THE HEALTH INSURANCE MAZE

How Cancer Patients Get Lost in the Red Tape of Utilization Management

A summary of findings from **CARE** —
Commercial Insurance and Pharmacy Benefit Manager
Impact on Cancer Treatment **A**ccess and Quality of Life:
A **R**esearch **E**valuation

JUNE 2025

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EXECUTIVE PERSPECTIVE:

Are Health Insurers Listening to People with Cancer?

Advocates understand the value of listening. Living with cancer and caring for someone with cancer can be isolating, despite the growing prevalence worldwide. These experiences unfold daily—in people's homes, at doctor's appointments, and while receiving treatment—all far removed from healthcare policy discussions between legislators, regulators, economists, industry, and payors.

At Cancer*Care*, we know that to create meaningful change, we must listen to people and learn from their lived experiences with the healthcare system. The broken ladder of modern health coverage and siloed care systems are having a profound impact on people who need immediate, often lifesaving, care.

Our study reveals that utilization management (UM) mechanisms designed to control costs—such as prior authorization, step therapy, and coverage stoppages due to formulary changes and shifting medical necessity criteria—often cause treatment delays and burdens that leave patients in a state of uncertainty and increase their health risks.

UM is not just an administrative inconvenience; it disrupts care continuity at moments when every minute matters. Many people with cancer face lengthy approval processes, unexpected out-of-pocket costs, and frustrating coverage gaps. As described in our findings, these barriers not only jeopardize access to timely care but also add practical, financial, and emotional burdens at an already vulnerable time. The complexity and lack of transparency in many insurance plans mean that people often struggle to understand their coverage, intensifying their stress and impeding their ability to navigate the system.

When given the chance to share their experience, people with cancer told us that navigating bureaucratic processes drained their time and created unnecessary burdens. In many cases, a single incident of prior authorization required multiple days of tackling red tape that patients could have instead spent caring for themselves, working, or being with family. Building a more transparent, efficient, and patient-centered system requires that policy reforms be grounded in the voices of those directly affected by these practices.

Decision makers, including policymakers, employers, and others have a critical role in driving system-level change. In our study, individuals with employer insurance plans were often sicker yet faced the heaviest insurance burdens, including multiple frequent and inefficient prior authorization requirements. In a competitive labor market, offering healthcare benefits that ensure timely, accessible, high-quality cancer care can be a significant advantage. Respondents with Medicare Advantage plans, which have seen widespread adoption, also reported more prior authorization and administrative barriers than those with Traditional Medicare. Collectively, these findings underscore the urgent need to reform UM policies to reduce red tape and ensure equitable access to timely, medically necessary care.

Improving outcomes requires reimagining prior authorizations, step therapies, formulary exclusions, and other purposeful restrictions within UM. Only by listening to and integrating patient experiences into policy discussions can we succeed in building a system that is both efficient in its delivery and responsive to the needs of its intended beneficiaries: people living with cancer.

Alexandra Zaleta, PhD
Associate Vice President, Research and Insights, Cancer*Care*
Principal Investigator, CARE Study

> **“*UM is not just an administrative inconvenience; it disrupts care continuity at moments when every minute matters. Many people with cancer face lengthy approval processes, unexpected out-of-pocket costs, and frustrating coverage gaps.”***
>
> *– Alexandra Zaleta*

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About Cancer*Care*

For over 80 years, Cancer*Care* has empowered millions of people affected by cancer through free counseling, resource navigation, support groups, educational resources, advocacy, and direct financial assistance. Our oncology social workers improve the lives of people diagnosed with cancer, caregivers, survivors, and the bereaved, by addressing their emotional, practical, and financial challenges.

In fiscal year 2024, Cancer*Care* delivered 163,917 services to people affected with 100 different types of cancer, spanning all 50 states, and provided approximately $50 million in financial assistance and co-pay support to 25,246 people for costs, including transportation and practical needs, and to help pay for cancer medications.

To learn more about Cancer*Care*, visit www.cancercare.org.

To inquire about the CARE study, email research@cancercare.org.

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Cancer*Care* maintains full intellectual and editorial independence in producing this report and retains ownership of all associated study data.

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BACKGROUND

How Utilization Management is Shaping the Cancer Care Experience

The U.S. healthcare system is a leader in medical science and technological innovation. Yet this system imposes numerous barriers that limit patients' access to scientific innovations. As a result, although healthcare spending is higher in the U.S. than in other high-income countries, Americans are more likely to die at a younger age and from preventable causes compared to people in those nations (Gunja, Gumas, & Williams, 2023).

In response to rising healthcare system costs, policymakers, commercial health insurance companies, and pharmacy benefit managers (PBMs) have implemented utilization management (UM) strategies to restrict access to healthcare. While UM strategies are intended to improve care and reduce costs, many of these policies lack transparency (Hoffman, 2018) and are implemented in ways that not only fail to consider patients' perspectives but also increase their burdens (Yaver, 2024).

For those facing the urgency, cost, and complexity of a cancer diagnosis and treatment, access barriers add unnecessary delay, cost, and stress to the patient experience. Access barriers influence treatment options and decisions, leading to delays in diagnosis, care, and treatment, and even causing patients to forgo necessary care (Kyle & Keating, 2023). This results in worse health outcomes and higher costs for individual patients, populations, and the healthcare system at large.

The consequences of poorly designed UM strategies for cancer patients can include reduced or delayed access to essential care, increased patient costs, and reduced quality of life. Prior survey research has demonstrated that:

- 1 in 3 patients and caregivers report delays in cancer care because of delayed insurance approval of physician-recommended treatment, tests, or prescription medicine (Harrington & Campbell, 2019).
- 1 in 3 cancer patients report that health insurance practices (including deductibles, prior authorization, co-pays, premiums, co-insurance, and lack of prescription drug coverage) make it difficult to obtain the best cancer care (Harris Poll on behalf of ASCO, 2020).
- Only half of cancer patients report understanding their health insurance coverage (Cancer*Care*, 2016).
- Prior authorization is associated with cancer patient anxiety and decreased trust in the healthcare system (Chino et al., 2023).

Despite these trends, UM strategies continue to expand in breadth and depth. In 2022 alone, over 1,150 medicines were omitted from standard formularies, a 1000% increase since 2014 (Xcenda, 2022). A separate investigation found that a major insurer automatically rejected over 300,000 claims in 2022 on medical grounds without opening patient files (Rucker, Miller, & Armstrong, 2023). Other novel strategies, such as alternative funding programs, have created new access challenges for people with cancer (Choi et al., 2024).

Thus, with the continued expansion of UM practices and growing use of artificial intelligence in these processes, there is an urgent need to understand the current reach and real-world impacts of UM and related cost-saving strategies from the cancer patient perspective, using patient-centered methods. Incorporating patient insights into healthcare policy and insurance design is essential to reversing current trends and building a system that prioritizes access, equity, and accountability.

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Survey Aims

To better understand cancer patients' risks and burdens due to utilization management (UM) strategies, Cancer*Care* developed CARE (**C**ommercial Insurance and Pharmacy Benefit Manager Impact on Cancer Treatment **A**ccess and Quality of Life: A **R**esearch **E**valuation) to:

1. Understand the experience of UM, especially prior authorization and coverage stoppages/formulary exclusions, for Employer Plans, Medicare Advantage, and Traditional Medicare among adults living with cancer across the US; and
2. Document how insurance UM practices affect timely access to care, financial and practical burdens, and well-being from the perspective of people with cancer.

Our intended impact is to:

- Present a clear and current understanding of the real-world impact of UM practices on people with cancer;
- Provide insights that can guide policymakers, insurers, pharmacy benefit managers (PBMs), and other stakeholders on the experiences and effects of UM practices from the patient perspective; and
- Establish a benchmark to monitor and compare future trends in patient impact as the healthcare policy landscape continues to evolve.

The patient-focused insights in this study complement previous studies on utilization management, including economic analyses of claims data and other health insurance outcomes. The findings from this survey offer concrete opportunities to guide advocacy, education, and healthcare policy.

METHODOLOGY

Person-Centered Research Approach

A person-centered research approach was adopted to engage people with cancer in shaping the study, from survey design through data interpretation and dissemination. Patient advocates and expert advisors identified priority topics for the survey and shaped the question structure, framing, and flow. They also pilot-tested the survey before its launch.

A key priority was to ensure that the survey questions used language reflecting the real-world experiences of people with cancer. For example, questions were framed as, "Did insurance ever start and later stop covering (paying for) your treatment?" instead of using terminology such as "formulary exclusions" or "non-medical switching." This pragmatic approach resulted in a project grounded in cancer patients' lived experiences within the current healthcare system and avoided jargon that may confuse survey respondents.

Survey Design and Recruitment

Survey Topics

The survey incorporated new questions developed for the current study, adaptations of questions from prior research (such as the Cancer*Care* 2016 Patient Access and Engagement Report), and other validated patient-reported measures. The survey covered multiple areas, including:

- Health insurance coverage and type;
- Prior authorization experiences and time burden;
- Coverage stoppages/formulary exclusions for ongoing treatment;
- Care delays and denials related to UM practices;
- Impact of health insurance problems on well-being and finances;
- Health insurance literacy and awareness of system factors such as pharmacy benefit managers;
- Cancer treatment and clinical history; and
- Socio-demographics.

Salus IRB, an independent institutional review board with expertise in oncology and social and behavioral research, reviewed the survey protocol. The IRB determined that the study was "minimal risk" research and qualified for exemption from further IRB review (Salus Study ID 24047-01). Salus IRB is an AAHRPP-accredited, non-profit IRB registered with the United States Department of Health and Human Services IRB Registration System.

Survey Recruitment

Cancer*Care* sought to gather information from a diverse sample of people with cancer across the U.S., including those enrolled in Employer Plans and Medicare Advantage plans. Respondents with Traditional Medicare plans were also recruited to serve as a reference group, as this program typically requires fewer UM practices.

The survey employed non-probability sampling methods, with respondents recruited through multiple national survey panels. Survey panel providers reached out to individuals who voluntarily participate in research surveys, ensuring a broad representation of patient experiences. To support the generalizability of the study, advocacy resources including Cancer*Care*’s client database, as well as online communities, chat rooms, and other advocacy organizations, were not used as recruitment sources.

To qualify, survey respondents had to meet specific criteria:

- Be age 26 or older (Affordable Care Act dependent coverage age limit);
- Have a cancer diagnosis;
- Be insured through 1) employer or union-sponsored coverage under their employer/union or their spouse’s employer/union (“Employer Plan”), 2) Medicare Advantage, or 3) Traditional Medicare;
- Have received at least one of the following treatments in the 12 months prior to the survey: chemotherapy (including oral or IV), targeted therapy, immunotherapy, radiation therapy, or stem cell transplant.

Data Collection

Praxis Research Partners fielded the survey using an online survey platform. Interested individuals underwent eligibility screening before taking the survey. Cancer*Care* and its research partners did not collect personally identifiable information. Instead, respondents were assigned a random participant ID, which was used only to report completion status to the survey panels for incentive distribution. Panel providers did not have access to the survey response data. The survey typically took 20 to 30 minutes to complete. Participation was voluntary, and respondents could skip questions they did not wish to answer.

Data Analysis and Reporting

To maximize survey engagement, 47,225 potential participants whose cancer status was unknown were screened online. From this group, 5,872 individuals who reported receiving cancer treatment in the past year were identified. The pool was then narrowed down by additional eligibility criteria, resulting in 1,947 people who met all the requirements and started the survey online. Of these, 79 (4%) did not complete the survey, and 667 (34%) were excluded after data quality screening due to factors such as atypical response patterns or speed. Respondents were considered complete if they provided sufficient information about their insurance coverage, cancer treatments, and experiences with UM.

The final analytic sample for this report includes **1,201 respondents** who completed the survey between **September and December 2024**, comprising 569 individuals with Employer Plans, 408 with Medicare Advantage, and 224 with Traditional Medicare.

Descriptive analyses were used to report frequencies and/or means (*M*) with standard deviations (*SD*). For clarity, all frequencies are rounded to the nearest whole percentage. Due to the nature of multiple response options for some questions, percentages may total more or less than 100%.

Survey responses were aggregated descriptively and, when applicable, segmented by insurance type (Employer Plan, Medicare Advantage, or Traditional Medicare). Descriptive statistics are provided for sub-samples with sufficient sample sizes. Bivariate analyses using chi-squared tests were conducted to assess differences between groups based on insurance status, and statistically significant differences ($p<.05$) are reported. All analyses were performed using Stata v.18.5.

Reading and Interpreting This Report

This report presents descriptive data on the UM experiences of people with cancer and explores key differences based on insurance type (Employer Plan, Medicare Advantage, and Traditional Medicare).

Report Terminology

The report balances the presentation of results using patient-centric language from the survey alongside the technical terminology common in insurance and payor systems, such as "prior authorization" and "coverage stoppages/formulary exclusions."

The term "Employer Plan" refers to respondents who reported being insured through their employer, union, or their spouse's employer/union; respondents were not asked to differentiate between self-funded and fully-insured plans.

The term "cancer treatment" is used to encompass the range of diagnostic, therapeutic, and surveillance tests, treatments, procedures, and medications involved in the cancer care continuum.

Similarly, the report uses person-centered language where possible to humanize people's experience within the healthcare system. In some instances, this report may refer to people living with cancer as "cancer patients" when describing respondents' experiences relative to their role as patient within health insurance and healthcare systems.

Report Interpretation

This report presents descriptive data on the UM experiences of people with cancer and explores key differences based on insurance type (Employer Plan, Medicare Advantage, and Traditional Medicare).

To provide context for these findings, overall trends in respondent characteristics are first highlighted, including socio-demographic factors, cancer status and clinical history, and treatment history. Select group differences for the three insurance types, including cancer status and clinical history, treatment history, and socio-demographic information, are then described.

Although multivariable analyses that account collectively for insurance group differences are beyond the scope of this report, such analyses are an important objective for future research. The **Study Limitations and Strengths** section includes additional details for consideration.

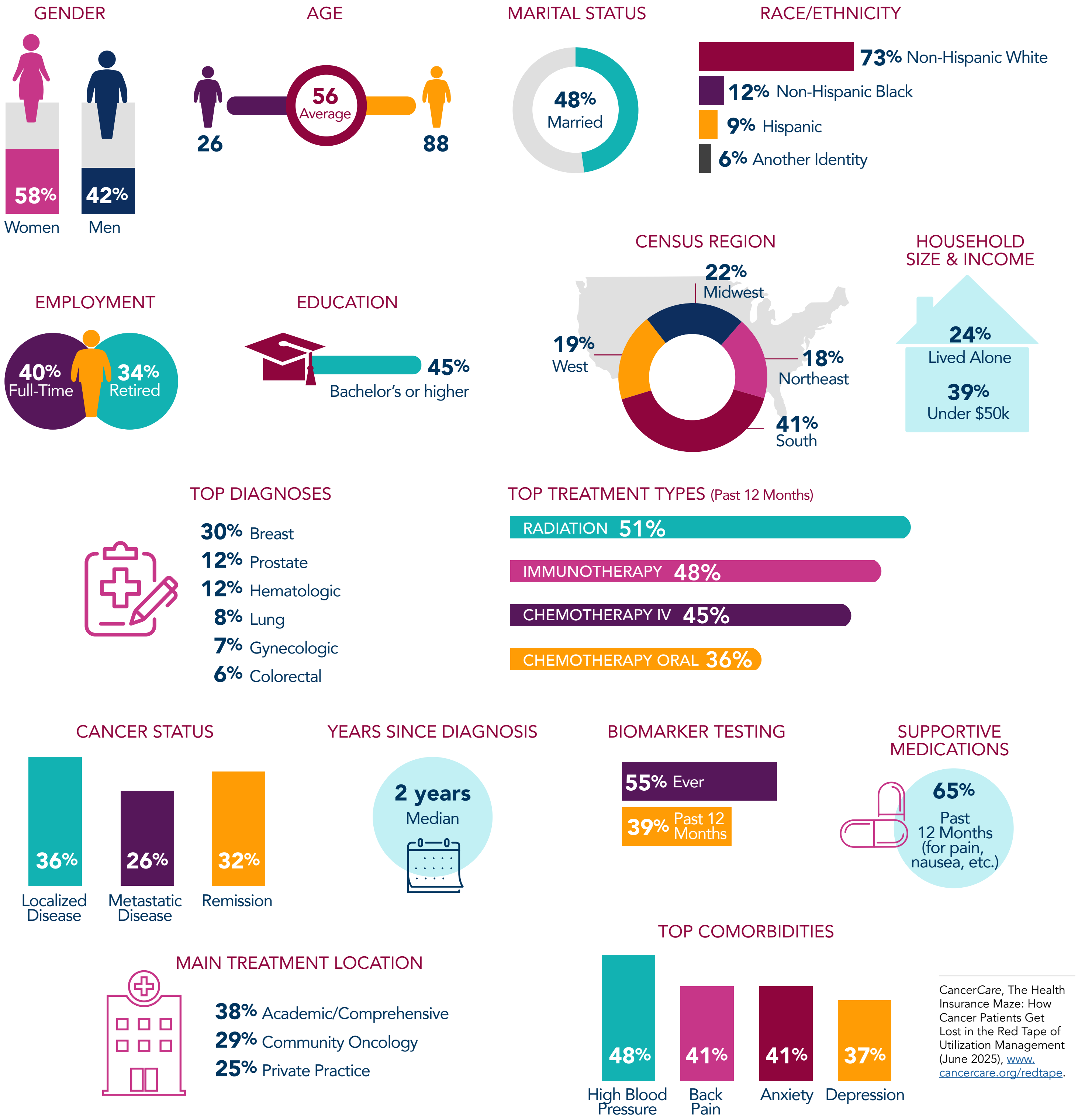
A comprehensive breakdown of all respondent characteristics and between-group differences by insurance type is available in the **Supplemental Information** section at the end of the report.

Respondent Characteristics: Key Highlights

Understanding the makeup of respondents is essential for interpreting survey findings. The following snapshot highlights key socio-demographic characteristics, diagnostic and clinical factors, and treatment history for all 1,201 respondents. While not an exhaustive review of all data collected about respondents' backgrounds, this overview is intended to give readers a sense of who participated in the survey and provide context for the trends discussed in the report.

FIGURE 1

Key Characteristics for 1,201 Survey Respondents



Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

It is also important to consider how respondents in the three insurance groups (Employer Plans, Medicare Advantage, and Traditional Medicare) differed according to certain background and clinical characteristics. This next snapshot presents a selection of factors for which the insurance groups differed significantly.

In this survey, respondents with Employer Plans more often reported having advanced disease, emergency care visits for their cancer, poor or fair mental health, and multiple cancer treatments in the last year, compared to those with Medicare Advantage or Traditional Medicare plans (*ps*<.05).

Additionally, Employer Plan respondents were younger on average, and more often identified as Black or Hispanic, attained at least a bachelor's degree, and were employed at the time of the survey, compared to those with Medicare Advantage or Traditional Medicare plans (*ps*<.05).

FIGURE 2

Key Differences in Respondent Characteristics Across Insurance Types

	Employer Plan	Medicare Advantage	Traditional Medicare
CANCER STATUS AND CLINICAL HISTORY			
Had Metastatic Disease	41% Ever 34% Current	28% Ever 20% Current	27% Ever 19% Current
In Remission	24%	38%	39%
ER Visit for Cancer, Past 12 Months	64%	34%	36%
Reported Poor or Fair Mental Health	45%	31%	32%
CANCER TREATMENT HISTORY			
Multiple Treatments, Past 12 Months	66% had 5+ types of care	38% had 5+ types of care	38% had 5+ types of care
SOCIO-DEMOGRAPHICS			
Age (Average)	46 years	66 years	65 years
Non-Hispanic Black or Hispanic	15% NH Black 16% Hispanic	9% NH Black 5% Hispanic	8% NH Black 2% Hispanic
Bachelor's Degree or Higher	50%	39%	41%
Employed	81%	18%	20%

Note: All between-group differences significant *p*<.05.
Respondents include *n*=569 Employer Plan, *n*=408 Medicare Advantage, *n*=224 Traditional Medicare
Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

For a detailed breakdown of respondent characteristics for the full sample, as well as differences by insurance type, please see the **Supplemental Information** section at the end of the report.

Prior Authorization is Widespread and Inefficient in Cancer

> *"Having to stress over insurance making decisions about my health after a medical doctor deems it necessary for survival is ridiculous."*
>
> *– Employer Plan Respondent*

From the moment a medical professional recommends treatment, people with cancer may face UM barriers—most commonly in the form of prior authorization. Prior authorization requires healthcare providers to obtain advance approval from an insurance company before delivering care to ensure reimbursement.

While the stated purpose of prior authorization is to verify the necessity and appropriateness of a prescribed treatment, it frequently creates administrative burdens for providers and patients alike. Delays while waiting for approval can interrupt timely access to care and potentially lead to worse health outcomes. To better understand these challenges, the survey examined how often respondents encountered prior authorization, how it affected their daily lives, and whether it led to delays in receiving necessary cancer care.

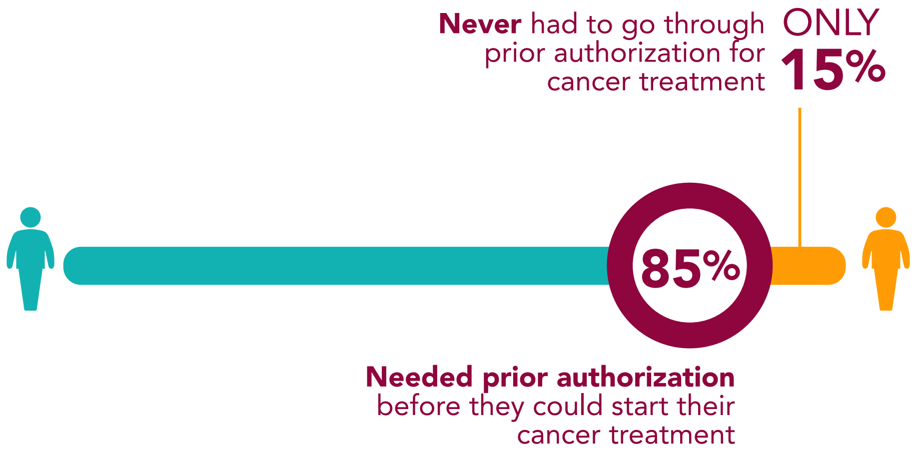
> ***Delays while waiting for approval can interrupt timely access to care and potentially lead to worse health outcomes.***

Lifetime Experience of Prior Authorization

Across all diagnostic and surveillance procedures, active treatments, and supportive medications for symptom management, **85% of respondents** reported undergoing prior authorization for at least one type of cancer treatment in their lifetime.

FIGURE 3

Lifetime Experience of Prior Authorization



Question: *Did any treatments, procedures, tests, or medications for your cancer ever need insurance approval before you could start it? (Response options: Yes, needed insurance approval in the past 12 months; Yes, needed insurance approval more than 12 months ago; No, did not need insurance approval; Don't Know. List of treatments: imaging, biomarker testing, IV chemotherapy, oral chemotherapy, targeted therapy, immunotherapy, radiation therapy, hormonal therapy, stem cell transplant, and/or supportive medications.)*

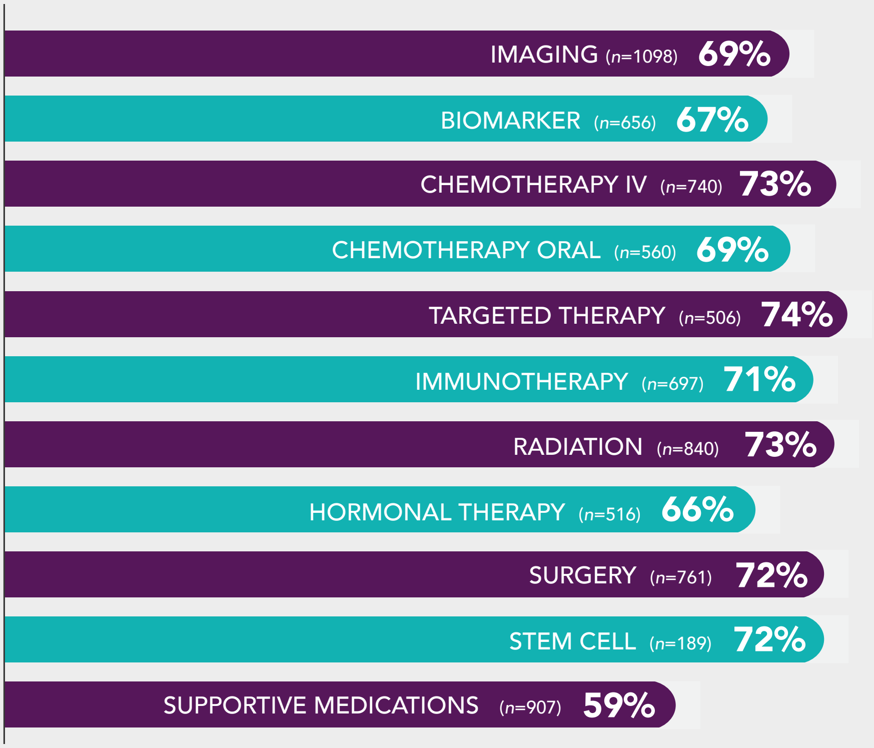
Percentage calculated out of *n*=1201 respondents who responded Yes (needed insurance approval in past 12 months OR more than 12 months ago) for one or more treatment types.

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Prior authorizations were common across all cancer treatment types received, especially targeted therapy (required for 74% of those receiving targeted therapy), IV chemotherapy (73%), radiation therapy (73%), surgery (72%), stem cell therapy (72%), and immunotherapy (71%).

FIGURE 4

Lifetime Experience of Prior Authorization, by Treatment Type



Question: *Did any treatments, procedures, tests, or medications for your cancer ever need insurance approval before you could start it? (Response options: Yes, needed insurance approval in the past 12 months; Yes, needed insurance approval more than 12 months ago; No, did not need insurance approval; Don't Know.)*

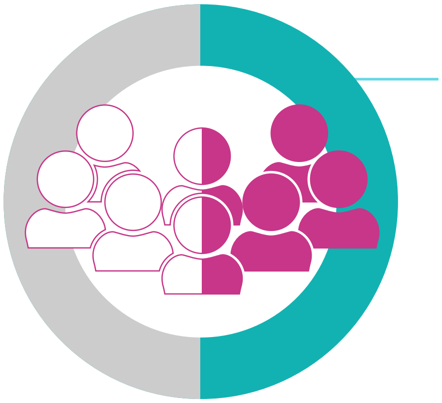
Percentages calculated out of the subsamples of participants who ever had each treatment type (ranging from *n*=189 ever having stem cell therapy to *n*=1098 ever having imaging for their cancer).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Of the 1,020 participants who underwent prior authorization at least once for their cancer treatment, half (50%) had to navigate prior authorization for one or more additional comorbidities while they had cancer, such as high blood pressure, diabetes, and depression. These findings highlight the multiple layers of administrative burden faced by people with cancer.

FIGURE 5

Lifetime Experience of Prior Authorization for Co-Morbid Conditions



50%

who **needed prior authorization** for cancer treatment also needed it for one or more **other medical conditions** while they had cancer

Question: *Did you need insurance approval before getting treatment for any other non-cancer medical condition while you also had cancer? Select all that apply. (Response options: Yes, I needed insurance approval for care related to this; No, I did not need insurance approval for care related to this. List of conditions: anemia or other blood disease, anxiety, back pain, depression, diabetes, heart disease, high blood pressure, kidney disease, liver disease, lung disease, osteoarthritis/ degenerative arthritis, rheumatoid arthritis, ulcer or stomach disease, something else).*

Percentage calculated out of *n*=1020 respondents who experienced prior authorization for cancer and also responded Yes (needed insurance approval in past 12 months) for one or more comorbid conditions.

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

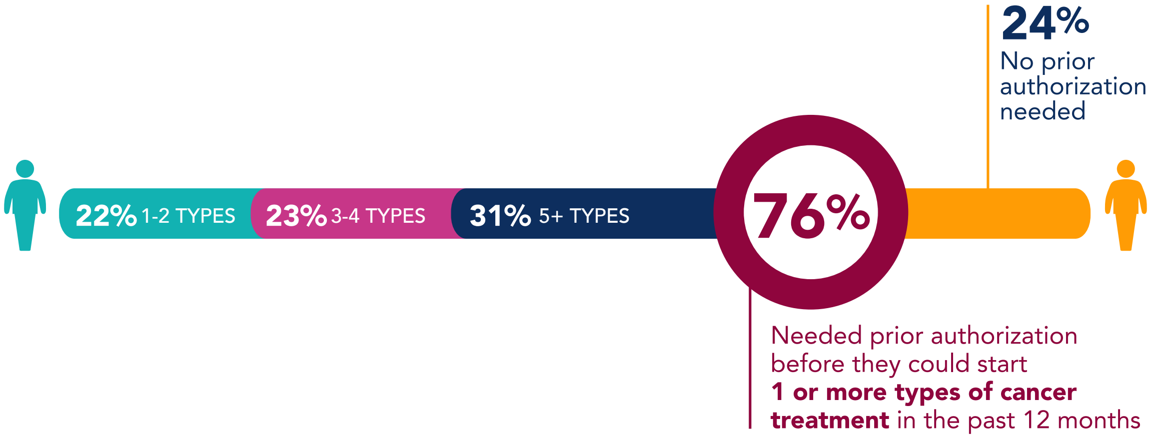
Frequency of Prior Authorization in Past 12 Months

Prior authorization was not only a lifetime problem, but also a current one: 76% of respondents reported undergoing at least one prior authorization for the treatment they received in the past 12 months. Additionally, most respondents experienced prior authorization for multiple types of cancer treatments in that time. Over half of all survey respondents (54%) faced prior authorization for three or more types of treatment in the past 12 months, and nearly one-third (31%) underwent prior authorization for five or more types, ranging from diagnostic to therapeutic procedures (e.g., imaging, biomarker testing, chemotherapy, surgery, supportive medications.)

> ***I have noticed that there is more red tape with these agencies in the past four years.***
>
> *– Employer Plan Respondent*

FIGURE 6

Prior Authorization Required, Past 12 Months



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Percentages calculated out of *n*=1201.

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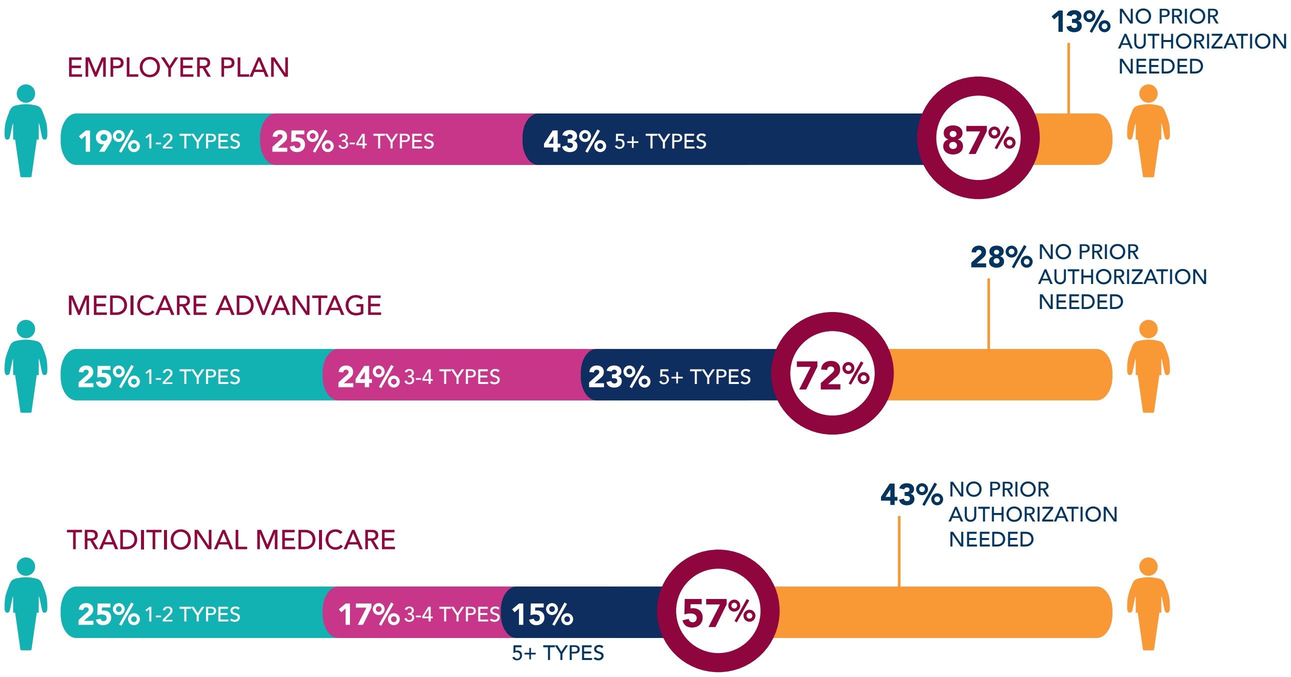
The frequency of prior authorizations in the past 12 months differed significantly by insurance type ($p<.001$): 87% of those with Employer Plans reported at least one prior authorization for cancer treatment, compared to 72% with Medicare Advantage and 57% with Traditional Medicare.

Further, respondents with Employer Plans more often reported that multiple types of treatment required prior authorization: 43% of those with Employer Plans reported that five or more types of cancer treatment required prior authorization in the past 12 months, compared to 23% of those with Medicare Advantage and 15% of those with Traditional Medicare.

FIGURE 7

Needed At Least One Prior Authorization for Cancer Treatment, Past 12 Months, by Insurance Type



Question: Did any treatments, procedures, tests, or medications for your cancer ever need insurance approval before you could start it? (Response options: Yes, needed insurance approval in the past 12 months; Yes, needed insurance approval more than 12 months ago; No, did not need insurance approval; Don't Know. List of treatments: imaging, biomarker testing, IV chemotherapy, oral chemotherapy, targeted therapy, immunotherapy, radiation therapy, hormonal therapy, stem cell transplant, and/or supportive medications.)

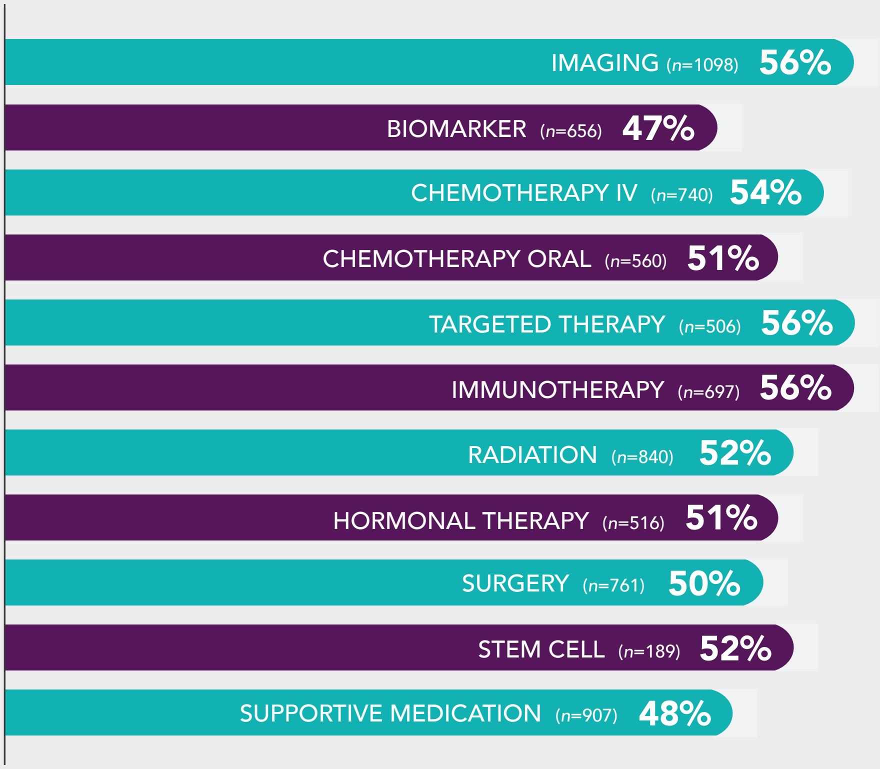
Percentages calculated out of n=569 Employer plan respondents, 408 Medicare Advantage, 224 Traditional Medicare; significant between-group differences ($p<.001$).

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Prior authorizations in the past 12 months were common across all cancer treatment types received, most frequently for imaging (56%), targeted therapy (56%), immunotherapy (56%), and IV chemotherapy (54%).

FIGURE 8

Prior Authorization for Cancer Treatments Received, Past 12 Months, by Treatment Type



Question: Did any treatments, procedures, tests, or medications for your cancer ever need insurance approval before you could start it? (Response options: Yes, needed insurance approval in the past 12 months; Yes, needed insurance approval more than 12 months ago; No, did not need insurance approval; Don't Know.)

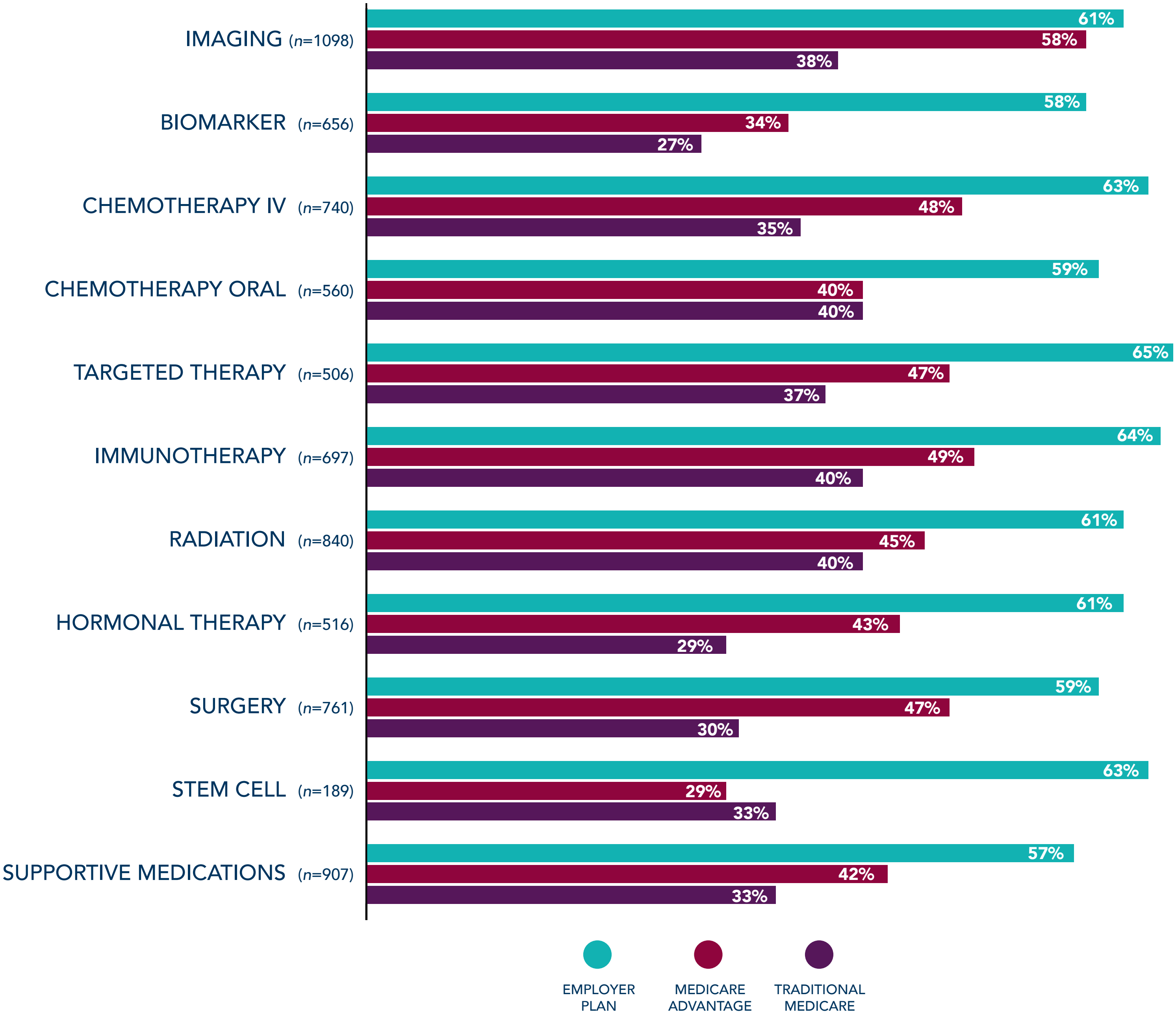
Percentages calculated out of the subsamples of participants who ever had each treatment type (ranging from *n*=189 ever having stem cell therapy to *n*=1098 ever having imaging for their cancer).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Whether respondents faced prior authorization for a particular type of treatment in the past year varied significantly by insurance type (*p*s<.001). Respondents with Employer Plans experienced the highest rate of prior authorization across all treatment types, ranging from 57% for supportive medications to 65% for targeted therapies. In some cases, the prior authorization rates for respondents with Employer Plans were nearly twice as high as those with Traditional Medicare or Medicare Advantage.

FIGURE 9

Prior Authorization for Cancer Treatments Received, Past 12 Months, by Insurance Type



Question: *Did any treatments, procedures, tests, or medications for your cancer ever need insurance approval before you could start it? If you did need insurance approval before you could start, please select the most recent time period from the options below. (Response options: Yes, needed insurance approval in the past 12 months; Yes, needed insurance approval more than 12 months ago; No, did not need insurance approval; Don't Know)*

Percentages calculated out of the subsamples of participants who ever had each treatment type (ranging from *n*=189 ever having stem cell therapy to *n*=1098 ever having imaging for their cancer). *n*=569 Employer plan respondents, *n*=408 Medicare Advantage, *n*=224 Traditional Medicare; subsample *n*s vary further per treatment type (*n*=15 to 530); significant between-group differences (*p*s<.001).

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Negative Impacts of Prior Authorization

To better understand how respondents navigated and were affected by prior authorization, all respondents who had undergone prior authorization shared details specific to their most recent experience (n=1020).

The following sections describe their experiences with the most recent prior authorization for their cancer care, with the majority occurring in 2023–2024.

Of the respondents, 25% described their experiences with prior authorization for diagnostic/surveillance procedures (imaging, biomarker testing), 35% for cancer medications (IV or oral chemotherapy, targeted therapy, immunotherapy), 32% for other cancer treatments (surgery, radiation therapy, hormonal therapy, stem cell treatment), and 8% for supportive medications.

Prior Authorization Creates Unexpected Burdens and Time Toxicity

While clinicians, advocates, and policymakers may be very aware of prior authorization, many people with cancer do not expect to undergo prior authorization for their treatment.

About 1 in 4 respondents (23%) were unaware of their most recent prior authorization in advance. Respondents with Employer Plans most often knew it was a possibility (79%) compared to those with Traditional Medicare (74%) and Medicare Advantage (70%) (n=1020; p<.05).

> *My doctors know what is best for me. That is their job. I don't believe a third party should be saying what I do or don't need.*
>
> *– Medicare Advantage Respondent*

FIGURE 10

Patient Awareness of Prior Authorization

23%
did not know in advance they might need insurer approval for a treatment

Question: *Did you know in advance that you might need insurance approval for your [treatment]? (Response options: No; Yes, my doctor/healthcare team told me it might happen; Yes, I've had this happen before with my current insurance; Yes, I've had this happen before with my past insurance; Yes, I've heard about this from others (family, friends, in the news); Don't Know.)*

n=1020

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

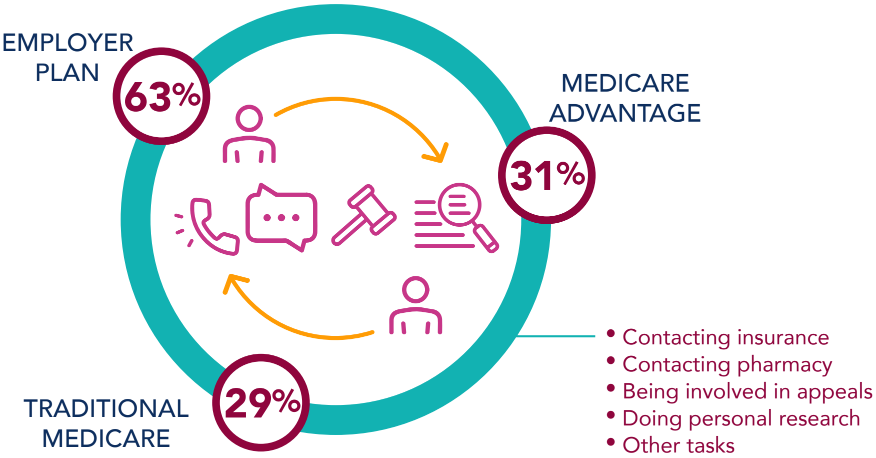
Among those who knew about the possibility of their most recent prior authorization, most said it was because their doctor or healthcare team told them it might happen (61%). Other reasons included having previously experienced prior authorization with their current insurance (18%) and/or with past insurance (6%), or hearing about it from others (5%).

The prior authorization process can also create significant time burdens for patients, their families, and healthcare providers. Reflecting on their most recent prior authorization, about half (49%) of respondents said their cancer care team fully handled the administrative aspects, while another 48% said they or their family got involved directly. This direct involvement differed significantly by insurance type, with 63% of Employer Plan respondents reporting they or their family had to spend time handling the prior authorization compared to 31% of Medicare Advantage and 29% of Traditional Medicare respondents having to get involved ($p<.001$).

> ***It was very hard to get the right person to help me. My [doctor's] office helped a lot. Very scary as they would not start until it was approved.***
>
> *– Employer Plan Respondent*

FIGURE 11

Percent of Patient and Family Involved in Most Recent Prior Authorization, by Insurance Type



Question: *How much time have you/your family spent dealing with insurance approval for [treatment]? This includes contacting your insurance, care team, pharmacy, etc., any appeals you might have made, and any personal research you did. If you are unsure, please make your best guess. (Response options: None, it was handled by my care team; 1-4 hours; 5-8 hours; 9-16 hours; 17-24 hours; 25-40 hours; 41-80 hours; More than 80 hours; Don't Know.)*

n=1020 (525 Employer Plan; 338 Medicare Advantage; 157 Traditional Medicare). Percentages represent those who reported 1 or more hours of involvement.

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

People who dealt directly with their most recent prior authorization (n=485) invested substantial time and effort navigating the process. This included contacting insurance companies, pharmacies, participating in appeals, and doing personal research. Respondents lost considerable time to a single incident of prior authorization: 51% who handled it directly lost up to 8 hours (a full business day), 27% lost 9–24 hours (up to two to three business days), and 12% lost 41–80+ hours (a full business week or more).

> *I had to deal back and forth with the insurance company. Every time you call them, they don't care. Takes forever to talk to a real person and they treat you like a joke.*
>
> *– Employer Plan Respondent*

FIGURE 12

Patient and Family Time Lost to a Single Incident of Prior Authorization

Question: *How much time have you/your family spent dealing with insurance approval for [treatment]? This includes contacting your insurance, care team, pharmacy, etc., any appeals you might have made, and any personal research you did. If you are unsure, please make your best guess. (Response options: None, it was handled by my care team; 1-4 hours; 5-8 hours; 9-16 hours; 17-24 hours; 25-40 hours; 41-80 hours; More than 80 hours; Don't Know.)*

n=485 respondents who dealt with prior authorization directly (excludes respondents who said it was handled by their care team or didn't know).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Prior Authorization Denials and Appeals Add to Red Tape

While prior authorization is intended to be efficient, in practice, insurers frequently take a considerable amount of time just to make an initial decision.

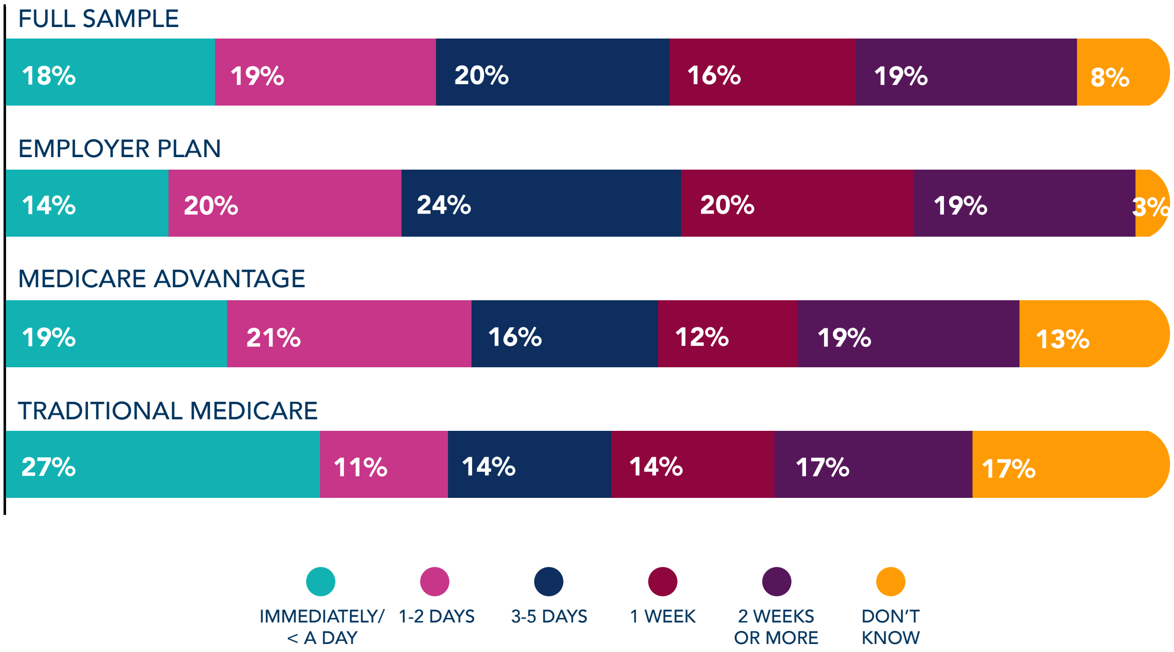
For their most recent prior authorization, just over half of respondents (57%) received an initial decision in less than one week, 16% had to wait a week, and nearly one in five (19%) waited two weeks or more. Decision response times differed significantly by insurance type, with respondents with Employer Plans more often reporting longer waits ($p<.001$) compared to those with Medicare Advantage or Traditional Medicare.

Despite delays, insurers overwhelmingly approved initial prior authorization requests: 89% of the full sample, 89% of those with Employer Plans, 90% of those with Medicare Advantage, and 86% of those with Traditional Medicare.

> *The doctor predicted it was going to be rejected the first time around.*
>
> *– Employer Plan Respondent*

FIGURE 13

Length of Time for Insurance to Approve or Deny Initial Prior Authorization Request



Question: *How long did it take the insurance to first say whether they approved or denied your [treatment], before any appeals? (Response options: Immediately/less than a day; 1-2 days; 3-5 days; 1 week; 2 weeks; 3-4 weeks; More than 4 weeks; Don't Know.)*

n=1020 for full sample (525 Employer Plan; 338 Medicare Advantage; 157 Traditional Medicare); significant between-group differences (*p*<.001).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

While most requests were approved, one in ten respondents experienced a denial of their initial prior authorization request. Respondents with Medicare Advantage reported fewer care denials (7%) compared to those with Employer Plans (11%) or Traditional Medicare (11%) (*p*<.01).

FIGURE 14

Denial of Initial Prior Authorization Request

Question: *What was your insurance's initial decision about the request for your [treatment], before any appeals? (Response options: My insurance approved the [treatment]; My insurance denied the [treatment] and said I had to try something else first before they would cover it; My insurance denied the [treatment] and said they would not cover it at all; Don't Know.)*

n=1020. Percentage represents the proportion of respondents whose insurance request was denied initially, prior to any appeals.

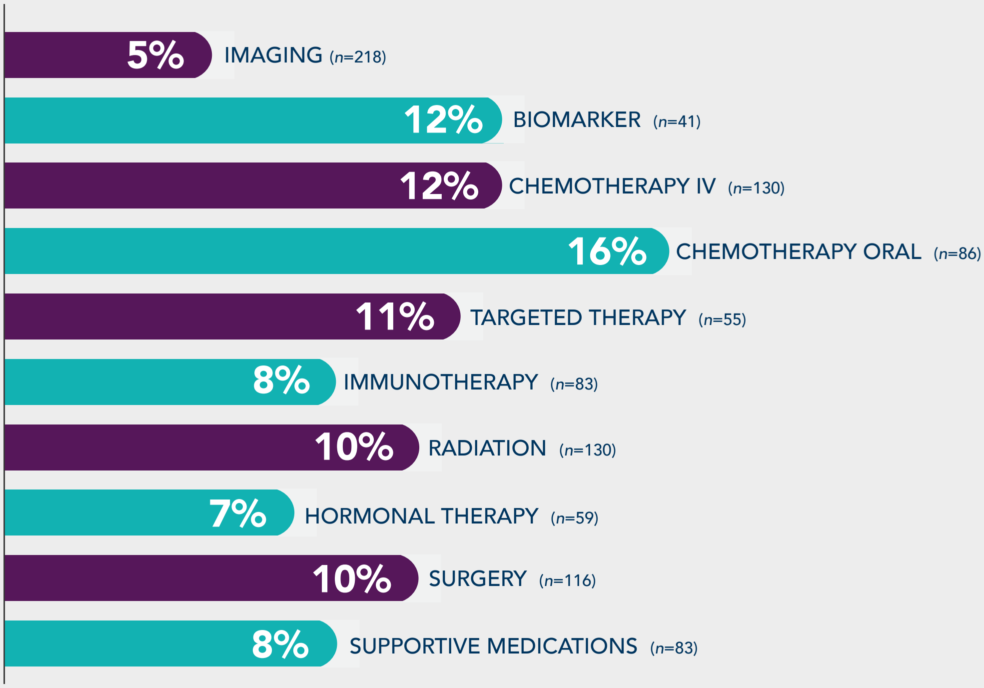
Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Most people reported learning about their denial from their doctor or cancer team (61%) and/or their health insurance (49%), with only a small number notified directly by their pharmacy (6%). About 10% found out because their procedure, treatment, or test was canceled, while 5% were informed when their prescription was canceled.

There was also variability in prior authorization denial rates across different types of cancer care. The highest denial rates were for oral chemotherapy (16%), followed by IV chemotherapy (12%), biomarker testing (12%), and targeted therapy (11%), while the lowest denial rate was for cancer-related imaging (5%).

FIGURE 15

Denial of Initial Prior Authorization Request, by Treatment Type



Question: *What was your insurance's initial decision about the request for your [treatment], before any appeals? (Response options: My insurance approved the [treatment]; My insurance denied the [treatment] and said I had to try something else first before they would cover it; My insurance denied the [treatment] and said they would not cover it at all; Don't Know.)*

Subsample *n*s vary by treatment type, ranging from *n*=41 for biomarker testing to *n*=218 imaging. Percentages represent the proportion of respondents whose insurance request was denied initially, prior to any appeals. Stem cell treatment excluded due to small sample size.

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

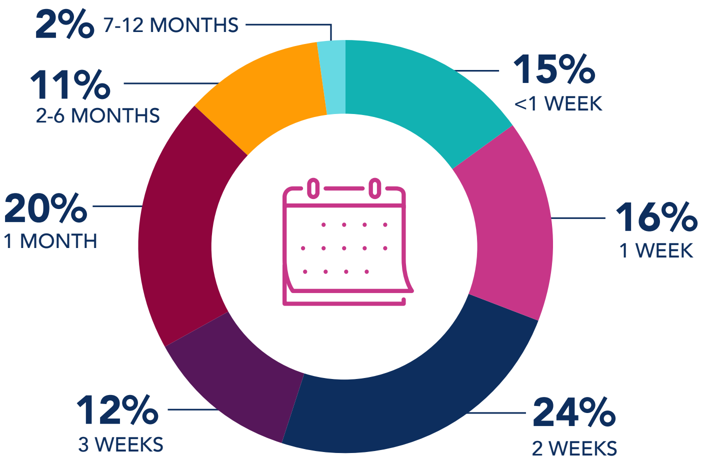
Following the denial of their most recent prior authorization request, 88% of the 98 affected respondents appealed the decision. Of these, 55% appealed once, 29% appealed twice, and 13% appealed three or more times. In many cases, their doctor led the appeal (57%), while 17% of patients and their families led the effort, and 26% took a combined approach.

Nearly three out of four appeals eventually resulted in a decision reversal (72%), and 73% said the insurer fast-tracked the appeal due to the life-threatening nature of their cancer. Still, many respondents faced long waits for treatment because of the prior authorization process. Among those who appealed, one in three (33%) reported the entire approval process, including appeals, took one month or more.

> “*It was unfortunate being denied initially for a potentially life-saving treatment.*”
>
> *– Employer Plan Respondent*

FIGURE 16

Total Time Elapsed Until Final Prior Authorization Decision Among Patients Who Appealed



Question: *How long did the insurance approval process take in total, including waiting to hear back about any appeals? If you are still in the appeal process, choose how much time it has taken so far. (Response options: Less than 1 week; 1 week; 2 weeks; 3 weeks; 1 month; 2-3 months; 4-6 months; 7-12 months; More than 12 months; Don't Know.)*

n=86 respondents who reported appealing their insurance's initial decision to deny coverage

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Other respondents were not able to overturn the prior authorization barrier. Specifically, 21% of those who appealed were told by their insurance provider that they must try another type of care first before coverage would be provided, while 5% reported that their insurance provider upheld the denial because it did not cover the prescribed type of care at all.

> ***I want you to know the wait was very long and it was scary.***
>
> *– Employer Plan Respondent*

Prior Authorization Leads to Delays in Cancer Diagnosis and Treatment

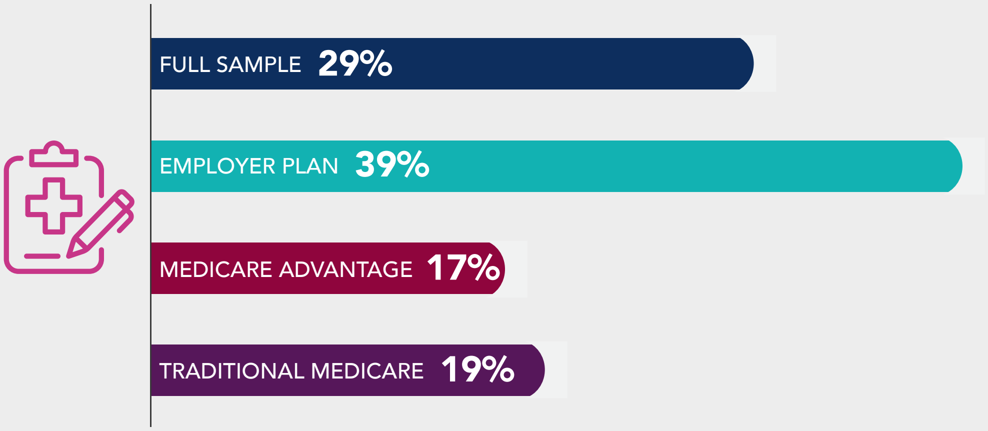
The process of prior authorization itself, regardless of eventual approval, often caused unncessary delays in diagnosis and treatment. Among the 1,020 respondents who experienced prior authorization, 95% ultimately had their most recent request approved—89% after initial review and 6% after appeals—yet delays still frequently occurred, even when the initial request was approved.

Nearly three in ten (29%) respondents reported that their cancer diagnosis was delayed due to their most recent prior authorization. Respondents with Employer Plans (39%) more often reported diagnostic delays compared to those with Medicare Advantage (17%) or Traditional Medicare (19%) (p<.001).

In terms of delay length, 20% of respondents with diagnostic delays reported a delay of two weeks due to prior authorization, while 21% reported a delay of three weeks to a month or more.

> *[I]t delayed things quite a bit to say the least. I should have had multiple things done months before the insurance finally agreed to cover it all for me. It was an absolute nightmare to go through.*
>
> *– Medicare Advantage Respondent*

FIGURE 17
Cancer Diagnosis Delayed Due to Prior Authorization

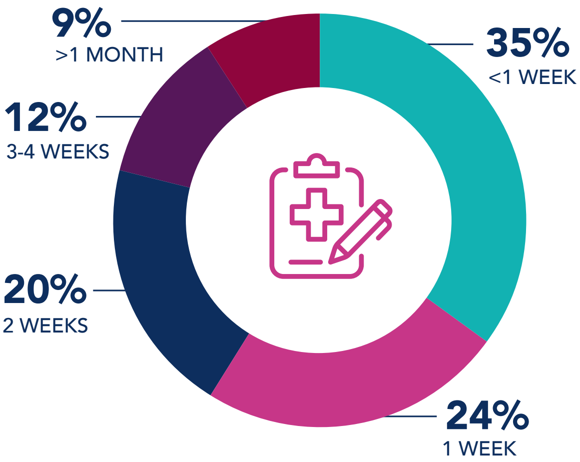


Question: *Did going through insurance approval for your [treatment] delay your final cancer diagnosis? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=1020 for full sample (525 Employer Plan; 338 Medicare Advantage; 157 Traditional Medicare); significant between-group differences (*p*<.001). Percentages represent the proportion of respondents who selected "Yes" their diagnosis was delayed.

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

FIGURE 18
Length of Delayed Diagnosis Due to Prior Authorization



Question: *Did going through insurance approval for your [treatment] delay your final cancer diagnosis? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=293 respondents who indicated "Yes" their cancer diagnosis was delayed due to insurance approval process

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

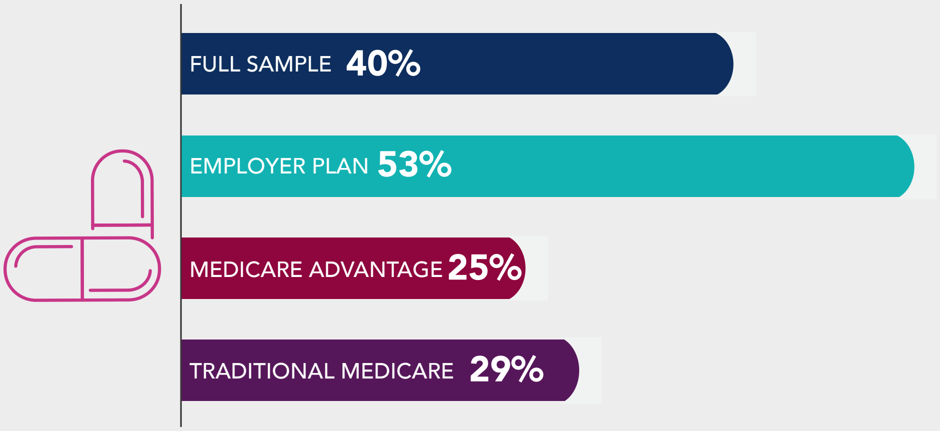
In addition to diagnostic delays, prior authorization also delayed the start of cancer treatment for 40% of respondents. These delays were more frequent among those with Employer Plans (53%) compared to those with Medicare Advantage (25%) or Traditional Medicare (29%) (*p*<.001).

Among the 407 respondents who reported a delay in their cancer treatment due to prior authorization, 21% experienced a delay of two weeks, while 22% faced delays ranging from three weeks to more than a month.

Of note, one in four (24%) of respondents who underwent prior authorization said they started their treatment before their insurance provider finalized its decision.

FIGURE 19

Cancer Treatment Delayed Due to Prior Authorization



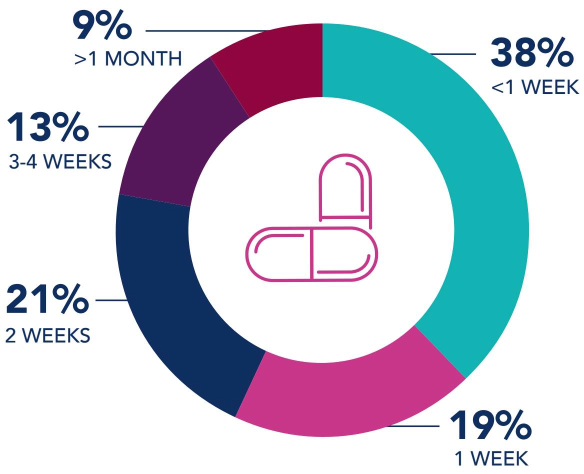
Question: *Did going through insurance approval for your [treatment] delay your cancer treatment? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=1020 for full sample (525 Employer Plan; 338 Medicare Advantage; 157 Traditional Medicare); significant between-group differences (*p*<.001). Percentages represent the proportion of respondents who selected "Yes" their treatment was delayed.

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

FIGURE 20

Length of Delayed Treatment Due to Prior Authorization



Question: *Did going through insurance approval for your [treatment] delay your cancer treatment? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=407 respondents who indicated "Yes" their cancer treatment was delayed due to insurance approval process

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> ***I think, if a person has for sure been diagnosed, insurance companies should take that as a sign that whatever treatment is needed, shouldn't have a prior authorization. Waiting any amount of time could be fatal.***
>
> *– Employer Plan Respondent*

Collectively, the data suggest that prior authorization creates unnecessary burdens and harmful care delays before patients can receive doctor-prescribed care. Delays in diagnosis can lead to more advanced disease, while delays in treatment can impede effective care, resulting in worse outcomes, including disease progression and even earlier death.

Given that the vast majority (95%) of prior authorizations were ultimately approved, either initially or through appeal, their widespread use appears overly broad and inefficient in the context of cancer care.

Unfortunately, for many people with cancer, prior authorization is just the first UM barrier to receiving and maintaining treatment. After clearing this hurdle, there is the risk of insurance stopping coverage for their ongoing care.

> ***I am so angry with this insurance company... I feel my cancer spread more because it took six months to get my referrals approved... I take it day by day and hope that I will be a survivor of this cancer. I'm not ready to leave my family.***
>
> *– Employer Plan Respondent*

When Insurance Stops Covering Cancer Treatment

> *"Cancer is very serious. Just stopping someone in the middle of treatment is wrong."*
>
> *– Traditional Medicare Respondent*

After treatment starts, people with cancer may face coverage stoppage during treatment, a UM strategy where insurance stops covering an existing treatment. While there are various reasons for implementing coverage stoppage, examples include new exclusions to the plan formulary or changes in the insurer's criteria for determining the medical necessity of certain treatments.

Every survey respondent was asked if their insurance had ever stopped covering a treatment they were already receiving, including cancer medications (IV and oral chemotherapies, targeted therapy, immunotherapy), hormonal therapy, and supportive care medications. We then confirmed that any coverage stoppages were due to an insurance provider's decision and not actions by the respondent, such as changing insurance plans or providers.

> ***We then confirmed that any coverage stoppages were due to an insurance provider's decision and not actions by the respondent.***

Lifetime Experience of Treatment Coverage Stoppage

Nearly one in five (18%) of all respondents reported that their insurance stopped covering one or more cancer treatments they were receiving at some point in their cancer care (*n*=1201).

The rate of insurance-driven coverage stoppages over a patient's lifetime varied across treatment types, ranging from 15% for IV chemotherapy, immunotherapy, and supportive medications to 20% for targeted therapy.

FIGURE 21

Lifetime Experience of Insurance Stopping Coverage for Cancer Treatment

nearly **1 in 5** said their insurance stopped covering ongoing treatment at some point in their cancer care

Question: *Did your insurance ever start and later stop covering (paying for) any of these treatments or medications for your cancer while you were getting that treatment? If so, please select the most recent time period they stopped coverage from the options below. (Response options: Yes, in the past 12 months, my insurance stopped covering it while I was getting it; Yes, more than 12 months ago, my insurance stopped covering it while I was getting it; No; Don't Know.)*

Question asked for each treatment type received: IV chemotherapy, oral chemotherapy, targeted therapy, immunotherapy, hormonal therapy, and/or supportive therapy.

Percentage calculated out of *n*=1201 respondents and represents the proportion who responded Yes (insurance stopped covering my treatment in past 12 months OR more than 12 months ago) for one or more treatment types.

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

FIGURE 22

Lifetime Experience of Insurance Stopping Coverage for Cancer Treatment, by Treatment Type

Question: *Did your insurance ever start and later stop covering (paying for) any of these treatments or medications for your cancer while you were getting that treatment? If so, please select the most recent time period they stopped coverage from the options below. (Response options: Yes, in the past 12 months, my insurance stopped covering it while I was getting it; Yes, more than 12 months ago, my insurance stopped covering it while I was getting it; No; Don't Know.)*

Percentages represent the proportion of respondents that responded "Yes in the past 12 months, my insurance stopped covering it while I was getting it" for one or more treatment types or "Yes, more than 12 months ago, my insurance stopped covering it while I was getting it."

Percentages were calculated based on the total number of respondents ever having received each treatment type, and ranged from *n*=506 (targeted therapy) to *n*=907 (supportive medications).

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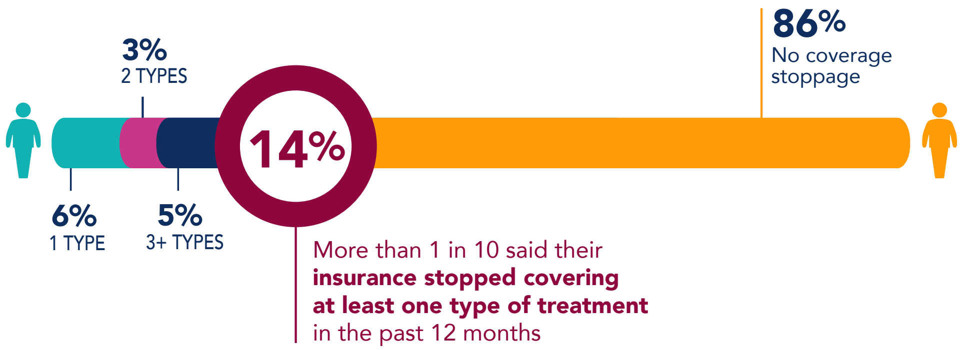
Frequency of Coverage Stoppage in Past 12 Months

Coverage stoppages were not just a lifetime problem for respondents—they were also a recent concern. In the past 12 months alone, more than one in ten respondents (14%) reported that their insurance had stopped covering their existing cancer treatment. Additionally, 8% said their insurance had stopped covering more than one type of treatment during that time.

> ***They stopped coverage for my medication due to the cost.***
>
> *– Medicare Advantage Respondent*

FIGURE 23

Insurance Stopped Coverage for Cancer Treatment, Past 12 Months



More than 1 in 10 said their **insurance stopped covering at least one type of treatment** in the past 12 months

Question: *Did your insurance ever start and later stop covering (paying for) any of these treatments or medications for your cancer while you were getting that treatment? If so, please select the most recent time period they stopped coverage from the options below. (Response options: Yes, in the past 12 months, my insurance stopped covering it while I was getting it; Yes, more than 12 months ago, my insurance stopped covering it while I was getting it; No; Don't know.)*

Question asked for each treatment type received: IV chemotherapy, oral chemotherapy, targeted therapy, immunotherapy, hormonal therapy, and/or supportive therapy.

Percentages calculated out of *n*=1201 respondents and represent the proportion who responded Yes (insurance stopped covering my treatment in past 12 months) for one or more treatment types.

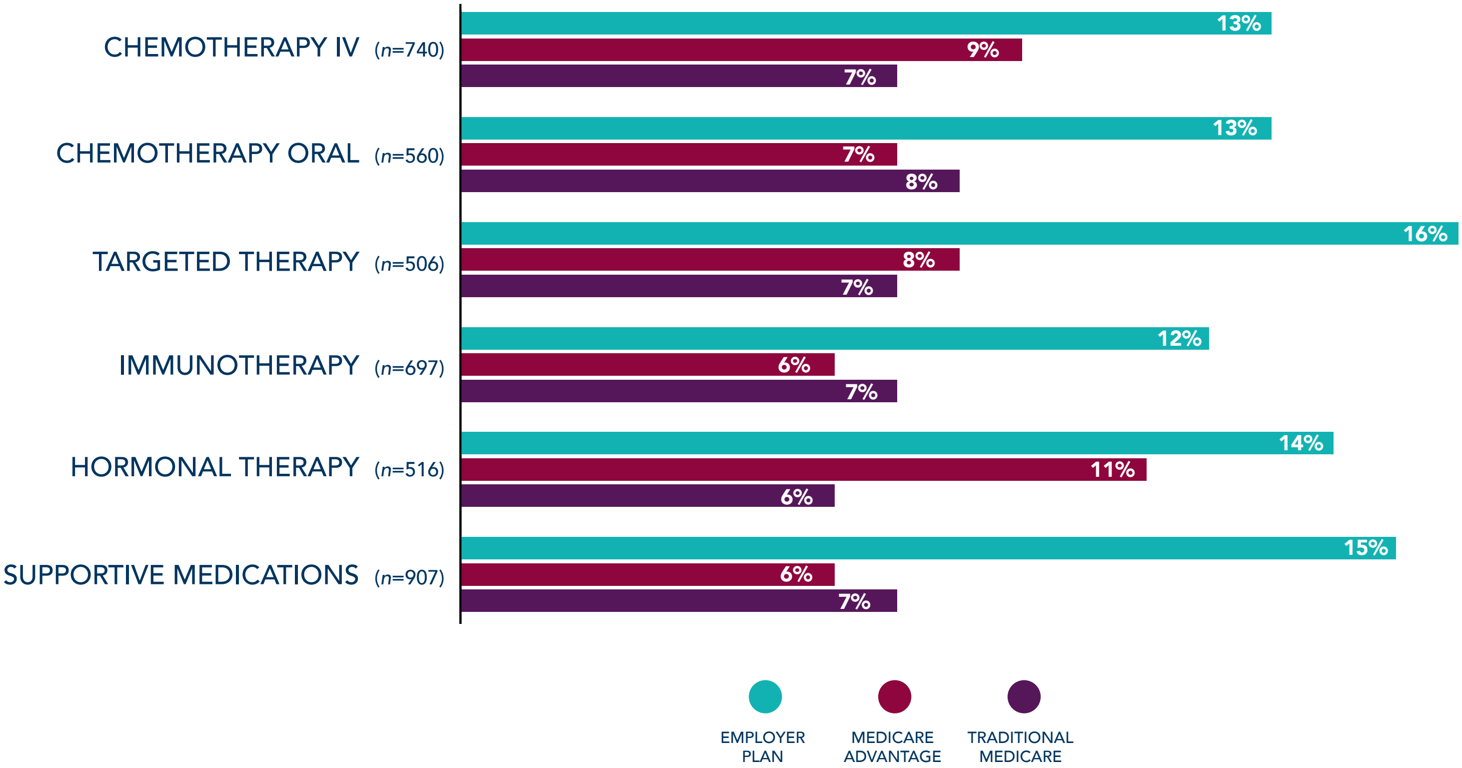
CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

The frequency of coverage stoppages varied significantly by insurance type ($p<.001$): 21% with Employer Plans reported at least one coverage stoppage in the past 12 months, compared to 9% with Medicare Advantage and 8% with Traditional Medicare. Employer Plan respondents also reported higher rates of stoppages for each treatment type (12%–16%) compared to those with Medicare Advantage (6%–11%) or Traditional Medicare (6%–8%) ($ps<.001$).

> ***21% with Employer Plans reported at least one coverage stoppage in the past 12 months, compared to 9% with Medicare Advantage and 8% with Traditional Medicare.***

FIGURE 24

Insurance Stopped Coverage for Cancer Treatment, Past 12 Months, by Treatment Type and Insurance Type



Question: *Did your insurance ever start and later stop covering (paying for) any of these treatments or medications for your cancer while you were getting that treatment? If so, please select the most recent time period they stopped coverage from the options below. (Response Options: Yes, in the past 12 months, my insurance stopped covering it while I was getting it; Yes, more than 12 months ago, my insurance stopped covering it while I was getting it; No; Don't Know.)*

Percentages represent the proportion of respondents that responded "Yes in the past 12 months, my insurance stopped covering it while I was getting it" for one or more treatment types.

Percentages were calculated based on the total number of respondents ever having received each treatment type, and ranged from *n*=506 (targeted therapy) to *n*=907 (supportive medications); significant between-group differences (*ps*<.001)

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

These findings highlight a critical issue: even after securing prior authorization, patients may still face uncertainty about the continuity of their care. Abrupt, insurance-driven coverage changes—such as new formulary exclusions or non-medical switching—can lead to serious consequences, including increased patient burden and costs, care interruptions, and more severe side effects, which collectively can reduce treatment effectiveness.

> ***Just another layer of bureaucracy to increase costs.***
>
> *– Medicare Advantage Respondent*

Impacts of Treatment Coverage Stoppages

Respondents who had insurance stop covering an existing treatment at least once also shared details specific to their most recent experience (*n*=219). The results in the following sections reflect respondents' experiences with their most recent coverage stoppage, the majority of which occurred in 2023–2024.

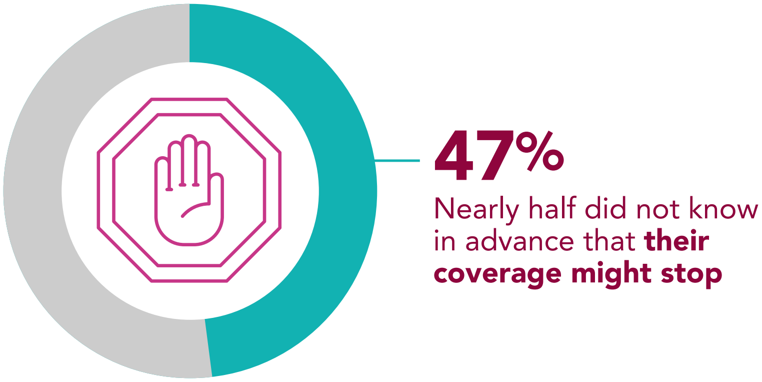
Among these respondents, 64% described recent coverage stoppages for cancer medications (IV or oral chemotherapy, targeted therapy, immunotherapy), 11% for hormonal therapy, and 26% for supportive medications.

Treatment Coverage Stoppages Create Unexpected Burdens and Time Toxicity

Nearly half (47%) of respondents who lost coverage for at least one type of treatment were not aware of this possibility in advance. Others reported that their doctor or care team informed them in advance of the possibility of a coverage stoppage (41%), while 11% knew from prior experience with their current insurance to expect that coverage could stop.

FIGURE 25

Patient Awareness of Possible Treatment Coverage Stoppages



Question: *Did you know in advance that your coverage might stop? (Response options: No; Yes, my doctor/healthcare team told me it might happen; Yes, I've had this happen before with my current insurance; Yes, I've had this happen before with past insurance; Yes, I've heard about this from others (family, friends, in the news); Don't Know.)*

n=219

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

When their treatment was no longer covered, most heard about it from their insurance provider (49%) and/or were told by their care team (47%). Nearly one in five (18%) learned their treatment was no longer covered from their pharmacy, while more that one in ten (12%) had their treatment coverage cancelled without notice at all.

Like prior authorization, coverage stoppages can create time toxicity for people with cancer, their families, and healthcare providers. Among those who experienced a coverage stoppage in the last year, three in four (76%) reported handling the administrative burden directly, while only 20% said their cancer care team fully managed it.

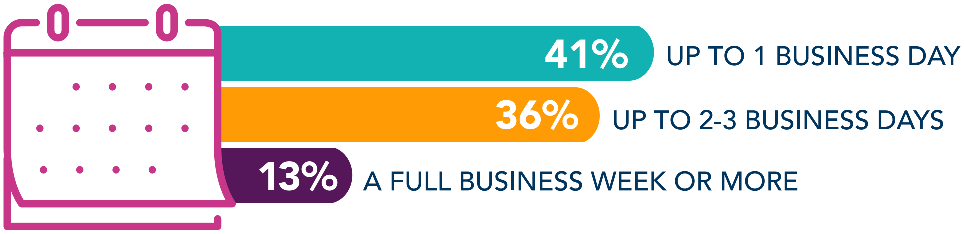
For those who dealt with the stoppage directly (*n*=167), many invested substantial time and effort, including contacting insurance companies and pharmacies, participating in appeals, and conducting personal research.

> ***My insurance made me change my pharmacy to another one so it delayed my drug three weeks.***
>
> *– Traditional Medicare Respondent*

When considering this time as lost productivity, 41% of those dealing directly with coverage stoppages lost up to 8 hours (a full business day), 36% lost 9–24 hours (up to two to three business days), and 13% lost 41–80+ hours (a full business week or more).

FIGURE 26

Patient Time Lost to a Single Incident of Insurance Stopping Coverage



Question: *How much time have you/family spent dealing with the change in insurance coverage for your [treatment]? This includes contacting your insurance, care team, pharmacy, etc., any appeals you might have made, and any personal research you did. If you are unsure, please make your best guess. (Response options: None, it was handled by my care team; 1-4 hours; 5-8 hours; 9-16 hours; 17-24 hours; 25-40 hours; 41-80 hours; More than 80 hours; Don't Know.)*

n=167 respondents who dealt with coverage change directly (excludes respondents who said it was handled by their care team).

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Coverage Stoppage Appeals Add to Red Tape

After insurance stopped covering existing care, 80% (*n*=176) of the affected respondents filed an appeal. Thirty-nine percent appealed once, 42% appealed twice, and 15% had to appeal three or more times. Doctors often made the appeal directly (55%) or in tandem with the respondent and their family (30%), further highlighting the importance of the doctor-patient relationship in complex care situations like cancer.

Most respondents who faced insurance stoppage (73%) said insurers fast-tracked their appeal due to the life-threatening nature of their cancer. For 20%, the appeal process and final decision took a month or more.

Similar to prior authorization findings, insurers ultimately reversed the denial for 72% of all stoppage appeals. Another 20% of respondents faced additional barriers such as step therapy, requiring that they try another type of treatment first before insurance would approve the original one. For some, insurance did not cover the prescribed treatment at all (5%).

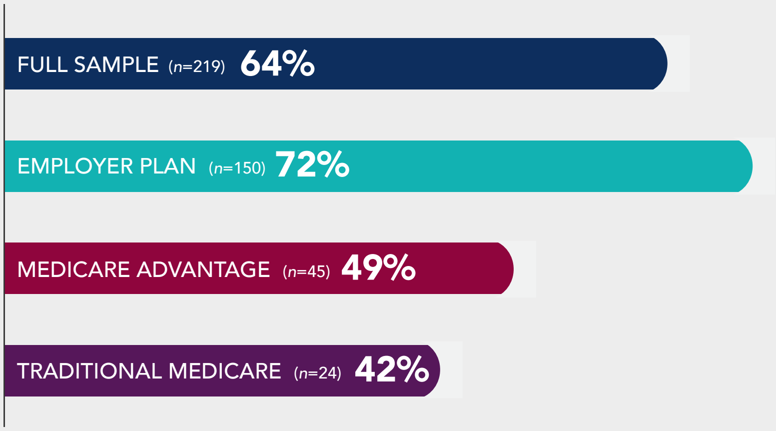
Coverage Stoppages Lead to Interruptions and Delays in Treatment

Two-thirds (64%) of the respondents who experienced coverage stoppage reported treatment interruptions or delays. The frequency of interruptions varied by insurance type: 72% of respondents with Employer Plans reported delays or interruptions to their care, compared to 49% with Medicare Advantage and 42% with Traditional Medicare ($p<.05$).

> ***This is a very difficult process to get authorized through my insurance. Had the nurses not been through it before, it would have taken way longer.***
>
> *– Employer Plan Respondent*

FIGURE 27

Treatment Interrupted Due to Insurance Stopping Coverage



Question: *Did having your insurance stop covering your [treatment] delay/interrupt your cancer treatment? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=219 for full sample (150 Employer Plan; 45 Medicare Advantage; 24 Traditional Medicare); significant between-group differences (*p*<.05). Percentages represent the proportion of respondents who selected "Yes" their treatment was interrupted.

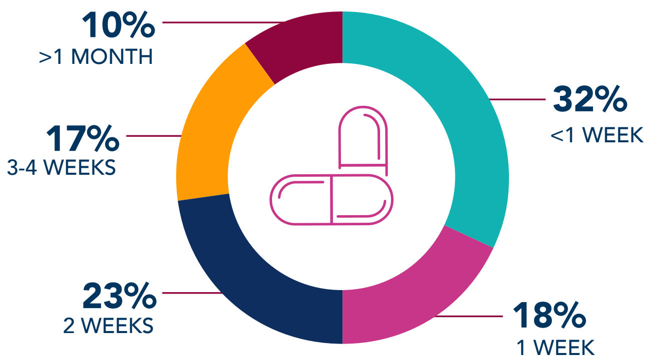
Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Among those who faced treatment interruption due to a coverage stoppage, 23% said the interruption lasted two weeks, while 27% reported an interruption lasting three weeks to more than a month.

Of note, 38% of respondents whose insurance stopped covering their treatment said they started their treatment again before their insurance finalized their decision.

FIGURE 28

Length of Treatment Interruption Due to Insurance Stopping Coverage



Question: *Did having your insurance stop covering your [treatment] delay/interrupt your cancer treatment? (Response options: No; Yes, by less than 1 week; Yes, by 1 week; Yes, by 2 weeks; Yes, by 3-4 weeks; Yes, by more than a month; Yes, by more than 3 months; Yes, by more than 6 months; Don't Know.)*

n=140 respondents who indicated "Yes" their cancer treatment was delayed or interrupted due to insurance stopping coverage.

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> ***When they stopped coverage for my original medication... I had worse side effects than my original medication. I also for some reason had to pay more out-of-pocket for the new treatment.***
>
> *– Employer Plan Respondent*

Coverage Stoppages Affect Side Effects and Patient Costs

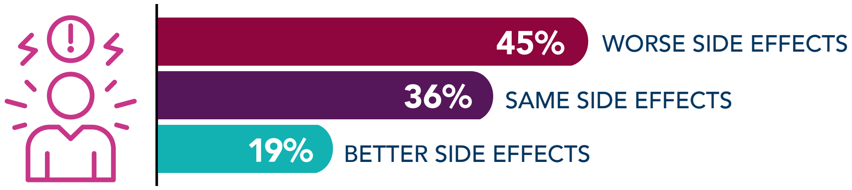
Respondents whose insurance stopped covering their treatment described how switching treatments affected both side effects and out-of-pocket costs.

Nearly half (46%) of those who reported on side effects (*n*=171) said their side effects worsened after switching treatments.

Additionally, over one-third (38%) of respondents who reported on out-of-pocket costs (*n*=175) said their costs increased after switching treatments, while only 14% said it cost them less.

FIGURE 29

Impact on Side Effects Due to Switching Treatment After Insurance Stopped Paying



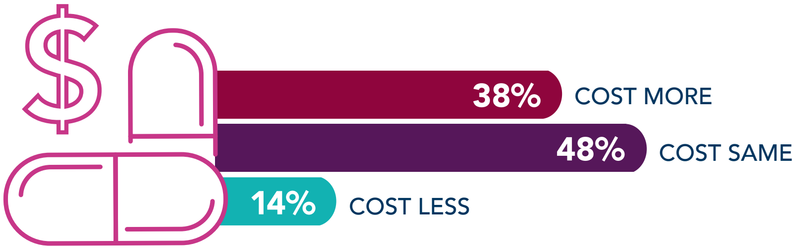
Question: *If you had to switch your [treatment] as a result of insurance no longer covering your original care, how did the side effects compare? (Response options: The new treatment side effects were worse than my original treatment; The new treatment side effects were the same as my original treatment; The new treatment side effects were better than my original treatment; Don't know; Not applicable (I did not have to switch).)*

n=171 (excluded those who replied "Don't know" or "Not applicable").

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

FIGURE 30

Impact on Out-of-Pocket Cost Due to Switching Treatment After Insurance Stopped Paying



Question: *If you had to switch your [treatment] as a result of insurance no longer covering your original care, how did your personal costs compare? (Response options: The new treatment cost me more than my original treatment; The new treatment cost me the same as my original treatment; The new treatment cost me less than my original treatment; Don't know; Not applicable (I did not have to switch).)*

n=175 (excluded those who replied "Don't know" or "Not applicable").

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Losing coverage mid-treatment leads to abrupt disruptions, forcing patients into time-consuming appeals and unplanned transitions in care. These changes add significant uncertainty into cancer treatment. For some, this resulted in worse side effects and higher costs. These added burdens compound the emotional and financial stress of a cancer diagnosis by creating even more red tape between patients and the treatments they need.

Real-World Impacts of Insurance Problems on Patients

> *“Essential treatments were delayed, I went into debt and had to use money saved for my child’s college fund for treatment. My stress level contributed to slow recovery during intensive treatment. The insurance company made the entire process a living hell.”*
>
> *– Employer Plan Respondent*

Navigating the administrative complexities of health insurance can seriously impact patients’ health, well-being, finances, and their relationship with the healthcare system. All 1,201 respondents shared how insurance-related problems directly affected their lives, including any trade-offs they made in their treatment due to financial burdens.

Impacts on Well-Being, Finances, and Trust in the Healthcare System

Respondents rated the extent to which they agreed that problems with their health insurance directly affected their emotional and social well-being, financial well-being, physical health, and relationships within the healthcare system.

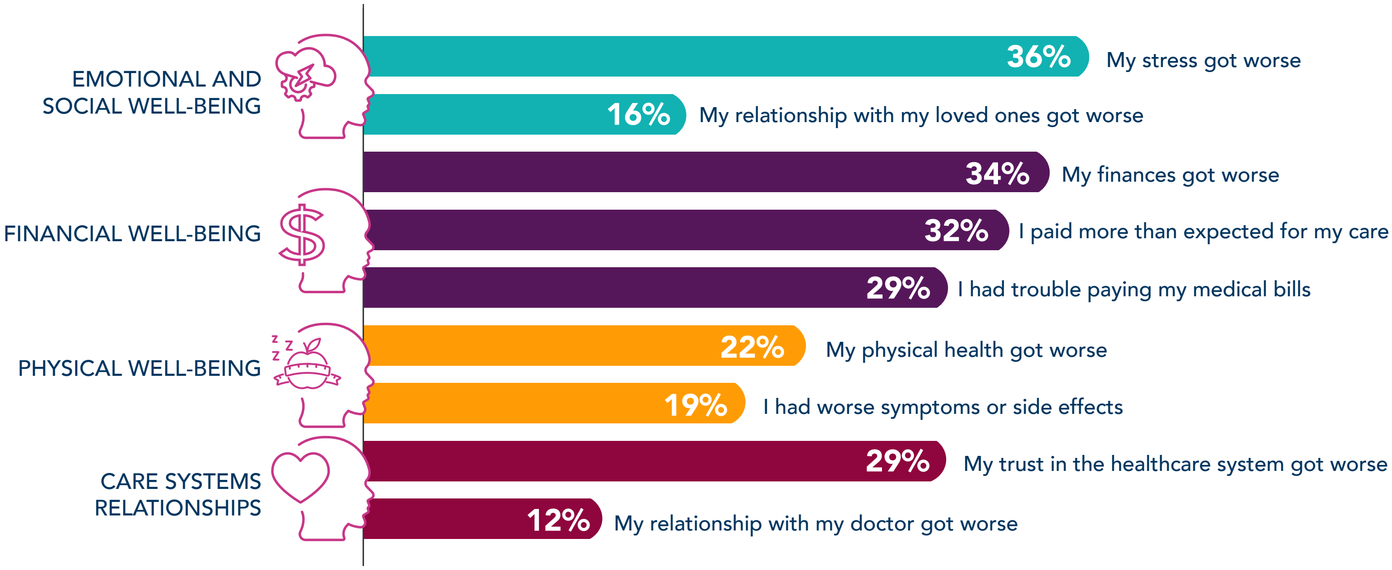
The most reported impact was increased stress, with 36% of all respondents saying their stress levels worsened due to insurance issues. Another 34% said their finances worsened and 22% said their physical health worsened due to insurance-related problems.

Insurance problems also eroded trust and relationships within the healthcare system. 29% of respondents reported a decline in trust in the healthcare system, while 12% said their relationship with their doctor worsened.

> *“I have become mistrusting of everything and everybody. All I get is the runaround...”*
>
> *– Medicare Advantage Respondent*

FIGURE 31

Direct Impacts of Insurance Problems on Patient Well-Being



Question: *Next, we would like to understand how problems with health insurance have affected your life. Please rate how much you agree or disagree with the following statements. "[X happened] as a direct result of problems with my health insurance." (Response options: Strongly disagree; Disagree; Neither agree nor disagree; Agree; Strongly agree.)*

n=1201; percentages represent the proportion of respondents that "Agree" or "Strongly agree" with each statement.

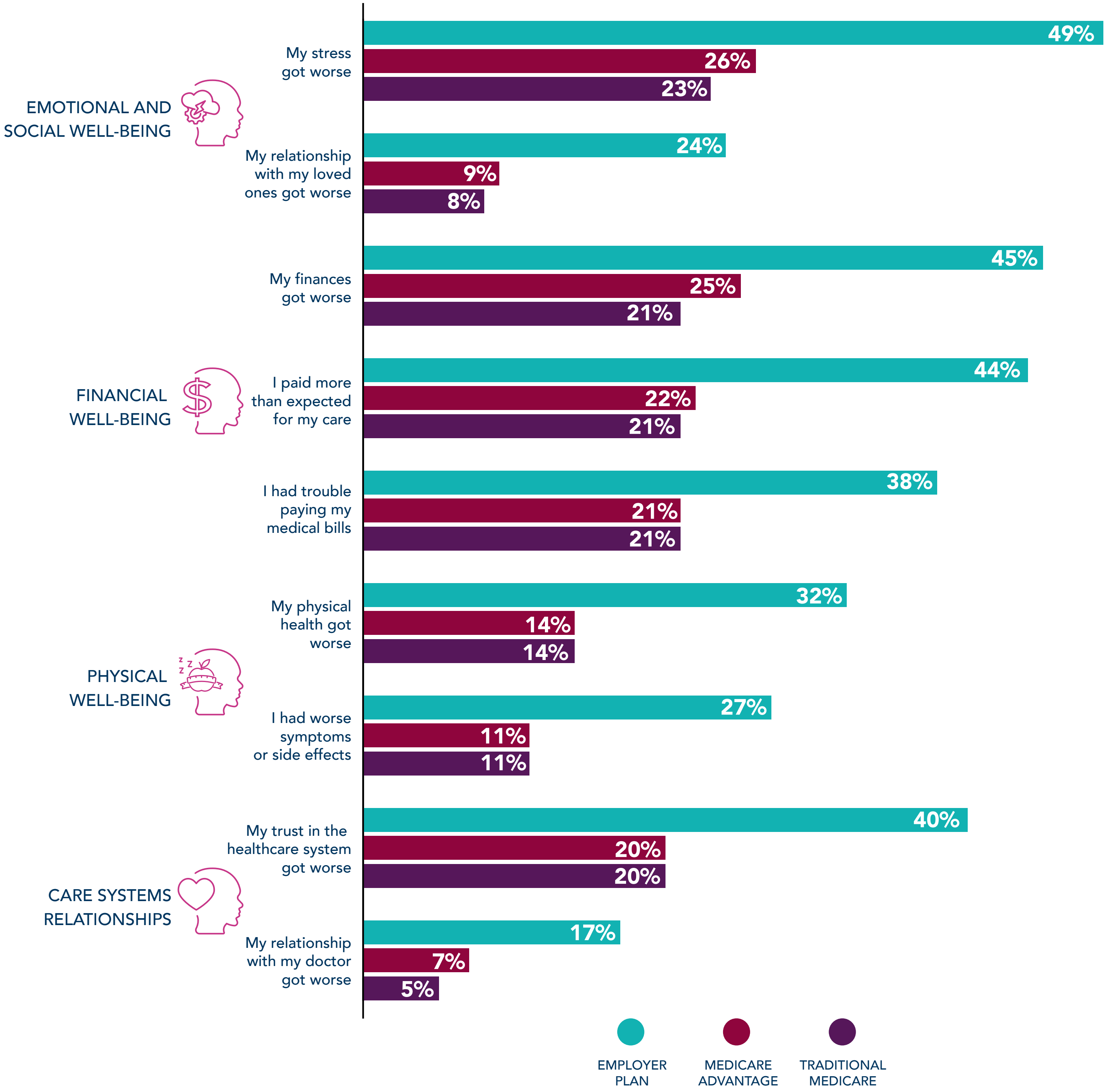
Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> ***I became stressed and depressed that my insurance wouldn't cover my treatments.***
>
> *– Employer Plan Respondent*

Notably, there were statistically significant differences across each item when examining the impacts of insurance problems by insurance type (*p*s<.001). Respondents with Employer Plans consistently reported higher rates of negative impacts on well-being (17–49%) compared to those with Medicare Advantage (7–26%) or Traditional Medicare (5–23%). In particular, the rates of stress, financial burden, and diminished trust in the healthcare system were nearly twice as high among Employer Plan enrollees compared to those with Medicare Advantage or Traditional Medicare.

FIGURE 32

Direct Impacts of Insurance Problems on Patient Well-Being, by Insurance Type



Question: *Next, we would like to understand how problems with health insurance have affected your life. Please rate how much you agree or disagree with the following statements. (Response options: Strongly disagree; Disagree; Neither agree nor disagree; Agree; Strongly agree.)*

n=569 Employer Plan, 408 Medicare Advantage, 224 Traditional Medicare; percentages represent the proportion of respondents that "Agree" or "Strongly agree" with each statement; between-group analysis confirmed statistically significant differences by insurance type for all items (*p*s<.001).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

These findings highlight the disproportional impacts that insurance-related problems place on people with cancer. The added strain of unexpected coverage losses, rising out-of-pocket costs, and eroded trust in the broader healthcare system compounds an already overwhelming experience.

While future research will explore how insurance barriers intersect with other personal and social determinants of health, these findings already signal an urgent need for systemic reforms. Policies that limit mid-treatment coverage changes, improve transparency in formularies, and protect patients from non-medical switching or arbitrary denials could significantly reduce harm. Ultimately, patients should be able to focus on healing, not on managing bureaucratic hurdles or fighting for the care they have already been prescribed.

> ***Some people just need help paying for their treatments without going through a whole bunch of mess.***
>
> *– Traditional Medicare Respondent*

Impacts on Out-of-Pocket Costs and Compensatory Trade-Offs

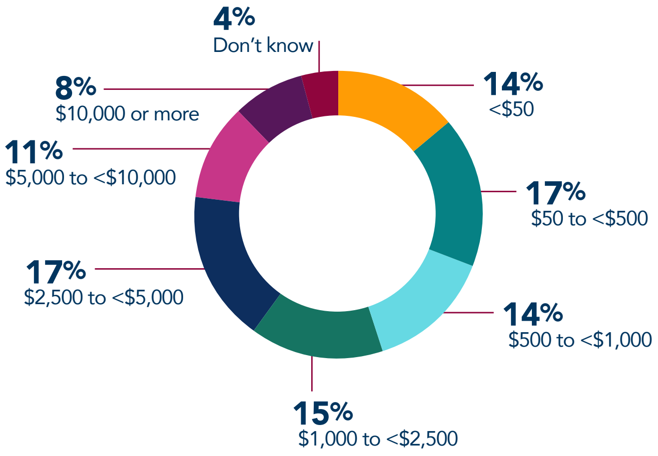
A substantial number of respondents reported that problems with their health insurance directly contributed to financial strain, including unexpected costs and an overall worsening of their financial situation.

All respondents shared their out-of-pocket costs for medical care over the past 12 months—including expenses for prescription drugs, co-payments, deductibles, and medical debt, but excluding health insurance premiums and any amounts covered by insurance.

Respondents experienced a wide range of costs: 31% reported less than $500 in annual out-of-pocket costs; 29% reported $500 to less than $2500; 28% reported $2500 to less than $10,000; and 8% reported $10,000 or more.

FIGURE 33

Total Out-of-Pocket Costs for Medical Care, Past 12 Months



Question: *During the past 12 months, how much did you and your family spend out-of-pocket for your medical care? Include out-of-pocket expenses for prescription drugs, copayments, and deductibles, as well as any medical debt (loans, credit cards) you took on, but do not include health insurance premiums or any costs paid by your health insurance. If you are unsure, try to make your best estimate. (Response options: Less than $50; $50 to less than $500; $500 to less than $1000; $1000 to less than $2500; $2500 to less than $5000; $5000 to less than $10,000; $10,000 to less than $25,000; $25,000 or more; Don't Know.)*

n=1201

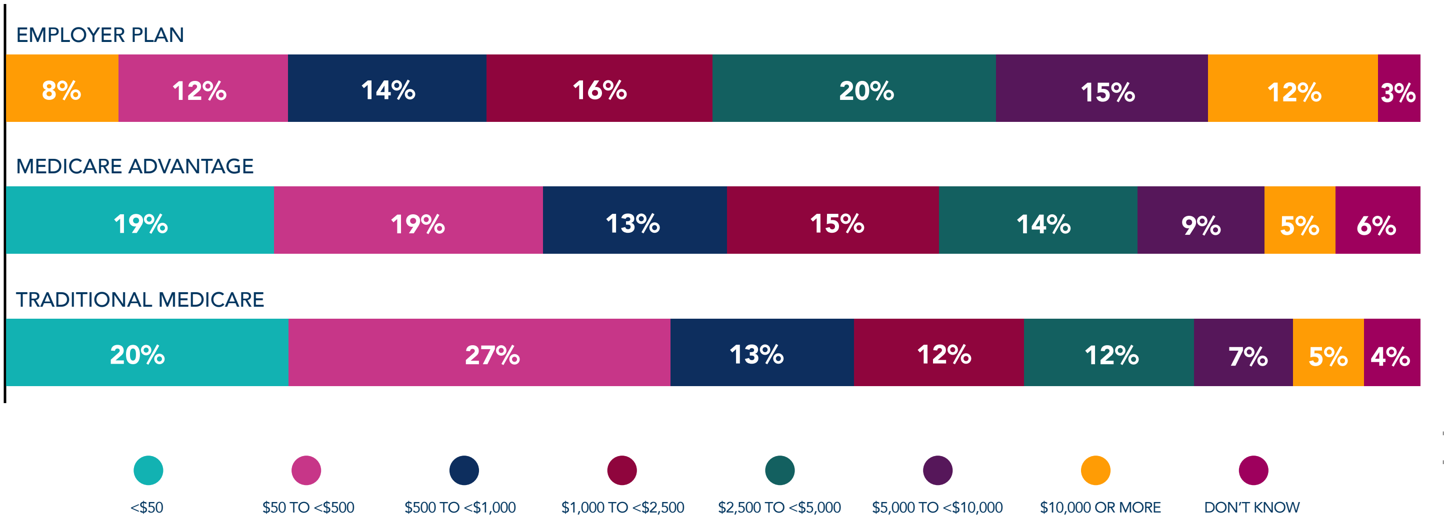
CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> *My savings got wiped out, and now that I'm 66 and want to retire, I can't. I have nothing left to live on. I have to go back to work, and no one wants to hire an old lady.*
>
> *– Medicare Advantage Respondent*

Out-of-pocket costs differed significantly by insurance type (*p*<.001) with those on Employer Plans reporting higher costs than their counterparts. Only 20% of respondents with Employer Plans reported paying less than $500 annually, compared to 38% of those with Medicare Advantage and 47% with Traditional Medicare. In contrast, 47% of Employer Plan respondents reported annual out-of-pocket costs of $2,500 or more, compared to 28% with Medicare Advantage and 24% with Traditional Medicare.

FIGURE 34

Total Out-of-Pocket Costs for Medical Care, Past 12 Months, by Insurance Type



Question: *During the past 12 months, how much did you and your family spend out-of-pocket for your medical care? Include out-of-pocket expenses for prescription drugs, copayments, and deductibles, as well as any medical debt (loans, credit cards) you took on, but do not include health insurance premiums or any costs paid by your health insurance. If you are unsure, try to make your best estimate. (Response options: Less than $50; $50 to less than $500; $500 to less than $1000; $1000 to less than $2500; $2500 to less than $5000; $5000 to less than $10,000; $10,000 to less than $25,000; $25,000 or more; Don't Know.)*

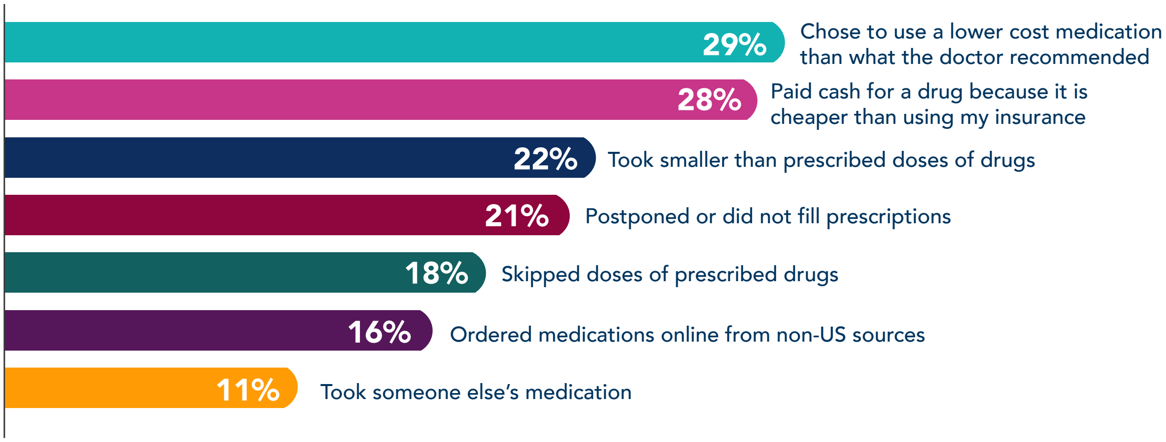
n=569 Employer Plan, 408 Medicare Advantage, 224 Traditional Medicare; between-group analysis confirmed statistically significant differences by insurance type (*p*<.001).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

To reduce expenses associated with their cancer treatment, many people with cancer made trade-offs that could impact their health. Nearly one-third (29%) used a lower-cost medication than what their doctor recommended, 22% took smaller-than-prescribed doses of medications, and 21% delayed or did not fill prescriptions. Additionally, 28% reported paying out-of-pocket (cash) for a drug because it was cheaper than using their insurance.

> *The out-of-pocket cost is adding up faster than I can pay it off. Being on a fixed income and retired makes it difficult to pay off my balance, as it goes up every three months.*
>
> *– Medicare Advantage Respondent*

FIGURE 35
Trade-Offs Made to Offset Costs of Cancer Treatment



Question: *How often do you do each of the following to reduce your expenses related to your cancer treatment? (Response options: Never; Rarely; Sometimes; Often; Always; Don't Know.)*

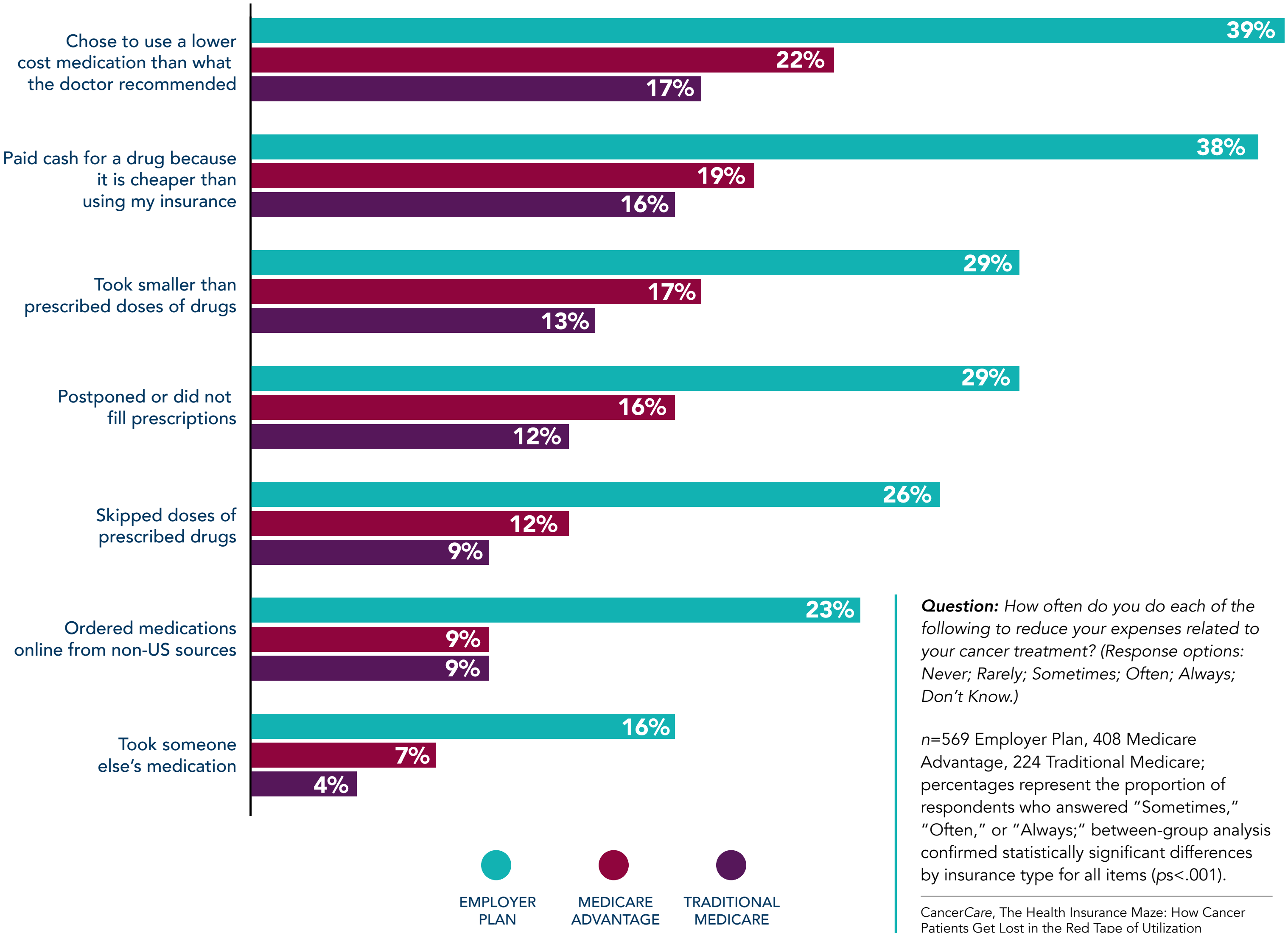
n=1201; percentages represent the proportion of respondents who answered "Sometimes," "Often," or "Always."

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Respondents' cost-related trade-offs also differed by insurance type. Those with Employer Plans most often reported such trade-offs (16–39%), followed by those with Medicare Advantage (7–22%) and Traditional Medicare (4–17%).

FIGURE 36

Trade-Offs Made to Offset Costs of Medications, by Insurance Type



Question: *How often do you do each of the following to reduce your expenses related to your cancer treatment? (Response options: Never; Rarely; Sometimes; Often; Always; Don't Know.)*

n=569 Employer Plan, 408 Medicare Advantage, 224 Traditional Medicare; percentages represent the proportion of respondents who answered "Sometimes," "Often," or "Always;" between-group analysis confirmed statistically significant differences by insurance type for all items (*p*s<.001).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> ***The insurance company didn't seem to understand that this was life-saving medication and insisted that it was optional. The lack of empathy was deeply upsetting.***
>
> *– Traditional Medicare Respondent*

People with cancer are making potentially dangerous trade-offs with treatment because of financial burdens. Respondents with Employer Plans consistently reported the highest rates of trade-offs, highlighting disparities in financial burden and affordability. The data underscore the urgent need for policy and system-level solutions that reduce out-of-pocket costs and ensure that financial concerns do not interfere with access to appropriate, timely cancer care.

Impacts on Satisfaction

Insurance plans with higher out-of-pocket costs, coverage disruptions, and excessive administrative hurdles can lead to greater dissatisfaction among patients.

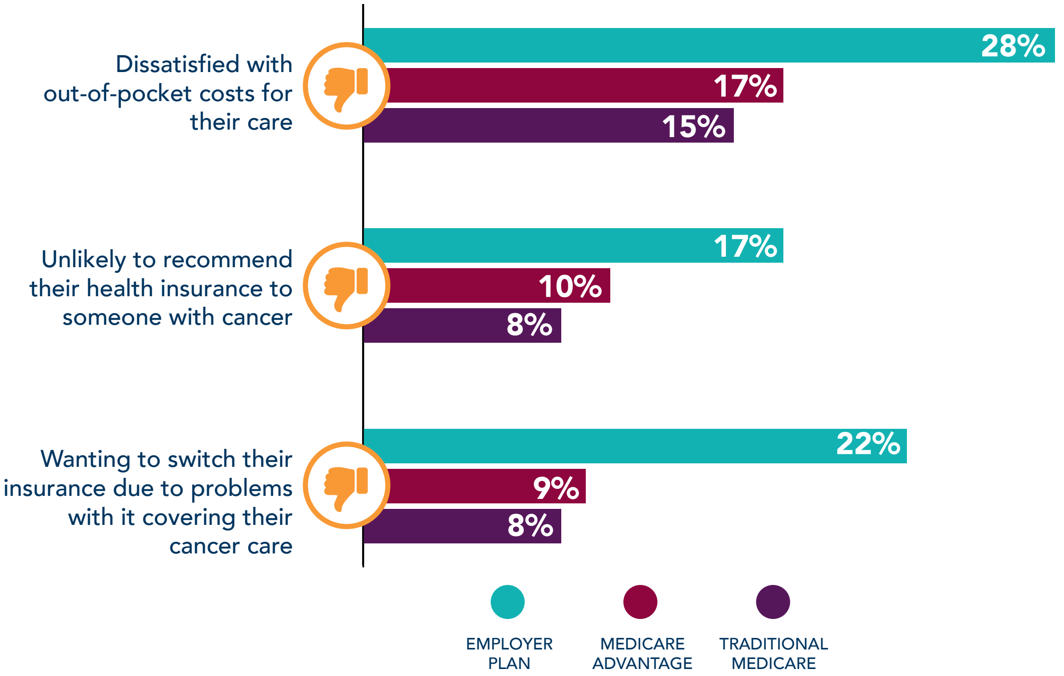
Among respondents, satisfaction with cancer care costs varied significantly by insurance type: 28% of those with Employer Plans were dissatisfied or very dissatisfied with out-of-pocket costs for their care, compared to 17% with Medicare Advantage and 15% with Traditional Medicare (*n*=1,201; *p*<.001).

These satisfaction gaps were reflected among the plans. More Employer Plan respondents (17%) said they were unlikely to recommend their health insurance to someone else with cancer, compared to those with Medicare Advantage (10%) and Traditional Medicare (8%) (*p*<.001).

Further, more than one in five (22%) of Employer Plan respondents said they wanted to switch insurance due to problems with coverage for their cancer care, compared to 9% with Medicare Advantage and 8% with Traditional Medicare.

FIGURE 37

Attitudes about Out-of-Pocket Costs and Insurance Coverage



Question 1: *How satisfied are you overall with the amount you have to pay (your personal out-of-pocket costs) for your cancer care? (Response options: Very dissatisfied, Dissatisfied, Neither satisfied nor dissatisfied, Satisfied, Very satisfied). Responses collapsed to Very Dissatisfied/Dissatisfied.*

Question 2: *How likely are you to recommend your health insurance to someone else with cancer? (Response options: Very unlikely, Unlikely, Neither likely nor unlikely, Likely, Very likely). Responses collapsed to Very unlikely/Unlikely.*

Question 3: *Have you wanted to switch your insurance because of problems with it covering your cancer care? (Response options: No; Yes, I already switched from another plan to my current insurance; Yes, I am in the middle of switching to a different insurance; Yes, I plan to switch my insurance in the next 12 months; Yes, I want to switch my current insurance, but was told I can't change it; Yes, I want to switch my current insurance to traditional Medicare, but was told I won't be able to get prescription drug coverage (Part D); Something else; Don't know.) Responses collapsed to all "Yes" responses except "Yes, I already switched."*

n=1201 (569 Employer Plan; 408 Medicare Advantage; 224 Traditional Medicare); between-group analyses confirmed statistically significant differences by insurance type for separate questions about satisfaction with cost, likelihood of recommending their insurance to someone with cancer, and desire to switch insurance due to problems covering cancer care (*ps*<.001).

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

BARRIERS TO SELF-ADVOCACY:

The Complexity of Health Insurance Plans and Payor Systems

> *"I understand the process and need for prior authorization. I also know that every health insurance carrier's rules are different, and the speed at which approvals get done are different. My concern is that someone's life could be hanging in the balance."*
>
> *– Employer Plan Respondent*

Insurance plans and payor systems are highly complex, and ideally, people with cancer should not be burdened with understanding these administrative intricacies. However, self-advocacy remains an important tool, yet many respondents were uncertain about the details of their coverage. Additionally, behind-the-scenes insurance practices, such as using pharmacy benefit managers (PBMs) and alternative funding programs (AFPs), were often unfamiliar or not well understood.

> ***Self-advocacy remains an important tool, yet many respondents were uncertain about the details of their coverage.***

Confidence in Determining Insurance Coverage for Treatments

Understanding health insurance coverage remains a significant challenge for some people with cancer. About one in four survey respondents (23–25%) reported limited confidence in their ability to figure out their insurance coverage or out-of-pocket costs for healthcare services and prescription medications.

FIGURE 38

Limited Confidence in Figuring out Insurance Coverage

ABOUT **1 in 4**

patients had **limited confidence in their ability** to figure out...

Coverage or costs for **healthcare visits & services** (23-25%)

Coverage or costs for **prescription drugs** (23-25%)

> ***Question:*** *How confident are you that you can do each of the following? (Response options: Not at all confident, A little bit confident, Somewhat confident, Quite a bit confident, Extremely confident. List of items: Figure out whether a service is covered by your plan; Figure out how much a healthcare visit or service will cost you; Figure out which prescription drugs are covered by your plan; Figure out how much you will have to pay for your prescription.)*
>
> *n*=1201; Percentages represent those who selected "Not at all confident" or "A little bit confident."
>
> Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Awareness of Pharmacy Benefit Managers (PBMs)

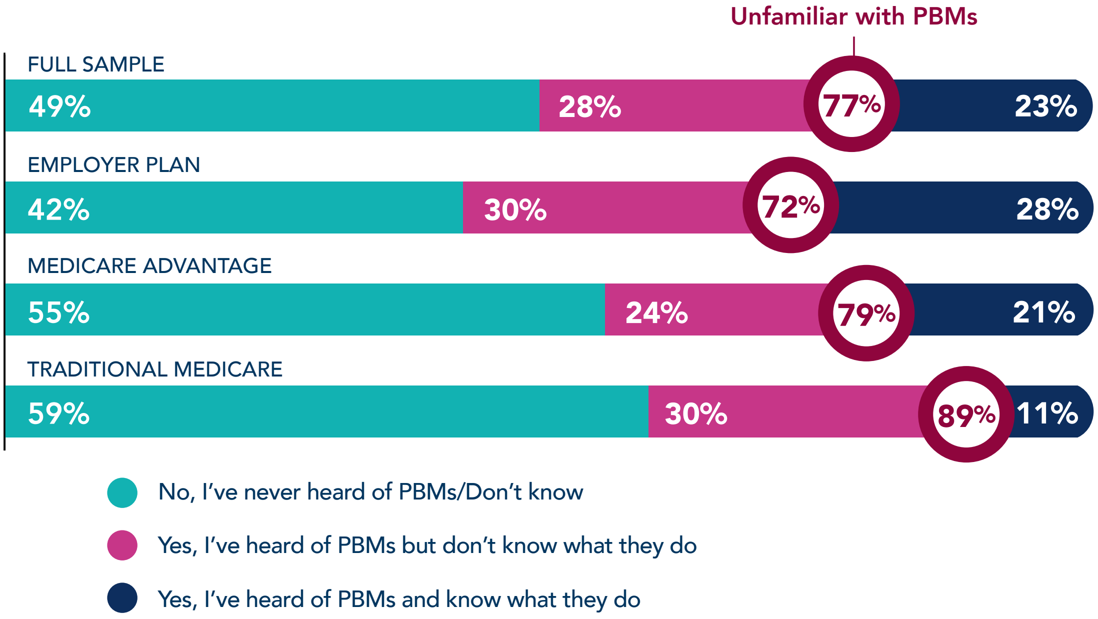
Pharmacy benefit managers (PBMs) play a central role in determining which treatments are covered and how much they cost. PBMs negotiate rates, discounts, and rebates with drug manufacturers; process prescription drug claims; and help determine an insurance plan's drug formulary.

For people with cancer—many of whom rely on high-cost specialty drugs—PBMs can significantly influence access to treatment and out-of-pocket spending. Yet despite the broad influence of PBMs, more than three-fourths of respondents (77%) either did not know what PBMs do or had never heard of them.

A limited awareness of PBMs may leave people with cancer at a disadvantage when trying to understand denials, explore alternative treatment access, or seek financial assistance. These findings underscore the need for clearer education and patient resources to improve insurance literacy and advocacy.

FIGURE 39

Familiarity with Pharmacy Benefit Managers (PBMs), by Insurance Type



Question: *Many insurance plans use something called a pharmacy benefit manager (PBM) to handle prescription drug benefits. Are you familiar with PBMs? (Response options: Yes, I've heard of PBMs and know what they do; Yes, I've heard of PBMs but don't know what they do; No, I've never heard of PBMs.)*

n=1201 for full sample (569 Employer plan, 408 Medicare Advantage, 224 Traditional Medicare); between-group analysis confirmed statistically significant differences by insurance type (*p*<.001).

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

> “*People want the best treatment that they and their doctor decide on, not what makes the most money for the PBM.*
>
> *– Employer Plan Respondent*”

Awareness of Self-Funded vs. Fully-Insured Employer Coverage

For people with cancer who receive insurance through an employer, the type of plan—self-funded or fully-insured—can affect what care and treatments are covered.

Fully-insured employer plans must comply with both state and federal regulations. Fully-insured small group plans are also required to cover the Affordable Care Act's ten essential health benefits, including hospitalization and prescription medications.

In contrast, self-funded employer plans are subject only to federal regulations, most notably the Employee Retirement Income Security Act of 1974 (ERISA). These plans give employers greater flexibility in designing benefits, which can lead to variation in coverage.

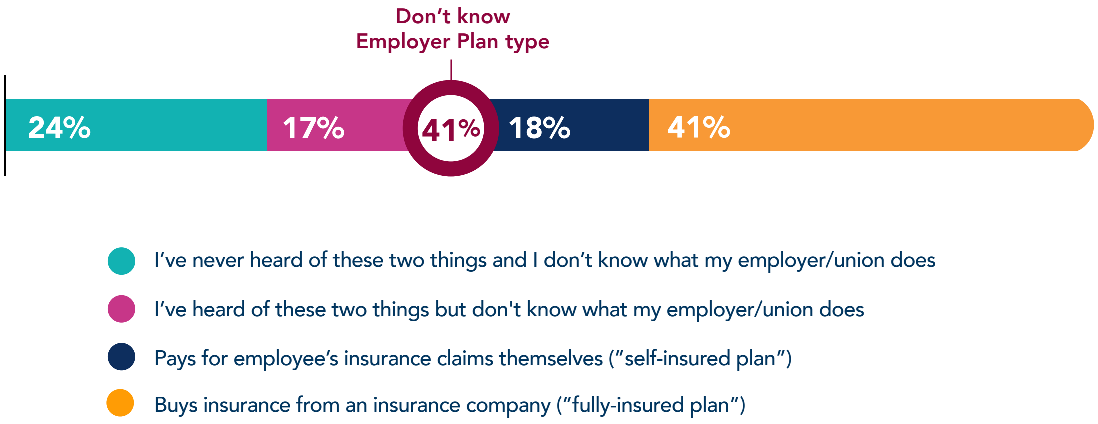
The two plan types may also differ in how they manage claims and appeals, depending on whether they are regulated at the state or federal level.

While plan structure matters for self-advocacy, awareness of these distinctions was limited among many Employer Plan respondents: 41% had either never heard of these plan types or did not know which kind their employer or union used.

> ***The so-called insurance from my employer is horrible.***
>
> *– Employer Plan Respondent*

FIGURE 40

Familiarity with Employer Insurance Type (Self-Funded vs. Fully-Insured)



Question: *Some employers/unions buy insurance from an outside insurance company which pays employees' claims ("fully-insured plan"). Other employers/unions set up their own insurance ("self-insured plan"). Do you know what kind of plan your employer or union uses? (Response options: Buys insurance from an insurance company ("fully-insured plan"); Pays for employees' insurance claims themselves ("self-insured plan"); I've heard of these two things, but don't know what my employer/union does; I've never heard of these two things, and I don't know what my employer/union does)*

n=569 Employer Plan respondents

CancerCare, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Awareness of Alternative Funding Programs (AFPs)

Alternative funding programs (AFPs) are becoming more common and may create serious barriers to timely treatment access. These programs are typically offered by vendors that contract with self-funded employers to exclude certain specialty medications from coverage or deny prior authorization. This effectively makes the patient uninsured or underinsured, so that they may qualify for free medications through a Patient Assistance Program (PAP).

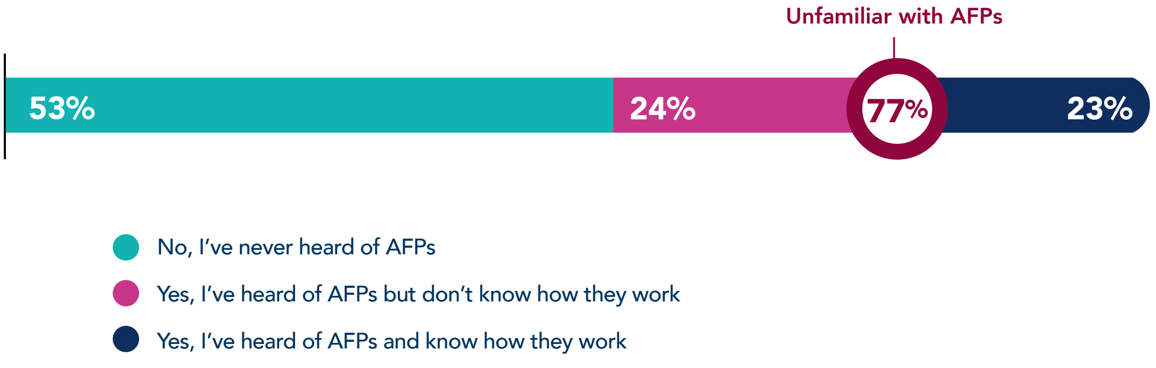
Patients must meet the AFP vendor's requirements to apply for a PAP, which often involve submitting personal documents to the vendor, such as tax returns, pay stubs, and a limited power of attorney. This process can delay treatment and may pose a privacy risk.

If patients do not comply, they may be responsible for the full costs of the medication, which do not count toward deductibles or out-of-pocket maximums. In cases where a PAP is unavailable or a patient is ineligible, insurers may deny coverage altogether. This had led to safety and regulatory concerns, as vendors may import medications or switch patients to alternatives from other sources.

Despite these possible risks, awareness was low: more than three-fourths (77%) of Employer Plan respondents had either never heard of AFPs or did not understand how they work.

FIGURE 41

Familiarity with Alternative Funding Programs (AFPs)



Question: *Question: Some health insurance plans use a special program called Alternative Funding Programs (AFPs). Are you familiar with AFPs? (Response options: Yes, I've heard of AFPs and know how they work; Yes, I've heard of AFPs, but don't know how they work; No, I've never heard of AFPs)*

n=569 Employer Plan respondents

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape.

Awareness of Co-Pay Accumulators/Maximizers

Co-pay accumulators and co-pay maximizers are insurance programs that can make it harder for cancer patients to afford their medications, even if they receive financial assistance. Because cancer treatment is often complex and expensive, pharmaceutical manufacturers may offer co-pay assistance to help reduce out-of-pocket costs for patients and improve access and adherence to treatment.

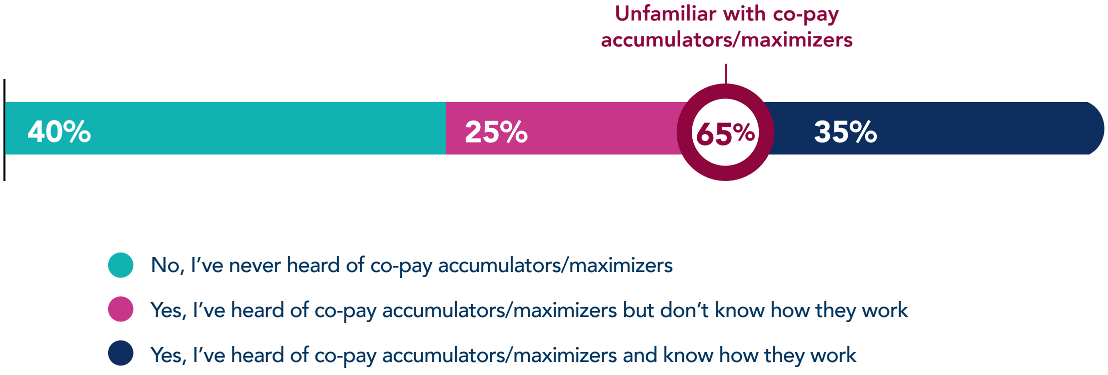
Co-pay accumulators allow insurers to accept this assistance without applying it toward a patient's deductible or out-of-pocket maximum. Once the assistance is used up, patients must cover the full cost of their deductible and cost-sharing themselves, essentially resetting their medication costs. This can undermine the intent of co-pay assistance programs and may make cancer treatment unaffordable.

With copay maximizers, the insurance plan adjusts the patient's monthly payment to match the total amount of co-pay assistance received. This means the patient may use up all available help without reducing their own yearly out-of-pocket costs. In some cases, co-pay maximizers may also classify certain medications as non-essential health benefits, allowing them to bypass Affordable Care Act limits on patient out-of-pocket costs for essential health benefits.

Awareness of these programs was low: nearly two-thirds (65%) of Employer Plan respondents had never heard of co-pay accumulators or maximizers or did not know how they work, underscoring the barriers faced by patients in navigating insurance coverage.

People can encounter significant barriers to care when faced with complex insurance programs they do not understand. Collectively, these findings underscore the need for clearer education and patient resources to improve insurance literacy and advocacy. The healthcare system, including insurers and employers, has a responsibility to close this knowledge gap through enhanced transparency and education—and to reconsider programs that may ultimately harm patients rather than support them.

FIGURE 42
Familiarity with Co-Pay Accumulators/Maximizers



Question: *Some health insurance plans use a special program called co-pay accumulators or co-pay maximizers. Are you familiar with these programs? (Response options: Yes, I've heard of co-pay accumulators/ maximizers and know how they work; Yes, I've heard of co-pay accumulators/maximizers but don't know how they work; No, I've never heard of co-pay accumulators/maximizers.)*

n=569 Employer Plan respondents

Cancer*Care*, The Health Insurance Maze: How Cancer Patients Get Lost in the Red Tape of Utilization Management (June 2025), www.cancercare.org/redtape

> ***Just how rich do insurance companies have to get before costs decline?***
>
> *– Medicare Advantage Respondent*

Recommendations and Conclusions

> *"People with cancer are dying and are very, very vulnerable. We are not in the mood for delays and red tape… Get out of the way and allow the health team [to] do their job."*
>
> *– Employer Plan Respondent*

This study reveals that utilization management (UM) practices—intended to reduce costs—frequently delay care and increase administrative burdens for people with cancer. Our data show that 85% of respondents have encountered prior authorization for their cancer care, with 76% experiencing it in the past year. These processes often cause emotional and financial strain, compounding the already difficult experience of managing cancer.

The pervasive administrative hurdles of UM delayed both cancer diagnosis and treatment. Respondents lost critical time due to these delays: 51% who got involved lost up to one business day, 27% lost up to two to three days, and 12% lost a full business week or more dealing with a single authorization. These findings underscore the "time toxicity" of current UM practices in cancer. Layered authorization processes and abrupt coverage changes—reported by 18% of respondents—further delay care and divert patients' focus from treatment to navigating bureaucracy.

Notably, respondents with Employer Plans bore a disproportionate burden of administrative hurdles and red tape—while also more frequently reporting advanced disease. They more often experienced long delays and greater administrative complexity compared to those with Medicare Advantage or Traditional Medicare. Only 13% of respondents with Employer Plans avoided prior authorization, while 43% faced prior authorization for five or more treatment types in the past year. These systemic barriers undermine timely access to care and erode patient trust, worsening both emotional and financial well-being: 40–49% of Employer Plan respondents reported negative impacts on stress, trust, and finances, compared to 20–26% with Medicare Advantage and 20–23% with Traditional Medicare.

> ***It is a nightmare waking up every day wondering if some people halfway across the country will approve what my doctors have said is my only chance.***
>
> *– Employer Plan Respondent*

Respondents with Medicare Advantage plans also reported more barriers and delays than those on Traditional Medicare. In the past year, 72% of Medicare Advantage Respondents faced prior authorization, compared to 57% of those with Traditional Medicare. They also faced higher out-of-pocket costs and more often made compensatory cost trade-offs, such as using a lower-cost medication than what the doctor recommended, not filling prescriptions, or taking smaller doses than prescribed.

These disparities demand urgent reform. Policymakers, insurers, employers, and advocates must collaborate to streamline UM processes, increase transparency, and prioritize person-centered care, so that patients can focus on recovery, not red tape. There is a critical need—and timely opportunity—to improve coverage offered under private and public insurance plans.

Implications for Insurance Providers and PBMs

Insurers and PBMs must urgently reform UM protocols by eliminating redundant authorization cycles and clarifying appeals processes to reduce delays and ease administrative burdens. Ten percent of respondents were denied authorization for their most recent treatment, yet insurers ultimately overturned 72% of these denials. One-third of appeals took more than a month to resolve. Eighteen percent of respondents also reported that their insurance stopped covering treatment they were already receiving, further disrupting care.

These findings point to an inefficient system that wastes time and resources. The routine use of prior authorization and repetitive approval cycles delays patient care, and reflects a critical disconnect between cost-saving goals and actual outcomes. Most respondents (95%) ultimately had their prior authorization approved, suggesting that these hurdles are inefficient and waste time and resources. Respondents with Employer Plans also experienced higher rates of coverage stoppage across treatment types compared to those with Medicare Advantage or Traditional Medicare, underscoring the need to overhaul authorization and coverage protocols.

These inefficiencies and delays do little more than expose patients to unnecessary risk and dissatisfaction. Streamlining approval processes could reduce delays, lower operational costs for insurers and providers, and improve patient outcomes and trust. Safeguards against abrupt coverage stoppages should be integrated into UM reforms to help prevent avoidable disruptions in care for people with cancer.

> ***Insurance can be a complete hassle sometimes.***
>
> *– Employer Plan Respondent*

Implications for Employers

Employers and unions have a pivotal role to play in reducing insurance red tape. They should prioritize benefits that support timely access to care and minimize administrative complexity to help maintain a healthy and productive workforce. Investments in insurance literacy programs and employee support services—such as benefits navigators—can empower individuals to better manage their coverage and advocate for themselves.

These results highlight how administrative barriers undermine not only patient well-being but also workplace productivity. For example, a single prior authorization process can cost patients and their families up to a full business week or more, disrupting their ability to work and maintain a healthy work-life balance.

In addition, mechanisms like alternative funding programs and co-pay accumulators or maximizers can create further access and cost barriers, yet most respondents were unaware of these programs or how they worked. Employers should require that all UM tools used by health plans are fully transparent, written in plain language, and clearly presented in plan documents and summary plan descriptions. Cost control mechanisms should not compromise people's timely access to, or continuity of, comprehensive, high-quality cancer care and treatment.

In a competitive labor market, robust health insurance is a differentiator. Employers that offer streamlined, accessible health coverage demonstrate a commitment to employee well-being and are better positioned to attract and retain top talent. By negotiating for more transparent plans with fewer exclusions and less reliance on prior authorization, companies can improve employees' access to care, protect their well-being and productivity, and reinforce the employer's role as supportive and forward-thinking.

> ***Too much red tape to go through. It's always something that has to get done and we're not able to get it done.***
>
> *– Employer Plan Respondent*

Advocacy and Policy Implications

There is an urgent need for comprehensive reform of UM practices. Prior authorization, coverage stoppages, and drawn-out appeals processes create inefficiencies that delay care, waste resources, erode trust in the healthcare system, and ultimately harm patients. These barriers can interfere with the patient-provider relationship and add stress at an already difficult time.

Given that nearly all of the prescribed care was eventually approved, these layers of red tape introduce unnecessary stress, time loss, and potential patient harms. Policy and advocacy efforts should focus on increasing transparency, expanding comprehensive coverage, and improving oversight of access-limiting practices to ensure cost control measures do not compromise care quality.

Respondents, especially those with Employer Plans, consistently reported that delays compounded the physical, emotional, practical, and financial toll of their cancer. There is both economic and civic value in reviewing programs that inadvertently harm patients by causing unnecessary delays or forcing non-medical switching of treatments. Reform efforts can prioritize standardized, evidence-based guidelines for prior authorization and appeals to increase transparency and oversight, reduce unnecessary delays, and streamline processes. Cross-sector collaboration among insurers, employers, policymakers, and advocates is essential to build a patient-centered system focused on timely, affordable, and high-quality cancer care.

Patient Education and Support Implications

To empower patients, it is essential to address ongoing gaps in understanding of UM processes and insurance system literacy. One in four respondents were caught off guard by their most recent prior authorization, and nearly half of those who experienced a coverage stoppage for ongoing treatment did not expect it in advance. One-fourth also lacked confidence in understanding their insurance coverage, and 77% were unaware of the role of pharmacy benefit managers (PBMs).

Healthcare providers played a key role in patient support, often alerting them to potential authorizations and stoppages. Close to half of respondents said their providers fully handled their prior authorizations, though this was much more common among Medicare Advantage and Traditional Medicare respondents than those with Employer Plans. Providers also supported more than 80% of appeals related to prior authorization and coverage stoppages. Their support role remains critical, but UM processes must be streamlined to reduce providers' time spent on administrative tasks rather than patient care.

Advocacy and support organizations must continue expanding their role in informing patients and families about insurance coverage, appeals processes, and other cost-control programs that can limit care access and affordability. Educational efforts should be co-created with patients and caregivers to address their highest-priority needs. Improving awareness of insurance systems and processes helps patients make informed decisions, advocate for themselves, and access needed treatments.

To support effective UM reform, advocacy organizations can also help patients become grassroots advocates. With effective training and tools, patients can share their stories with policymakers, employers, and other stakeholders, ensuring that their lived experiences inform healthcare policy and insurance coverage design.

> ***We shouldn't have to fight for approval. Thank God for the care team [who] relieved a lot of stress.***
>
> *– Traditional Medicare Respondent*

Summary

This study reveals that most people with cancer face multiple cycles of prior authorization, leading to care delays and excessive red tape that drain time and increase stress. These inefficiencies do not improve cancer care—they obstruct it. Patients and their families lose valuable time that could otherwise be spent on treatment and recovery.

UM and other cost-containment strategies must be designed to preserve timely access to high-quality, affordable cancer care. When insurance systems prioritize administrative bureaucracy over outcomes, patients, families, and providers all suffer. Reforming these systems is essential to reduce burden, improve care, and ensure that administrative processes support, rather than hinder, treatment.

Achieving this will require coordinated action from insurers, employers, policymakers, and advocates. It also means equipping patients with the tools and support they need to navigate insurance challenges and participate in shaping the policies that affect their care.

Study Strengths and Limitations

This study gathered perspectives from people across the U.S. Data were collected via a non-probability online survey administered to a sample of 1,201 respondents who met all eligibility criteria, including receiving active cancer treatment within the 12 months prior to taking the survey. The survey engaged people nationally with a broad range of cancer diagnoses and was not targeted to individuals affiliated with advocacy groups. Respondents were unaware of the study purpose until after pre-screening questions, to reduce the risk of fraudulent responses.

In addition to its large sample size and broad reach, this study offers several important strengths. It focuses on a high-need population—individuals actively undergoing cancer treatment in diverse care settings—whose insurance experiences are often overlooked. Including both private and public insurance types (Employer Plans, Medicare Advantage, and Traditional Medicare) allows for a broad understanding of coverage-related barriers. Blind pre-screening reduced self-selection and response bias, while the patient-centered design ensured that lived experiences were captured directly rather than inferred from claims or administrative data. The timeliness of the topic adds practical relevance for policy and advocacy work, and the dataset provides a foundation for future multivariable analyses.

As with all research, limitations may affect how findings are interpreted or applied. Some limitations are due to the survey design itself, while others relate to the methods used to reach the target population. While the study includes a large sample size and diverse representation across age, education, household income, geography, diagnosis type, cancer status, and treatment setting, notable limitations include reliance on self-reported data, potential recall bias, underrepresentation of certain racial, ethnic, gender, and sexual identities, and the use of non-probability sampling, which may affect the generalizability of the findings.

All data were self-reported, which assumes respondents shared their experiences accurately and honestly. The online format allowed for broad reach among people recently treated for cancer and enrolled in Employer or Medicare plans, but it excluded individuals with low digital literacy, limited internet access, or those outside the panels used by Praxis Research. Individuals who did not participate may have different experiences or perspectives than those who completed the survey. The survey was administered exclusively in English, excluding those with limited English proficiency. Because the study focuses on insurance experiences within the U.S. healthcare system, the findings apply to those receiving care in the U.S.

Future research using probability sampling could broaden the generalizability of results and reduce potential bias, but that may be challenging with populations undergoing active cancer treatment and enrolled in specific insurance types. The three insurance groups differed across certain socio-demographic, clinical, and treatment variables; it is unclear the extent to which these differences reflect true population differences vs. methodological constraints. Further work is needed to evaluate the representativeness of these findings, especially among underrepresented racial, ethnic, gender, and sexual identities.

This report presents primarily descriptive results. Future work will leverage multivariable statistical methods to examine topics in greater depth, accounting more comprehensively for differences between insurance groups and for subgroups warranting further exploration. Although statistical comparisons were made across insurance types, no adjustments were made for multiple comparisons. This increases the risk of type I error; however, effect sizes were consistently in the same direction, and their magnitudes are meaningful for real-world application.

Finally, this study focused on individuals with Employer Plans, Medicare Advantage, and Traditional Medicare. Future research is warranted to examine barriers faced by people with Medicaid, Marketplace plans, or other insurance types not included in the current work.

SUPPLEMENTAL INFORMATION:

Participants: Cancer Status and Clinical History

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
In past 12 months, primary cancer being treated for									***
Breast (net)	358	30%	188	33%	120	29%	50	22%	
Metastatic breast	185	15%	120	21%	45	11%	20	9%	
Non-metastatic breast	173	14%	68	12%	75	18%	30	13%	
Prostate	149	12%	58	10%	55	13%	36	16%	
Hematologic	148	12%	58	10%	56	14%	34	15%	
Lung	100	8%	30	5%	45	11%	25	11%	
Gynecologic	82	7%	46	8%	23	6%	13	6%	
Colon or rectal	77	6%	47	8%	19	5%	11	5%	
Skin cancer (non-melanoma)	44	4%	21	4%	15	4%	8	4%	
Thyroid	28	2%	15	3%	10	2%	3	1%	
Kidney / renal	23	2%	13	2%	9	2%	1	0%	
Bladder	22	2%	9	2%	6	1%	7	3%	
Melanoma	19	2%	8	1%	6	1%	5	2%	
Other	151	13%	76	13%	44	11%	31	14%	
Years since diagnosis (categorical)									***
Less than 1 year	143	12%	48	8%	59	14%	36	16%	
1 year	368	31%	186	33%	124	30%	58	26%	
2 years	218	18%	128	22%	52	13%	38	17%	
3 years	116	10%	64	11%	37	9%	15	7%	
4-5 years	163	14%	84	15%	55	13%	24	11%	
6-10 years	99	8%	30	5%	39	10%	30	13%	
11 or more years	83	7%	24	4%	38	9%	21	9%	
Missing	11	1%	5	1%	4	1%	2	1%	
What stage best describes your cancer at diagnosis									***
Stage 0	58	5%	20	4%	24	6%	14	6%	
Stage 1	299	25%	142	25%	104	25%	53	24%	
Stage 2	268	22%	170	30%	59	14%	39	17%	
Stage 3	181	15%	89	16%	70	17%	22	10%	
Stage 4 (advanced or metastatic)	227	19%	108	19%	76	19%	43	19%	
Something else	19	2%	4	1%	9	2%	6	3%	
Don't know	51	4%	9	2%	24	6%	18	8%	
My cancer doesn't have a stage	91	8%	24	4%	41	10%	26	12%	
Prefer not to answer	7	1%	3	1%	1	<1%	3	1%	

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
What best describes the current status of your cancer									***
Localized disease	438	36%	218	38%	145	36%	75	33%	
Metastatic / Stage IV	318	26%	195	34%	80	20%	43	19%	
I am in remission	380	32%	139	24%	153	38%	88	39%	
Something else	39	3%	10	2%	18	4%	11	5%	
Don't know	23	2%	6	1%	11	3%	6	3%	
Prefer not to answer	3	<1%	1	<1%	1	<1%	1	<1%	
Have you ever been told you have metastatic/Stage IV cancer									***
No	782	65%	331	58%	295	72%	156	70%	
Yes	407	34%	234	41%	113	28%	60	27%	
Don't know	12	1%	4	1%	0	--	8	4%	
Have you ever had a recurrence of your cancer									***
None	606	50%	199	35%	266	65%	141	63%	
One	174	14%	100	18%	47	12%	27	12%	
Two	199	17%	119	21%	52	13%	28	13%	
Three	100	8%	74	13%	17	4%	9	4%	
Four	49	4%	32	6%	13	3%	4	2%	
Five or more times	63	5%	39	7%	11	3%	13	6%	
Don't know	10	1%	6	1%	2	<1%	2	1%	
In general, how would you rate your physical health									***
Poor	188	16%	90	16%	59	14%	39	17%	
Fair	451	38%	217	38%	146	36%	88	39%	
Good	355	30%	152	27%	142	35%	61	27%	
Very good	148	12%	76	13%	46	11%	26	12%	
Excellent	52	4%	29	5%	15	4%	8	4%	
Prefer not to answer	7	1%	5	1%	0	--	2	1%	
In general, how would you rate your mental health and emotional well-being									***
Poor	142	12%	89	16%	34	8%	19	8%	
Fair	312	26%	166	29%	93	23%	53	24%	
Good	337	28%	146	26%	126	31%	65	29%	
Very good	251	21%	107	19%	86	21%	58	26%	
Excellent	155	13%	59	10%	68	17%	28	13%	
Prefer not to answer	4	<1%	2	<1%	1	<1%	1	<1%	

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
Comorbidities									
Anemia	195	16%	89	16%	60	15%	46	21%	
Anxiety	488	41%	276	49%	135	33%	77	34%	***
Back pain	495	41%	246	43%	164	40%	85	38%	
Depression	443	37%	259	46%	126	31%	58	26%	***
Diabetes	317	26%	167	29%	108	26%	42	19%	*
Heart disease	182	15%	68	12%	69	17%	45	20%	**
High blood pressure	575	48%	244	43%	211	52%	120	54%	**
Kidney disease	124	10%	53	9%	50	12%	21	9%	
Liver disease	54	4%	30	5%	16	4%	8	4%	
Lung disease	153	13%	54	9%	65	16%	34	15%	**
Osteoarthritis, degenerative arthritis	275	23%	99	17%	117	29%	59	26%	***
Rheumatoid arthritis	179	15%	106	19%	54	13%	19	8%	**
Ulcer or stomach disease	108	9%	64	11%	25	6%	19	8%	*
Count of comorbid conditions (range: 0-13)	*M*=3.0; *SD*=2.5		*M*=3.1; *SD*=2.6		*M*=2.9; *SD*=2.4		*M*=2.8; *SD*=2.2		**

Note: *$p<.05$; **$p<.01$; ***$p<.001$; *M*=mean; *SD*=standard deviation; other diagnoses included anal, bone or sarcoma, brain or spinal cord, esophageal, head or neck, liver, pancreatic, stomach/gastric, and testicular, among others.

SUPPLEMENTAL INFORMATION:

Participants: Treatment History

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
Frequency of respondents reporting ever having each treatment									
Imaging	1098	91%	529	93%	368	90%	201	90%	
Biomarker	656	55%	382	67%	186	46%	88	39%	***
Chemotherapy IV	739	62%	383	67%	235	58%	121	54%	***
Chemotherapy Oral	560	47%	305	54%	168	41%	87	39%	***
Targeted therapy	505	42%	302	53%	138	34%	65	29%	***
Immunotherapy	696	58%	393	69%	188	46%	115	51%	***
Radiation	839	70%	420	74%	266	65%	153	68%	*
Hormonal therapy	516	43%	279	49%	162	40%	75	33%	***
Surgery	760	63%	365	64%	255	63%	140	63%	
Stem cell	188	16%	128	22%	45	11%	15	7%	***
Supportive medications	907	76%	488	86%	271	66%	148	66%	***
Frequency of respondents reporting having each treatment in past 12 months									
Imaging	966	80%	475	83%	309	76%	182	81%	*
Biomarker	469	39%	289	51%	120	29%	60	27%	***
Chemotherapy IV	535	45%	300	53%	153	38%	82	37%	***
Chemotherapy Oral	436	36%	233	41%	138	34%	65	29%	**
Targeted therapy	384	32%	225	40%	106	26%	53	24%	***
Immunotherapy	580	48%	318	56%	159	39%	103	46%	***
Radiation	614	51%	332	58%	175	43%	107	48%	***
Hormonal therapy	407	34%	216	38%	129	32%	62	28%	*
Surgery	475	40%	261	46%	145	36%	69	31%	***
Stem cell	117	10%	89	16%	23	6%	5	2%	***
Supportive medications	786	65%	442	78%	222	54%	122	54%	***
Count of treatments in past 12 months (range: 1-11)	*M*=4.8; *SD*=2.3		*M*=5.6; *SD*=2.3		*M*=4.1; *SD*=2.0		*M*=4.1; *SD*=1.9		***
In the last 12 months, where was most of your cancer treatment delivered									
Large academic hospital or comprehensive cancer center	459	38%	232	41%	151	37%	76	34%	
Community hospital or community cancer center	353	29%	164	29%	112	27%	77	34%	
Private oncology practice	300	25%	139	24%	112	27%	49	22%	
Veterans or military hospital	20	2%	15	3%	2	<1%	3	1%	
Somewhere else	48	4%	12	2%	24	6%	12	5%	
Don't know	15	1%	4	1%	5	1%	6	3%	
Prefer not to answer	6	<1%	3	1%	2	<1%	1	<1%	

Note: *p<.05; **p<.01; ***p<.001; *M*=mean; *SD*=standard deviation.

SUPPLEMENTAL INFORMATION:

Participants: Socio-Demographics

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
Age	*M*=56.3	*SD*=15.7	*M*=46.0	*SD*=12.2	*M*=65.6	*SD*=12.2	*M*=65.4	*SD*=12.9	***
Gender identity									
Man	503	42%	229	40%	172	42%	102	46%	
Woman	694	58%	338	59%	236	58%	120	54%	
Other	4	<1%	2	<1%	0	--	2	1%	
Race/ethnicity									***
American Indian or Alaskan Native, Non-Hispanic	12	1%	5	1%	7	2%	0	--	
Asian or Asian American, Non-Hispanic	19	2%	11	2%	7	2%	1	<1%	
Black or African American, Non-Hispanic	141	12%	85	15%	37	9%	19	8%	**
Hispanic, Latino, or Spanish	114	9%	91	16%	19	5%	4	2%	***
Middle Eastern or North African, Non-Hispanic	2	<1%	2	<1%	0	--	0	--	
Native Hawaiian or Pacific Islander, Non-Hispanic	2	<1%	1	<1%	1	<1%	0	--	
White, Non-Hispanic	876	73%	352	62%	327	80%	197	88%	***
Multiple races, Non-Hispanic	34	3%	22	4%	9	2%	3	1%	
Prefer not to share	1	0%	0	--	1	<1%	0	--	
Marital status									***
Married	576	48%	286	50%	184	45%	106	47%	
Living as married or living with a romantic partner	89	7%	50	9%	21	5%	18	8%	
Divorced	184	15%	63	11%	93	23%	28	13%	
Separated	32	3%	18	3%	9	2%	5	2%	
Widowed	122	10%	29	5%	63	15%	30	13%	
Single or dating, never been married	193	16%	121	21%	36	9%	36	16%	
Prefer not to answer	5	<1%	2	<1%	2	<1%	1	<1%	
Sexual identity									**
Asexual	8	1%	3	1%	3	1%	2	1%	
Bisexual	37	3%	30	5%	5	1%	2	1%	
Gay or lesbian	42	3%	21	4%	13	3%	8	4%	
Pansexual	6	1%	5	1%	0	--	1	<1%	
Straight or heterosexual	1101	92%	510	90%	384	94%	207	92%	
Don't know	1	<1%	0	--	1	<1%	0	--	
Prefer not to answer	6	1%	0	--	2	<1%	4	2%	

	Full Sample *n*=1201		Employer Plans *n*=569 (47%)		Medicare Advantage *n*=408 (34%)		Traditional Medicare *n*=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
Educational attainment									*
Some high school, did not graduate	9	1%	3	1%	4	1%	2	1%	
High school diploma or GED	218	18%	92	16%	87	21%	39	17%	
Trade or vocational school	48	4%	16	3%	20	5%	12	5%	
Some college, did not graduate	218	18%	87	15%	80	20%	51	23%	
Associate's degree	167	14%	85	15%	53	13%	29	13%	
Bachelor's degree	359	30%	196	34%	104	25%	59	26%	
Master's degree	154	13%	81	14%	49	12%	24	11%	
Doctorate degree	27	2%	9	2%	10	2%	8	4%	
Prefer not to answer	1	<1%	0	--	1	<1%	0	--	
Current employment status									***
Working full time (30+ hours per week)	480	40%	409	72%	48	12%	23	10%	
Working part time (less than 30 hours per week)	101	8%	54	9%	24	6%	23	10%	
Not employed	615	51%	104	18%	334	82%	177	79%	
Not employed, retired	412	34%	33	6%	249	61%	130	58%	
Not employed, disability	119	10%	34	6%	58	14%	27	12%	
Not employed, homemaker	29	2%	10	2%	13	3%	6	3%	
Not employed, looking for work	21	2%	10	2%	4	1%	7	3%	
Not employed, short-term leave from work	34	3%	17	3%	10	2%	7	3%	
Prefer not to answer	5	<1%	2	<1%	2	<1%	1	<1%	
Household income									***
$0	3	<1%	2	<1%	1	<1%	0	--	
$1 to $9,999	20	2%	9	2%	6	1%	5	2%	
$10,000 to $24,999	151	13%	22	4%	92	23%	37	17%	
$25,000 to $49,999	285	24%	91	16%	132	32%	62	28%	
$50,000 to $74,999	279	23%	150	26%	80	20%	49	22%	
$75,000 to $99,999	167	14%	103	18%	37	9%	27	12%	
$100,000 to $149,999	157	13%	97	17%	32	8%	28	13%	
$150,000 to $249,999	94	8%	72	13%	12	3%	10	4%	
$250,000 and above	27	2%	19	3%	7	2%	1	<1%	
Prefer not to answer	18	2%	4	1%	9	2%	5	2%	

	Full Sample n=1201		Employer Plans n=569 (47%)		Medicare Advantage n=408 (34%)		Traditional Medicare n=224 (19%)		Between-Group Difference
	n	%	*n*	%	*n*	%	*n*	%	
Household size									***
1	285	24%	86	15%	134	33%	65	29%	
2	433	36%	150	26%	174	43%	109	49%	
3	199	17%	141	25%	38	9%	20	9%	
4	177	15%	126	22%	33	8%	18	8%	
5	56	5%	40	7%	13	3%	3	1%	
6	24	2%	14	2%	8	2%	2	1%	
7	11	1%	6	1%	2	<1%	3	1%	
8	3	<1%	2	<1%	0	--	1	<1%	
10	2	<1%	1	<1%	1	<1%	0	--	
Missing	11	1%	3	1%	5	1%	3	1%	
Census region									*
Northeast	212	18%	111	20%	55	13%	46	21%	
Midwest	261	22%	110	19%	94	23%	57	25%	
South	487	41%	237	42%	165	40%	85	38%	
West	234	19%	109	19%	92	23%	33	15%	
Missing	7	1%	2	<1%	2	<1%	3	1%	
Census division									*
New England	55	5%	25	4%	15	4%	15	7%	
Mid Atlantic	157	13%	86	15%	40	10%	31	14%	
E.N. Central	188	16%	87	15%	62	15%	39	17%	
W.N. Central	72	6%	23	4%	31	8%	18	8%	
S. Atlantic	255	21%	125	22%	85	21%	45	20%	
E.S. Central	83	7%	33	6%	31	8%	19	8%	
W.S. Central	149	12%	79	14%	49	12%	21	9%	
Mountain	89	7%	36	6%	37	9%	16	7%	
Pacific	145	12%	73	13%	55	13%	17	8%	
Missing	8	1%	2	<1%	3	1%	3	1%	
Medicare Part D									*
Yes	529	44%	--		374	92%	155	69%	
No	71	6%	--		20	5%	51	23%	
Don't know	32	3%	--		14	3%	18	8%	

Note: *$p<.05$; **$p<.01$; ***$p<.001$; *M*=mean; *SD*=standard deviation.

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