who were insured for all 12 months in the past year and were also insured at the time of the survey.
Note: Coverage type given at time of survey.
Data: Commonwealth Fund Affordability Survey (2023).

Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

More than two of five respondents reported either they or a family member received a bill or were charged a copayment in the past 12 months for a health service they thought was free or covered by their insurance.

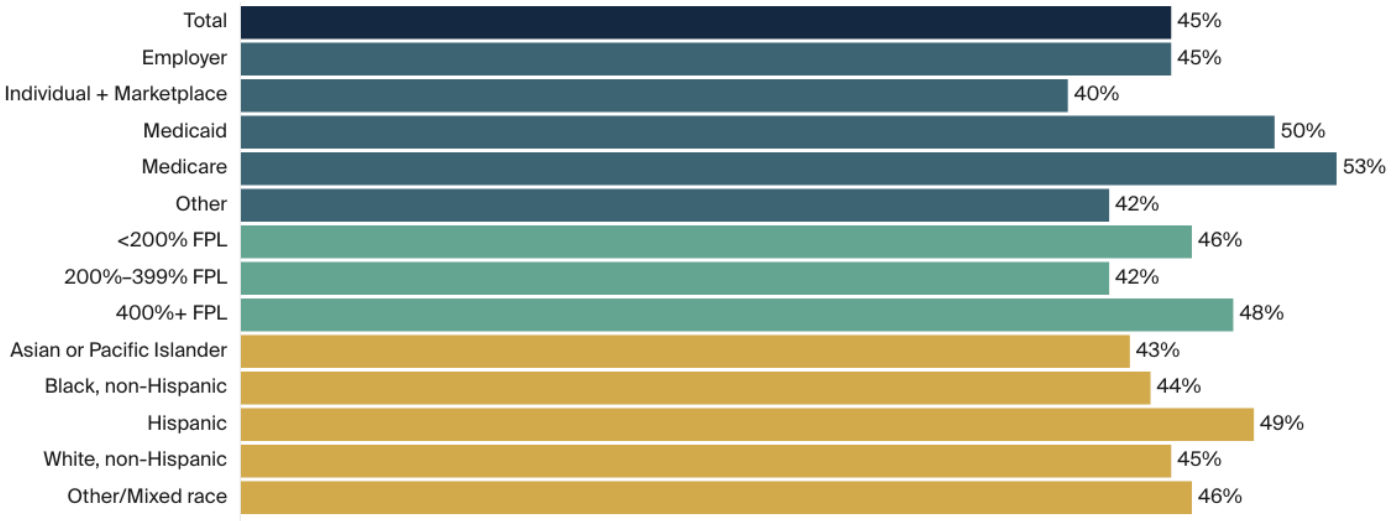
Plan complexity and the heterogeneity of benefits across plans may leave people unable to identify what is and is not covered, and when a bill is incorrect.[5] While the Affordable Care Act (ACA) requires all insurers to cover preventive services like colon cancer screening free of charge, some states and the federal government also require certain plans, such as marketplace plans, to cover additional services either free of charge, like annual checkups, or prior to meeting deductibles. Many employer plans exclude some services and prescription drugs from deductibles.

People across all insurance types reported such billing problems, but those covered by employer plans, marketplace or individual market plans, and Medicare reported them at higher rates.

Fewer than half of adults challenged their unexpected bills by contacting their provider or insurer.

Percentage of insured adults ages 19–64 who attempted to challenge bill(s) by contacting their provider or insurance company, by insurance type, income level, and race/ethnicity

You said you received a bill or were charged a copayment for a health care service you thought should have been free or covered by your insurance. Did you attempt to challenge the bill by contacting your provider or insurance company?



Download data

Base: Adults ages 19–64 who were insured for all 12 months in the past year, were also insured at the time of the survey, and who received a bill for a service they thought should have been covered.
Notes: FPL = federal poverty level. Coverage type given at time of survey.
Data: Commonwealth Fund Affordability Survey (2023).

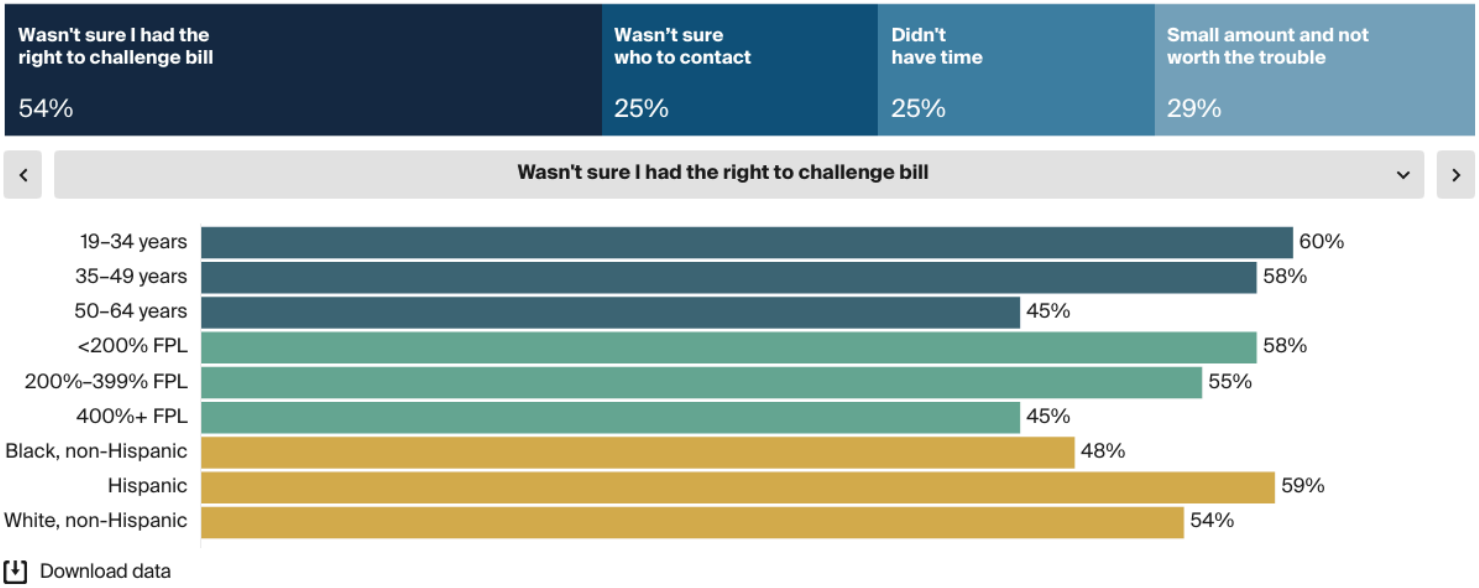
Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Of the respondents who thought they had received a bill in error, fewer than half attempted to challenge the bill. People with marketplace or individual market plans challenged these bills at a rate lower than those covered by Medicaid or Medicare (the difference was not statistically significant). This is despite the ACA's requirement for insurers to have systems in place for consumers to appeal and challenge their bills. There were no significant differences by race and ethnicity or poverty level.

Over half of those who did not challenge their bills were not sure they had the right to do so.

Percentage of insured adults ages 19–64 who did not attempt to challenge their bill, by reasons for not challenging across age, income level, and race/ethnicity

Why didn't you attempt to challenge the bill? Select all that apply.



Download data

Base: Adults ages 19–64 who were insured for all 12 months in the past year, were also insured at the time of the survey, who received a bill for a service they thought should have been free or covered but did not challenge the bill.
Notes: FPL = federal poverty level. Coverage type given at time of survey.
Data: Commonwealth Fund Affordability Survey (2023).

Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Of those who did not challenge their bills, over half said it was because they were not sure they had the right to do so. Other reasons included not knowing who to contact (25%), lacking the time (25%), and viewing the amount as too small to spend time challenging the bill (29%).

People with low and moderate incomes, those younger than age 50, and Hispanic respondents reported at the highest rates that they were unsure of their right to challenge a

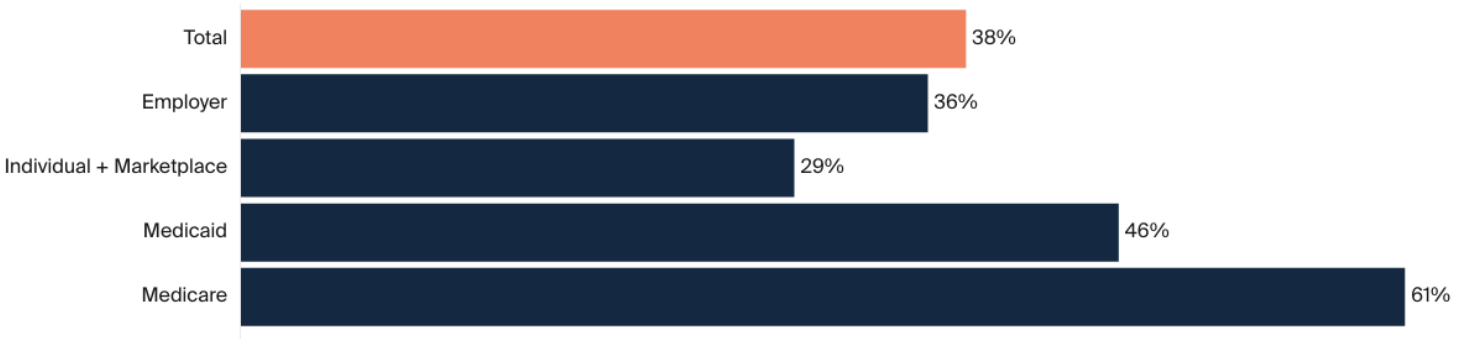
bill. Those younger than 50 also had the highest rates of not knowing who to contact to challenge a bill.

People with higher income cited a lack of time and the amount not being worth the trouble at higher rates than those with low or moderate income.

Of those who challenged their bills, 38 percent said bills were ultimately reduced or eliminated.

Percentage of insured adults ages 19–64 whose bills were ultimately reduced or eliminated, by insurance type

If you attempted to challenge your bill(s), was the bill or were any of the bills ultimately reduced or eliminated?



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Base: Adults ages 19–64 who were insured for all 12 months in the past year, were also insured at the time of the survey, who received a bill for a service they thought should have been covered and attempted to challenge the bill.
Note: Coverage type given at time of survey.
Data: Commonwealth Fund Affordability Survey (2023).

Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

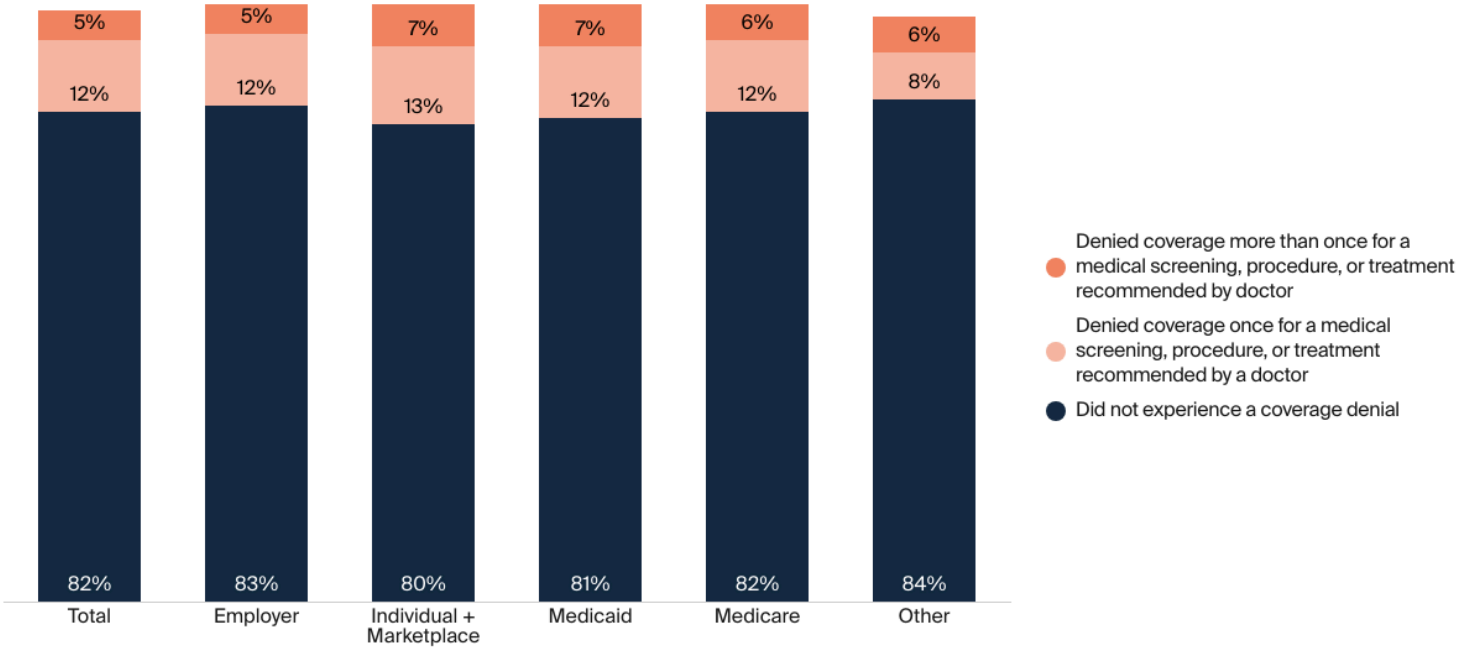
Nearly two of five adults who challenged a bill said the amount was ultimately reduced or eliminated. People with Medicare or Medicaid reported higher rates of bill reduction or elimination. This may reflect more standardized and well-defined benefits in public programs compared to the heterogeneity of plan products and benefits offered by employers and commercial insurers.

Coverage Denials

Seventeen percent of adults were denied coverage for care recommended by a doctor.

Percentage of insured adults ages 19–64 who were denied coverage for recommended care, by insurance type

In the past 12 months, has your insurance denied coverage for a medical screening, procedure, or treatment recommended by a doctor for you or a family member?



Download data

Base: Adults ages 19–64 who were insured at time of survey.
Notes: Coverage type given at time of survey. Column segments may not sum to 100% because of rounding and nonresponse.
Data: Commonwealth Fund Affordability Survey (2023).

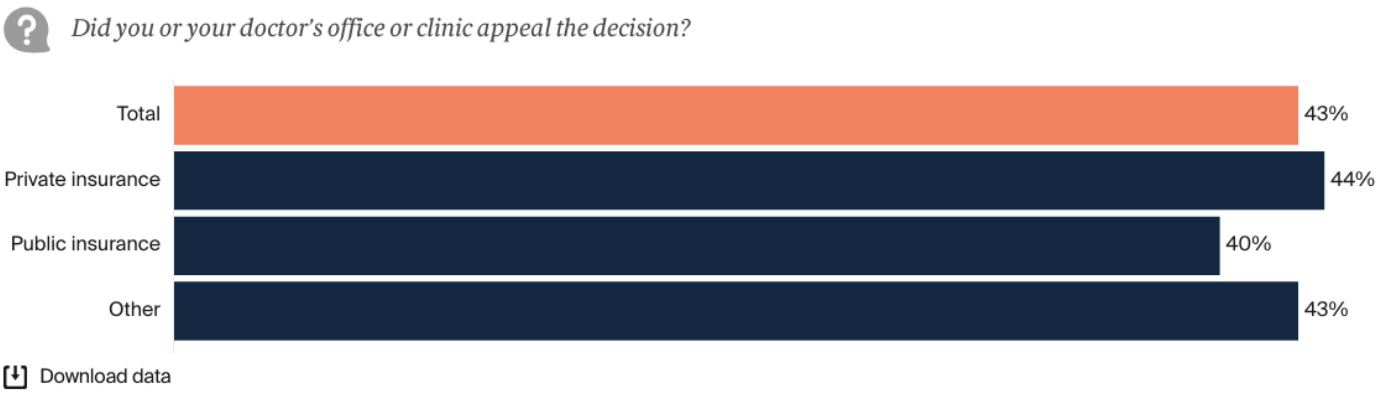
Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Seventeen percent of respondents or one of their family members were denied coverage for care recommended by a doctor, and these rates were similar across insurance types. While we did not ask survey respondents why their coverage was denied, common reasons include a service that is deemed medically unnecessary by the insurer or delivered in a setting the insurer considers inappropriate, visiting an out of network provider, a medication that is not on a plan formulary, or an experimental procedure.

Many health insurers require a review of claims or prior authorization requests by a nurse and a doctor, both employed by the insurer.[6] Recent media investigations have found that some insurance company doctors are not incentivized to spend the time needed to scrutinize patients' medical records and follow guidelines for making informed decisions about approving or denying a care request.[7] Rather, some doctors are incentivized to deny care using a "click and close" policy, which promotes bonuses based on the quantity of cases reviewed and hence incentivizes speedy reviews. This can lead to wrongfully denied care.[8]

Only 43 percent of adults said they or their doctor challenged an insurer denial of care.

Percentage of insured adults ages 19–64 who appealed insurer denial of service(s)



Base: Adults ages 19–64 who were insured at time of survey, were denied coverage for a medical screening, procedure, or treatment recommended by a doctor for them or a family member in the past 12 months.
Note: Coverage type given at time of survey.
Data: Commonwealth Fund Affordability Survey (2023).

Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

The ACA granted people the right to appeal decisions made by their health insurers, regardless of their insurance type or state of residence.[9] The law also put in place rules for how insurance companies should handle initial appeals and allowed consumers to request a reconsideration of decisions to deny payment.[10] If an insurer upholds its decision to deny payment, people also have the right to file for an external appeal.

Despite these protections, less than half of those denied coverage for a recommended procedure challenged the denial. Rates were similar across insurance types.

Among those who didn't challenge their coverage denial, 45 percent said they were not sure they had the right to appeal.

Percentage of insured adults ages 19–64 who did not appeal insurer denial of service(s), by the reason for not appealing

Why didn't you appeal [the insurance coverage] denials? Select all that apply.

Download data

Base: Adults ages 19–64 who were insured at time of survey, were denied coverage for a medical screening, procedure, or treatment recommended by a doctor for them or a family member in the past 12 months, and who did not appeal insurer's decision.
Data: Commonwealth Fund Affordability Survey (2023).

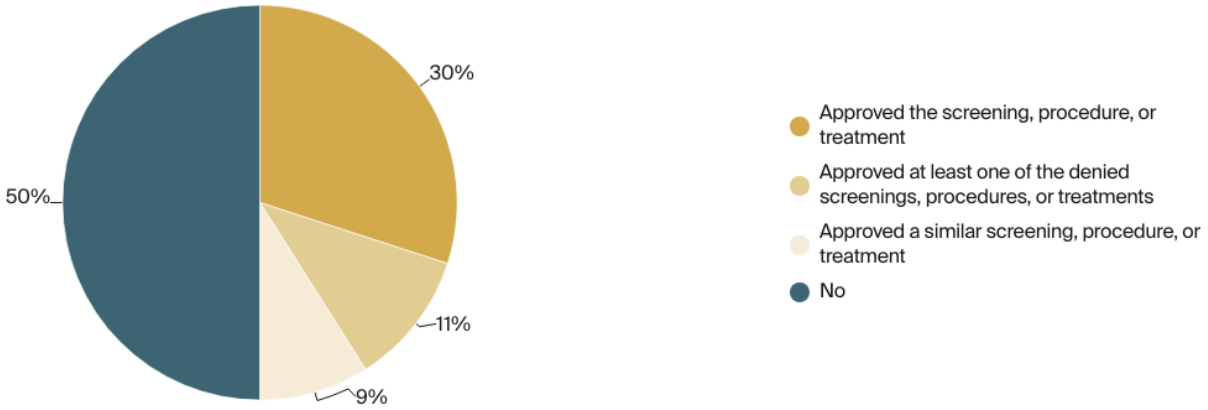
Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Forty-five percent of those who did not challenge their insurers' coverage denial reported they were not sure they had the right to do so. Despite the ACA's rules for insurance companies to handle appeals and standardize appeals processes, 40 percent of those who did not challenge their denial reported that they did not know who to contact to appeal.

Half of those who challenged their care denials said their insurer ultimately approved their care.

Percentage of insured adults ages 19–64 who appealed insurer denial of service(s), by the outcome of appeal

Did the insurer ultimately approve the procedure?



Download data

Base: Adults ages 19–64 who were insured at time of survey, were denied coverage for a medical screening, procedure, or treatment recommended by a doctor for them or a family member in the past 12 months, and who appealed insurer decision to deny them coverage.
Data: Commonwealth Fund Affordability Survey (2023).

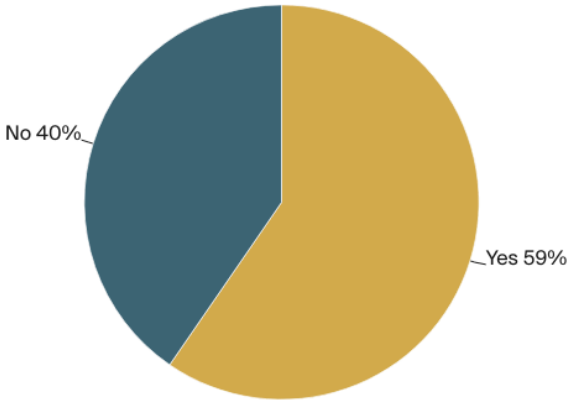
Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Half of respondents who challenged their coverage denial reported that some or all of the denied services were ultimately approved by the insurer.

Almost three of five adults who experienced a coverage denial said their care was delayed as a result.

Percentage of insured adults ages 19–64 whose care was delayed as a result of the coverage denial

Was your or your family member's care delayed as a result of the denial?



Download data

Base: Adults ages 19–64 who were insured at time of survey, who were denied coverage for a medical screening, procedure, or treatment recommended by a doctor for you or a family member in the past 12 months.
Note: Pie segments may not sum to 100% because of rounding and nonresponse.
Data: Commonwealth Fund Affordability Survey (2023).

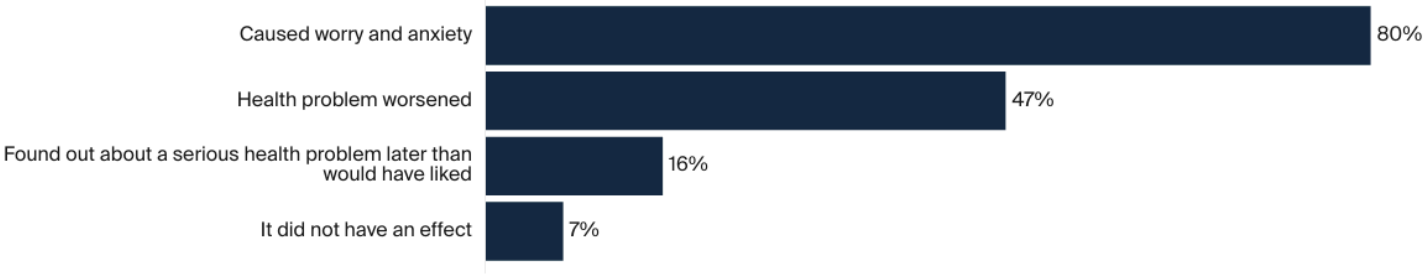
Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

Coverage denials can lead to significant delays in getting care while patients and their doctors' appeal. Almost three of five respondents who reported that their insurer denied coverage for recommended care said they experienced delays in attaining care as a result.

Nearly half of adults who experienced care delays because of a denial of coverage said their health problem worsened as a result.

Percentage of insured adults ages 19–64 by the effect of delayed care as a result of the coverage denial

What effect, if any, did the delay in your care or your family member's care have on you or your family member?



Download data

Base: Adults ages 19–64 who were insured at the time of survey, whose care was delayed as a result of denied coverage for a medical screening, procedure, or treatment recommended by a doctor for you or a family member in the past 12 months.
Data: Commonwealth Fund Affordability Survey (2023).

Source: Avni Gupta et al., *Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.* (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/jqpw-jz55

We found that nearly half of respondents who experienced a delay in care following a coverage denial said that a health problem got worse as a result. Nearly one in six reported that care denials delayed the diagnosis of a serious health problem. Worry and anxiety among those experiencing delays were nearly universal.

Delays in care after coverage denials can have long-term health consequences. In a recent *New York Times* story, patients reported that denials of care led to lost vision, paralysis, and death.[11]

Discussion

The complexity of the health insurance system in the United States has left many people struggling to understand what services are and aren't covered, and their financial liabilities when they get care.[12] On top of this complexity, insurers are motivated to avoid paying for care. Many insurers appear to be utilizing increasingly aggressive tactics to do so, deploying technology and applying pressure to company physicians to scrutinize services recommended by patients' physicians and often to deny coverage, leaving patients with unexpected bills or delays in care.

When looking at people's billing disputes and denials of coverage, what emerges is that many realize positive outcomes when they appeal decisions they perceive to be in error. Yet

only half of those who believed they were erroneously billed or denied care actually challenged the decision or had a doctor challenge it on their behalf. The survey shows considerable consumer confusion among patients and their families about their right to appeal and who to contact. This may stem from lack of transparency and standardization in the appeals process. The responsibility of appealing may not be clear between patients and providers, or between employers and employees, and the documentation requirements to appeal can create additional barriers.

The high frequency of successful appeals also suggests the initial determination process may be flawed, with many patients being denied coverage for care they need to access. The current system with its complicated appeals processes can be detrimental to patients who are most in need of services.

To ensure patients can access the care they need, federal and state policymakers and regulators could consider the following actions:

- **Track claims denials**: The U.S. Department of Health and Human Services could better fulfill the requirements of the ACA to monitor rates of claims denials in all commercial insurance plans, including those offered through the marketplaces, individual market, and employers.[13]

- **Hold insurers accountable**: Policies might be needed that penalize insurers for repeatedly wrongfully denying coverage or billing erroneously. Public reporting of such data can also incentivize insurers to limit such practices. As of May 2023, nearly 90 legislative bills had been considered across 30 states to reform prior-authorization requirements.[14] Some states have passed legislation, such as New Jersey and Washington D.C.,[15] while California[16] and North Carolina have bills under consideration. Recently, the Committee on Education and the Workforce urged the U.S. Department of Labor to strengthen disclosure requirements for self-funded employer plans — how most employer-insured individuals receive their coverage — around the number of claims denied and appealed, and the outcomes of those appeals.[17]

- **Promote consumer awareness**: Promoting state- or federal-level consumer information systems to spread awareness about a beneficiary's right to appeal their insurer's billing and care denial decisions could help, particularly among those groups the survey revealed to be least aware of their rights: those with low income, Hispanic people, and younger adults. Though the ACA marketplace and Centers for Medicare and Medicaid Services (CMS) webpages explain such rights, this information may not be equally accessible or understood by everyone.[18]

- **Support consumers**: As the process of submitting an appeal can be complex, requiring the completion of several forms or communicating with the insurer's customer service, a state or federal consumer support system could be helpful.[19] While some states have set up customer assistance programs for those experiencing health insurance problems, 20 states lack such a resource.[20]

HOW WE CONDUCTED THIS SURVEY

The Commonwealth Fund Health Care Affordability Survey, 2023, was conducted by SSRS from April 18 through July 31, 2023. The survey consisted of telephone and online interviews in English and Spanish and was conducted among a random, nationally representative sample of 7,873 adults age 19 and older living in the continental United States. A combination of address-based (ABS), SSRS Opinion Panel, and prepaid cell phone samples were used to reach people. In all, 4,417 interviews were conducted online or on the phone via ABS, 2,718 were conducted online via the SSRS Opinion Panel, and 738 were conducted on prepaid cell phones.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses from low-income households. Statistical results were weighted in stages to compensate for sample designs and patterns of nonresponse that might bias results. The data are weighted to the U.S. adult population by sex, age, education, geographic region, family size, race/ethnicity, population density, civic engagement, and frequency of internet use, using the 2022 U.S. Census Bureau's Current Population Survey (CPS).

The resulting weighted sample is representative of the approximately 251 million U.S. adults age 19 and older. The survey has an overall maximum margin of sampling error of +/– 1.5 percentage points at the 95 percent confidence level. As estimates get further from 50 percent, the margin of sampling error decreases. The ABS portion of the survey achieved a 15 percent response rate, the SSRS Opinion Panel portion achieved a 2.8 percent response rate, and the prepaid cell portion achieved a 2.9 percent response rate.

This brief focuses on 5,602 adults under age 65 who were insured at the time of the survey. The resulting weighted sample is representative of approximately 178.4 million U.S. adults ages 19 to 64. The survey has a maximum margin of sampling error of +/– 1.7 percentage points at the 95 percent confidence level for this age group. Analysis of billing issues was further limited to the 4,803 individuals who were insured for the entire year.

ACKNOWLEDGMENTS

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NOTES

1. Sara R. Collins, Shreya Roy, and Relebohile Masitha, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer — Findings from the Commonwealth Fund 2023 Health Care Affordability Survey* (Commonwealth Fund, Oct. 2023). ↩

2. Sara R. Collins, Shreya Roy, and Relebohile Masitha, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer — Findings from the Commonwealth Fund 2023 Health Care Affordability Survey* (Commonwealth Fund, Oct. 2023). ↩

3. Patrick Rucker and David Armstrong, "A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her.," *ProPublica and The Capitol Forum*, Apr. 29, 2024; Patrick Rucker, Maya Miller and David Armstrong, "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," *ProPublica and The Capitol Forum*, Mar. 25, 2023; David Armstrong, Patrick Rucker, and Maya Miller, "UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings," *ProPublica and The Capitol Forum*, Feb. 2, 2023; and Elizabeth Rosenthal, "Analysis: Health Insurance Claim Denials Are on the Rise, to the Detriment of Patients," *PBS News*, May 28, 2023. ↩

4. Emily Featherston et al., "Permission to Practice: Doctors, Patients Say Insurance Prior-Authorizations Put Profits over People," *InvestigateTV*, Mar. 20, 2023. ↩

5. Lexi Sutter, Tom Jones, and Abra Richardson, "Medical Billing Errors Are Common and Costly. Here's How to Spot Them Before Paying.," *NBC 5 Responds*, June 7, 2023. ↩

6. Patrick Rucker, Maya Miller and David Armstrong, "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," *ProPublica and The Capitol Forum*, Mar. 25, 2023. ↩

7. Patrick Rucker and David Armstrong, "A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her.," *ProPublica and The Capitol Forum*, Apr. 29, 2024. ↩

8. Patrick Rucker and David Armstrong, "A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her.," *ProPublica and The Capitol Forum*, Apr. 29, 2024. ↩

9. Centers for Medicare and Medicaid Services, "External Appeals," last updated Sept. 6, 2023. ↩

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11. Alexander Stockton, "'What's My Life Worth?': The Big Business of Denying Medical Care," *New York Times*, video, Mar. 14, 2024. ↩

12. Saurabh Bhargava and George Loewenstein, "Choosing a Health Insurance Plan: Complexity and Consequences," *JAMA* 314, no. 23 (Dec. 15, 2015): 2505–6; and Karen Pollitz et al., *Consumer Survey Highlights Problems with Denied Health Insurance Claims* (KFF, Sept. 2023). ↩

13. Elizabeth Rosenthal, "Analysis: Health Insurance Claim Denials Are on the Rise, to the Detriment of Patients," *PBS News*, May 28, 2023. ↩

14. Kevin B. O'Reilly, "Bills in 30 States Show Momentum to Fix Prior Authorization," American Medical Association, May 10, 2023. ↩

15. "New Jersey Assembly Bill 1255," passed Jan 16, 2024; and "Washington D.C. Council Bill 250124," passed Nov. 15, 2023. ↩

16. "California SB598, Health Care Coverage: Prior Authorization," Feb 15, 2023. ↩

17. Representative Robert C. "Bobby" Scott and Representative Mark Desaulnier, Letter to Honorable Acting Secretary Su and Assistant Secretary Gomez, U.S. Department of Labor, Committee on Education and the Workforce, June 17, 2024. ↩

18. HealthCare.gov, "Appealing a Health Plan Decision: Internal Appeals," n.d.; and CMS.gov, "Your Situation: Your Health Insurance Plan Denied a Request to Pay a Medical Bill," Centers for Medicare and Medicaid Services, last updated June 22, 2023. ↩

19. National Association of Insurance Commissioners, "Health Care Bills: How to Appeal a Denied Claim," n.d. ↩

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PUBLICATION DETAILS

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CONTACT

Avni Gupta, Researcher, Health Care Coverage and Access, The Commonwealth Fund

agupta@cmwf.org

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TOPICS

Medical Bills and Debt,
Coverage and Access