



## *New Survey: One in Five Privately Insured U.S. Adults Are Denied Coverage for Doctor-Recommended Care*

Coverage denials delay care, worsen health, and lead to medical debt; only half of patients appeal insurer decisions, often uncertain of their rights

A new Commonwealth Fund survey finds that one in five (21%) U.S. working-age adults with private insurance reported that they or a family member were denied insurance coverage for doctor-recommended medical care in the past year. The survey examines two distinct types of denials: prior authorization denials, which occur before care is received, and claim denials, which occur after care has already been provided.

The report, *How Health Insurance Coverage Denials Affect Americans*, draws on findings from the Commonwealth Fund 2025 Affordability Survey of U.S. adults ages 19 to 64, including responses from 4,589 adults with private insurance, as well as eight online focus groups in which participants described denials as eroding their trust in both insurers and health care providers. Private insurance includes coverage through an employer, the Affordable Care Act marketplaces, or the individual market.

Key findings include:

- **One in five privately insured adults report that they or a family member were denied coverage for doctor-recommended care in the past year.** Thirteen percent experienced a prior authorization denial before care was received, while 8 percent experienced a claim denial after care had already been provided. One percent experienced both types of denials.
- **Prior authorization denials often delay medical care, worsen health problems, and cause worry and anxiety.** Forty-one percent of people who experienced a prior authorization denial said it delayed their care, and more than a quarter (28%) said their health problem worsened as a result. More than 60 percent reported that the denial caused worry and anxiety. Some focus group participants said the experience of a coverage denial had led them to avoid seeking care afterwards.
- **Claim denials often leave patients with unexpected medical bills and long-term debt.** Nearly 70 percent of people who experienced a claim denial said it cost their household more money. Two in five (43%) said the denial led to medical debt they are still paying off; more than half reported the original denied bill was \$1,000 or more.

**EMBARGOED**

**NOT FOR RELEASE BEFORE**

**12:01 a.m. E.T.**

**Thursday, June 4, 2026**

For further information,  
contact:

Bethanne Fox  
212.606.3853  
[bf@cmwf.org](mailto:bf@cmwf.org)

Maya Brod  
301.467.4917  
[mbrod@burness.com](mailto:mbrod@burness.com)

 [@commonwealthfund.org](https://twitter.com/commonwealthfund.org)

*The Commonwealth Fund is a private, nonprofit foundation supporting independent research on health policy reform and a high-performance health system.*

- **Only about half of people who experience a coverage denial choose to appeal, often because they are unsure they have the right to challenge the decision or because they doubt it would make a difference.** Among those who did appeal a prior authorization denial, more than half ultimately received some form of coverage — either for the recommended care (30%) or an alternative (25%). One-third (33%) of those who challenged a claim denial had their bills reduced or eliminated. Many patients reported waiting two weeks or longer for a decision.

## POLICY IMPLICATIONS

The study authors note that the rules governing insurance coverage denials and patients' appeal rights vary widely across health plans and have not kept pace with changes in the insurance market. They identify several policy options aimed at strengthening consumer protections, including:

- expanding patients' right to appeal and making all denials eligible for third-party, independent review
- standardizing and streamlining prior authorization procedures across health plans
- restoring federal funding for consumer assistance programs that help patients understand their coverage and appeal insurers' decisions
- expanding public reporting requirements on claim denials and appeals to improve transparency and accountability, and
- requiring clear, plain-language explanations of coverage decisions and appeal rights, and making the appeals process easier for patients and caregivers to navigate.

**The full report will be available after the embargo lifts at:**  
<https://www.commonwealthfund.org/publications/surveys/2026/jun/how-health-insurance-coverage-denials-affect-americans-2025-affordability-survey>

## HOW WE CONDUCTED THIS SURVEY

The 2025 Commonwealth Fund Affordability Survey was conducted by SSRS from July 22 through October 27, 2025. The survey consisted of telephone and online interviews conducted in English and Spanish among a random, nationally representative sample of 6,353 adults ages 19 to 64 years in the United States. A combination of three probability-based sampling frames — address-based (ABS), SSRS Opinion Panel, and prepaid cell phone — were used to reach people. The majority of respondents completed the survey online.

Statistical results were weighted to compensate for sample designs and patterns of nonresponse that might bias results. The resulting weighted sample is representative of the approximately 196 million U.S. adults ages 19 to 64. The survey has an overall maximum margin of sampling error of +/- 1.5 percentage points at the 95 percent confidence level.

The ABS portion of the survey achieved a 14.4 percent response rate, the SSRS Opinion Panel portion achieved a 2.5 percent response rate, and the prepaid cell portion achieved a 1.5 percent response rate.

This report focuses on 4,589 respondents with private insurance either through an employer or the Affordable Care Act marketplaces and individual insurance market. The resulting weighted sample is representative of approximately 130.6 million U.S. adults ages 19 to 64 with private insurance. The margin of sampling error for the subgroup of those with private insurance is +/- 1.7 percentage points at the 95 percent confidence level.

## FROM THE EXPERTS

**Sara R. Collins**, study coauthor and Commonwealth Fund Senior Scholar for Expanding Coverage and Access and Tracking Health System Performance

*“The complexity of the U.S. health care system is leaving many patients and their families caught between their providers and their insurance companies. When an insurer denies coverage for care their doctor recommends, patients are frequently unsure of how to appeal decisions or even if they have a right to appeal. We need greater transparency, expansion of appeal rights, and standardization of utilization review processes across all insurance plans to help patients have confidence in their insurance — that it will enable them to stay healthy and avoid medical debt.”*

**Joseph R. Betancourt, M.D.**, Commonwealth Fund President

*“When delivering health care, the goal is to get patients what they need, when they need it — and decisions about care should be guided by the clinicians and care teams who understand their patients best. As a primary care physician, I’ve seen firsthand how challenging it is for patients trying to manage the complexity of the prior authorization process. It is difficult, time-consuming, and frustrating for all involved. In many cases, it leads to delayed care or no care at all; in the worst cases, it puts patients’ lives at risk. When oversight overrides clinical judgment without good reason, quality of care and patient safety suffer, and that demands a policy response.”*