



HOW THE HEALTH CARE INDUSTRY STACKS THE DECK AGAINST WORKING FAMILIES

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INTRODUCTION

Health insurance is, fundamentally, a promise between consumers and their health plan. When Americans do their part by paying thousands of dollars in premiums annually; shouldering burdensome copays, deductibles, and coinsurance; and leaping through administrative hoops and paperwork, they rightfully expect their insurance to pay for the care they need when they need it.

But, too often, Americans find that despite coverage on paper for a wide breadth of treatments and services, their plan may not always pay in full (or at all) for the care they actually receive. When an insured consumer goes to a doctor or a hospital, the bill is typically sent to the health plan or insurer, rather than the consumer. This bill, which is submitted as a **claim** for health benefits, is then reviewed by the health plan or insurer to determine whether it will be approved or denied based on a number of factors. If this adjudication process results in a denial for payment, or a determination that only a portion of the amount will be paid, the outstanding charges may become the consumer's responsibility.

In an ideal world, health plans and insurance companies are conducting fair and consistent assessments of claims based on their coverage terms, with most being approved and a few that are correctly denied.

But what happens when health insurance does not meet its end of the bargain?

Even though workers and their families are paying more in premiums, deductibles, and copays year after year for coverage,ⁱ claim denials are growing.ⁱⁱ In many cases, workers' health plans are providing coverage for care. But working people are also increasingly seeing health care claims that their insurer should be responsible for paying being rejected, often through confusing processes with inadequate recourse available to challenge these denials. These improper claim denials can have catastrophic effects on working people's lives and livelihoods. A wrongful rejection can force consumers to make impossible choices, such as deciding whether to wipe out their savings or skip a critical surgery. At the same time, in 2024, six of the largest health insurance companies in the country raked in over \$31 billion in profits.ⁱⁱⁱ

Over the last several years, public scrutiny has grown on arbitrary, improper, and mass claim denials, revealing high denial rates and self-dealing practices by some in the health care industry. Claim denials have increasingly caught Congress's attention, with a recent investigation into Medicare Advantage and post-acute care.^{iv} However, the private insurance market, through which a majority of Americans get their health coverage, has not received sufficient attention to date. In



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particular, the employer market, which covered over 181 million people in 2024,^v has largely escaped needed scrutiny.

This report is a first step in closing this gap. It will shed light on claim denials in employer-sponsored health coverage and the challenges consumers face by outlining the effects of improper denials; discussing what is known about the growing prevalence of claim denials; describing consumers' rights and protections under current law; highlighting the limitations on claim denial information; and examining how the lack of accountability and inadequate consumer protections make this problem worse.

THE CONSEQUENCES OF HEALTH CARE CLAIM DENIALS FOR CONSUMERS

Improper claim denials impose serious health and financial hardships on individuals. Often, these denials lead to delays in necessary treatments, deterioration of one's health, and high out-of-pocket costs.^{vi} A KFF survey found that, among individuals experiencing issues with their health insurance, 55 percent who had a denied claim paid more than they had anticipated; 24 percent saw themselves become sicker; 24 percent could not get the care recommended by their doctor; and 26 percent faced "significant delays in receiving medical care or treatment."^{vii}

Claims that are wrongly denied can also have a disproportionate impact on certain populations, blocking access to important health care. A 2024 study analyzing denials of preventive care, which is required by federal law to be covered with zero patient cost-sharing, found that private insurance denials disproportionately affected lower-income households, consumers with less education, and marginalized racial and ethnic communities.^{viii} The study also observed a heightened denial rate for mental health screenings and contraceptives relative to other preventive services for the same demographics.^{ix}

Another survey, conducted by The Commonwealth Fund, asked individuals about the effect that postponing care due to a denied claim had on them or a relative: 80 percent of respondents felt worried and anxious; 47 percent stated the health problem was exacerbated; and 16 percent "found out about a serious health problem later than [they] would have liked."^x For the consumers who cannot defer medical care even after a coverage denial or do not learn about their plan's denial until after the care is provided, their health may not be negatively impacted directly, but they could be personally responsible for a significant portion or the aggregate cost of the procedures and treatments rendered.

There will inevitably be people who cannot afford to pay these medical bills, forcing them to join a growing segment of the public that is saddled with medical debt.^{xi} According to an estimate by



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the Consumer Financial Protection Bureau, approximately 100 million Americans are trapped with \$220 billion in medical debt.^{xii} Even though medical debt is not solely attributable to claim denials, its harms are the same to working people, whether or not they are insured. KFF's Health Care Debt Survey highlights how individuals face harrowing financial strain due to medical debt:

“[M]ore than four in ten [of the adults surveyed] say they or a household member have used up all or most of their savings due to their health care debt. Many also report more serious consequences like skipping payment on other bills, delaying college or buying a home, or changing their housing situation as a result of their debt... Other reported consequences of debt, such as being contacted by debt collectors and having their credit scores negatively affected, can lead to additional financial problems such as difficulty buying vehicles needed for work or buying or renting a home.^{xiii}”

Debt from unpaid bills can also prevent individuals from getting or continuing treatments or other services in the future, with five percent of Americans with medical debt skipping care and 15 percent being denied care because of outstanding debt.^{xiv}

The medical bills following a denied claim can be catastrophic, with patients sometimes owing thousands of dollars:

- In 2024, a woman went into cardiac arrest and was transported by an air ambulance to a Kentucky hospital after a doctor at the local Indiana hospital decided that it was not equipped to treat her. The surgeons successfully operated and saved her life. After learning what had transpired, the woman said “[i]f it weren’t for the helicopter, I’d be dead’.” Weeks later she would learn that she owed nearly \$65,000 because her insurance company had denied the claim for the air ambulance transport, stating that it required preapproval.^{xv}
- In 2016, a college professor was admitted to a hospital due to “severe electrolyte abnormalities that were causing fatigue, muscle cramps[,] and chest discomfort.” Even though she was struggling to take her medicine and her nutrient levels were below a healthy range, thus necessitating hospitalization, she received a nearly \$30,000 bill from her insurer. The denial was issued on the basis that the treatment was purportedly not medically necessary.^{xvi}

Claim denials can create financial instability for working people, but in some instances, the consequences are a matter of life and death.



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- A father of three was battling stage 4 stomach cancer when his doctor recommended a treatment to improve his health and extend his life. In 2023, the night before the operation, he was notified that coverage for the treatment was denied, stating it was “not medically necessary.” Despite falling within the National Comprehensive Cancer Network’s guidelines, the insurer maintained the denial—with one of the reviewing physicians being an obstetrician-gynecologist. In January 2024, the man passed away.^{xvii}
- In 2018, a 27-year-old flight attendant learned that he had a heart condition that required a heart transplant. His health plan denied prior authorization for a heart transplant because he failed to “meet certain alcohol-abuse criteria allegedly required by the plan.” Almost a month after his death, an “external reviewer overturned the previous claim denials, finding that the plan document did not contain the alcohol abuse exception” the plan had relied upon to deny lifesaving care.^{xviii}
- In 2023, a West Virginia man “was diagnosed with cholangiocarcinoma, a rare cancer of the bile ducts that had spread throughout his body.” After roughly two years of unsuccessful treatments, his doctors recommended trying a new procedure that could possibly eradicate his largest tumor. His health plan, offered by West Virginia’s Public Employees Insurance Agency, and the insurer hired to administer the plan repeatedly denied his prior authorization request. It was only after media outlets questioned the denials that the claim was approved, but it was too late. He had been hospitalized, and the cancer continued to spread, leaving him unable to undergo the treatment. In September 2025, he died.^{xix}

The physical and financial harms from wrongful claim denials can be significant on working families. But every one of these harms is avoidable if health plans and insurance companies provide the coverage they have promised. Yet, despite gaps in existing data, strong evidence suggests these denials are common and the problem is only getting worse.

CLAIM DENIALS ARE INCREASINGLY COMMON FOR CONSUMERS WITH COMMERCIAL INSURANCE

Despite incomplete and limited data collected by federal regulators (see below), it is nonetheless apparent that claim denials are common and on the rise. While group health plans and insurance companies can conceal their denial rates from full scrutiny, it is increasingly clear that many insurers and health plans are wrongfully denying coverage.



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Denial Rates Are High and Growing

Researchers have documented that claim denials are highly prevalent among health care payers, with one estimate finding that health insurers across the United States reject approximately 850 million claims each year.^{xx} An analysis using privately-sourced data found that, between 2016 and 2023, private insurers' denials for prescription drug benefits increased from an average of 18.3 percent to 22.9 percent—a 25 percent increase.^{xxi} Some large insurers similarly saw heightened denial rates relative to 2016.^{xxii} Additionally, three insurers exceeded the average in 2023, with Cigna denying 25 percent of claims, Aetna 24 percent, and UnitedHealthcare 23 percent.^{xxiii}

While insurance denials are growing across the entire market, they seem to be especially prevalent for those enrolled in private coverage. A 2023 survey by KFF recorded that consumers with private health coverage, specifically employer-sponsored coverage and ACA Marketplace plans, were more likely to have a claim unexpectedly denied in the last year than adults enrolled in Medicaid and Medicare.^{xxiv} Twenty-one percent of respondents with a job-based plan, and 20 percent enrolled in a Marketplace plan, experienced a claim denial compared to just 12 percent for those with Medicaid and 10 percent with Medicare coverage.^{xxv}

The comparable exposure to claim denials by consumers in ACA and employer-sponsored plans, as well as the overlap of insurers in both markets,^{xxvi} suggests that data from the ACA Marketplace can shed some light on what is happening within job-based health plans. To that end, in 2023, insurance companies operating in the federal ACA Marketplace cumulatively denied 19 percent of in-network claims, a three percent increase over 2022 and the highest rate since 2015.^{xxvii} It is important to note that denial rates are not uniform across Marketplace insurers, ranging from one percent to as high as 54 percent.^{xxviii} However, only 22 out of 175 insurers that submitted disclosures “had an in-network denial rate of less than 10% while [29] insurers had a denial rate of 30% or more.”^{xxix}

Many Claim Denials May Be Improper

If a health plan denies a legitimate claim by failing to adhere to its own coverage policies or violating a requirement of state or federal law, the denial may be improper. While it would be nearly impossible to analyze the validity of each claim against the respective plan documents, there is a smaller set of claims that can elucidate how many claims are wrongly denied: denials overturned on appeal. Arguably, the most definitive evidence of an improper denial is when a claim that was originally rejected is later reversed through an appeal.

Even though consumers rarely appeal denied claims, the proportion of reversals can be substantial.^{xxx} In 2023, fewer than one percent of denied claims were appealed by consumers enrolled in the federal ACA Marketplace.^{xxxi} However, of the appeals that did occur, nearly 44



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percent of denials were overturned by the health plan.^{xxxii} In California's state-operated Marketplace, approximately 60 percent of appeals filed with the insurers and over half of the appeals to an external review entity were overturned.^{xxxiii} In its first year of operation, Pennsylvania's external review program reversed 50 percent of denied claims submitted by consumers in state-regulated insurance.^{xxxiv}

For employer-sponsored group health plans, denials overturned on appeal can also be high. A 2024 Commonwealth Fund survey found that 36 percent of people enrolled in employer-sponsored plans who challenged their medical bills saw their bill reduced or eliminated.^{xxxv} These staggeringly high reversal rates do not even include claims that are overturned by most external review programs and the courts. Given the minimal proportion of appeals and limitations on the availability of data, wrongful denials may be even more prevalent, hurting an untold number of Americans' health and finances.

Practices to Deny Claims

Behind the growing crisis of claim denials are a number of tactics and systematic efforts that increasingly result in worse access to medical care and more costs being shifted onto consumers. Numerous media investigations and exposés have uncovered an array of troubling practices by health plans, insurance companies, and corporate middlemen, including arbitrary, improper, and mass denials of health claims.

- **A Denial Every Second:** A 2023 ProPublica investigation found that Cigna constructed a claims review system, called PxDx, that allowed “its doctors to instantly reject a claim on medical grounds without opening the patient file,” spending, on average, just over a single second to review each claim.^{xxxvi} Over a span of two months, the doctors on the insurer's payroll rejected over 300,000 claims under this system.^{xxxvii} One medical director alone recorded over 120,000 denials across two months.^{xxxviii} Former employees stated that the company's PxDx program allowed physicians to speedily rubber stamp denials without a thorough examination.^{xxxix} In addition, “Cigna estimated that only 5 [percent] of people would appeal a denial resulting from a PDX review.”^{xl}
- **The Denials Dial:** Another investigation discovered how EviCore—a company contracted by the nation's largest insurance companies that together provide coverage to 100 million individuals—utilizes a secretive, artificial intelligence-supported algorithm to increase rejections of prior authorization requests to lower insurers' costs and to boost its own revenue.^{xli} EviCore's tool does not reject claims itself, however, the company “can adjust the algorithm to increase the number of requests sent for review,” which heightens the probability of denials.^{xlii} One former employee noted executives requesting to “[k]eep a



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closer eye on the guidelines for reviews for a particular company because we're not showing savings."^{xliii} EviCore's medical guidelines have also been criticized by health care providers for deficiencies.^{xliv}

Tactics to evade payments for treatments are not just limited to algorithms. A media investigation discovered multiple instances of insurance companies refusing to furnish information and documents used to deny claims to consumers.^{xlv} These claim files—which federal law mandates be handed over upon request—can help individuals compose an effective appeal. Instead, insurers incorrectly required a subpoena or court order for the claim files, confused the requests for appeals, and failed to respond within the necessary timeframe.^{xlvi}

These media reports provide crucial information into how certain companies are manufacturing denials to cut their expenses and even to maximize revenue. Yet, it is a limited snapshot of the self-dealing practices that may be in operation across the sector. Over the last decade, there has been a dramatic growth of corporate middlemen in the American health care system—each focused on increasing its own revenue.^{xlvii} Claim denial management has grown to be a lucrative business for corporate middlemen, with one estimate finding that the market will reach nearly \$9 billion in value by 2030.^{xlviii} The prevalence of middlemen processing claims along with the wave of investigations uncovering dubious practices by service providers raises concerns that there may be more ways in which consumers are being harmed.

CURRENT LAW PROVIDES A FRAMEWORK TO ADDRESS CLAIM DENIALS, BUT IT LACKS ENFORCEMENT

Under federal law, consumers who are denied coverage have avenues to appeal claim denials and may seek certain remedies when denials are wrongful or improper. Under the *Employee Retirement Income Security Act* (ERISA), workers have basic protections that safeguard their job-based benefits, including employer-sponsored group health plans.^{xlix} Approximately 134 million workers and their family members are enrolled in ERISA-covered health plans, which include both self-insured and fully insured plans.^l

Congress has repeatedly amended ERISA to address new and emerging issues that undermine access to health benefits for working people.^{li} Additionally, since its enactment in 1974, ERISA has mandated that plans provide “a reasonable opportunity to any participant [in an employee benefit plan] whose claim for benefits has been denied for a full and fair review[.]”^{liii} The Employee Benefits Security Administration (EBSA) within the U.S. Department of Labor (DOL) has promulgated regulations implementing this requirement, setting important minimum standards for how ERISA plans operate and providing consumers critical rights and protections.^{liii} To ensure fair



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administration of health coverage, these regulations (Claims Procedure regulations) generally require group health plans to have reasonable procedures for the submission of claims for health benefits, timely notification of whether a claim is approved or denied, and a fair process for appealing claim denials.^{liv}

Time Limits

The Claims Procedure regulations provide specific timelines within which group health plans must notify consumers (claimants) whether their claim was approved or denied (i.e., benefit determination), and the requirements are distinguished among three primary categories of claims:

- **Urgent Care Claims:** For claims where the standard decision-making timeframe could impose significant pain or endanger the life or livelihood of a claimant, group health plans must inform claimants as soon as possible, with a maximum period of 72 hours, of the plan's benefit determination.^{lv}
- **Pre-Service Claims:** Pre-service claims—also referred to as prior authorization—are when a health plan requires a claim to be approved to receive coverage before providing certain medical services.^{lvi} For pre-service claims, group health plans have an upper bound of 15 days to notify a claimant of its benefit determination, and an additional 15 days due to exigent circumstances.^{lvii}
- **Post-Service Claims:** Post-service claims are the most common type of claim processed by health plans, in which claims for benefits are filed after medical services have been rendered.^{lviii} For post-service claims, group health plans have 30 days to notify claimants if their claim has been denied (adverse benefit determination).^{lix} Plans are afforded a 15-day extension in the event of exigent circumstances to make a benefit determination.^{lx}

Claim Denial Information

Under the Claims Procedure regulations, consumers are also afforded the right to know why their claims are denied. The regulations require health plans to provide the specific rationale for an adverse benefit determination; the coverage provision the decision is based on; if there are supplemental documents or information needed to “perfect the claim”; and information on the plan's appeal process, including the right of a claimant to go to court.^{lxi} Group health plans are also required to provide internal criteria utilized to assess the claim and further information for adverse benefit determinations issued on the basis of lack of medical necessity or experimental treatment or similar grounds.^{lxii}



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Right to Appeal

Under the Claims Procedure regulations, group health plans must provide claimants a minimum of 180 days to appeal an adverse benefit determination.^{lxxiii} Once an appeal is filed, claimants can submit and request relevant documentation and materials to support a “full and fair review” as required under ERISA.^{lxxiv} Group health plans must then complete an independent evaluation without any deference to the initial decision, and if necessary, with the consultation of an appropriately trained health care professional.^{lxxv} Even on appeal, group health plans must abide by timely notice requirements, such as a maximum of 72 hours for urgent care claims.^{lxxvi}

Internal Appeals and External Review

In 2010, the Patient Protection and Affordable Care Act^{lxxvii} (ACA) not only improved the affordability and quality of health coverage for millions of Americans, it also strengthened ERISA’s protections for workers and their families by enshrining their right to appeal—both within their health plan and to an outside entity—claim and coverage determination denials.^{lxxviii} The implementing regulations of claimants’ appeal rights^{lxxix} (Internal Appeals & External Review regulations) supplement the existing Claims Procedure regulations by expanding the definition of adverse benefit determination to include rescissions of coverage;^{lxxx} mandating claimants’ access to new or additional evidence and rationales used for benefit determinations;^{lxxxi} and providing additional safeguards for personnel reviewing claims and appeals to maintain fairness.^{lxxxii} The Internal Appeals & External Review regulations also increase the information group health plans and insurance companies must furnish to claimants in connection with a denied claim, such as information to identify the claim; diagnosis, treatment, and denial codes, along with its definitions; and “a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.”^{lxxxiii}

Most notably, the Internal Appeals & External Review regulations expand the recourse available to claimants for denied health claims by establishing an external appeals process.^{lxxxiv} Under this process, claimants can challenge denials that have not first been overturned through a health plan’s internal mechanism by appealing to an independent review organization (IRO), which is separate from the group health plan.^{lxxxv} Generally, consumers have four months to file for an external review after receiving notice of a claim denial.^{lxxxvi} If the regular review timeframe poses a risk to a claimant’s life or wellbeing (urgent care claim), they can request an expedited review by an IRO, including before the internal process has been completed.^{lxxxvii} For expedited reviews, IROs must issue a final decision within 72 hours.^{lxxxviii} However, the regulations limit eligibility for external review to adverse benefit determinations that involve “medical judgement,” including medical necessity; surprise medical bills; and coverage rescissions.^{lxxxix}



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Even though the law and its implementing regulations provide consumers with the right to have their claims fairly assessed and attempt to curb the potential for abuse by health plans and insurance companies, the reality for consumers is different.

Currently, EBSA is not authorized to assess civil monetary penalties for any violation of the aforementioned regulations, regardless of severity. In the absence of such penalties, health plans and insurers face minimal consequences when they break the law and ignore consumers' rights and, even if they are held accountable, face no additional cost for their illegal conduct. In the end, either through the appeals process or the courts, a group health plan that wrongly denies a claim is often only responsible for paying what it originally owed. Further, the lack of monetary penalties ensures there is no deterrent or disincentive against future violations. The cost of getting caught and following the law is the same, which emboldens insurers to put their bottom line ahead of working Americans trying to access care.

CONSUMERS ARE OFTEN UNAWARE OF HOW TO EXERCISE THEIR RIGHTS

Health insurance in the United States is uniquely complicated. Many Americans struggle to comprehend their coverage, the specifics of their plan, and even their plan's notice of whether they approved or denied a claim.^{lxxx} There are numerous regulatory regimes due to the variety of private health plan options,^{lxxxi} which also means that internal and external appeal processes can vary.^{lxxxii} Confusing and burdensome internal systems can be challenging for consumers to navigate. One study found that Americans spend approximately 12 million hours a week speaking to their insurer.^{lxxxiii}

Working people should not need to be experts on regulations and the bureaucracy of their plans to get the medical services to which they are entitled. Yet, the generally low rate of appeals and the high rate of reversals of claim denials suggest knowledge of one's rights can have an impact. Unfortunately, an overwhelming majority of individuals with employer-sponsored insurance are unaware that they have recourse for denied claims.^{lxxxiv} A 2023 KFF survey found that 57 percent of respondents with job-based health plans were "unsure" if they had "the legal right to appeal to a government agency or an independent medical expert," and 9 percent affirmatively believed they had no such right.^{lxxxv} Setting aside the lack of knowledge regarding appeal rights, 83 percent of adults in these plans do not know which government agency to contact for assistance.^{lxxxvi}

The unfamiliarity with EBSA, specifically, is concerning because the agency administers a program through which "Benefit Advisors" routinely help workers and their families navigate their plans, exercise their rights, and get medical care.^{lxxxvii} Benefit Advisors help working families recover



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hundreds of millions of dollars in health benefits each year.^{lxxxviii} Yet the availability and capacity of these critical consumer services are reliant on the size of EBSA's budget.

THE TRUMP ADMINISTRATION HAS BLOCKED— AND CONTINUES TO TAKE NO ACTION ON— BASIC TRANSPARENCY REQUIREMENTS THAT WOULD SHED A LIGHT ON CLAIM DENIALS

Over the last several years, media reports and exposés have unearthed numerous accounts of Americans being improperly denied coverage for critical medical services and saddled with exorbitant medical bills. These individuals' stories provide an important glimpse into the growing crisis of claim denials and the issues that must be tackled to protect consumers.

However, there is a foundational impediment to combatting wrongful claim denials: no one knows how many claims are even denied each year.^{lxxxix}

Many Americans can recount one or multiple unpleasant instances of their health benefit claims being rejected, yet there is minimal data available on the number of claims that are denied, internally or externally appealed, and the outcome of those appeals for the largest source of health insurance in the country—ERISA-covered health plans. This is a product of years of inaction by federal regulators, who have failed to move forward with necessary reforms that would shed light on this issue.

In 2010, congressional Democrats passed, and President Barack Obama signed, the ACA into law, transforming health care for millions of Americans. Among its many reforms, the ACA required the U.S. Secretary of Labor to issue regulations to harmonize certain group health plan disclosure requirements with those that applied to qualified health plans offered through the ACA Marketplaces.^{xc} One of the items subject to this requirement is “data on the number of claims that are denied.”^{xcii}

In 2016, the Obama Administration took an important step to implement this requirement when EBSA published a proposed rule (2016 Proposed Rule)^{xciii} to revise and improve the existing annual report that employee benefit plans, including group health plans, are required to submit under ERISA, known as the Form 5500.^{xciii} Specifically, the 2016 Proposed Rule would have dramatically improved data collection from group health plans by requiring detailed information of claims payment data, including the number of approved and denied claims; appeals and their outcome; claims and appeals that were not assessed within the required intervals; unpaid claims; and the annual dollar value of paid claims, among other information.^{xciv}



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The 2016 Proposed Rule also addressed a major deficiency in the current regulations governing the Form 5500 that provides an excessively broad exemption for the vast majority of health plans. Under regulations issued by DOL in 1975, millions of health plans with fewer than 100 participants are completely exempt from filing even a partial version of the Form 5500.^{xcv} As a result, only 81,800 plans—approximately 3 percent of all ERISA-covered group health plans—submitted an annual report in 2021, the most recent year for which reliable data is available.^{xcvi} An audit by the DOL Office of the Inspector General (OIG) found that this vast gap in data collection prevents EBSA from performing basic oversight duties on behalf of nearly 80 million Americans in health plans with less than 100 participants.^{xcvii} The OIG also explained that “[a]s a result of this lack of information, EBSA was unable to effectively target its resources. EBSA was also unable to fully comply with the ACA requirement to report on national claim denial rates.”^{xcviii} The audit’s findings prompted the Inspector General to recommend the issuance of regulations to revise or eliminate this exemption.^{xcix} In line with this recommendation, the 2016 Proposed Rule would have eliminated the regulatory exemption for small plans to ensure that all ERISA-covered group health plans would be required to file Form 5500 annual reports.^c

However, these improvements were ultimately not finalized following the change of political leadership by the first incoming Trump Administration. And, yet again, a potential rulemaking begun under the Biden Administration that could have addressed this issue^{ci} no longer appears on the Department’s most recent regulatory agenda following the beginning of the second Trump Administration.^{cii}

Without public disclosures of denial rates, group health plans and insurance companies are operating under a shroud of secrecy, allowing some to conduct arbitrary, improper, and mass claim denials without any accountability. Failure to collect this fundamental information deprives consumers of information about their health plans but also hinders both EBSA and Congress from conducting the necessary oversight to curb patterns of wrongful denials of health benefits.



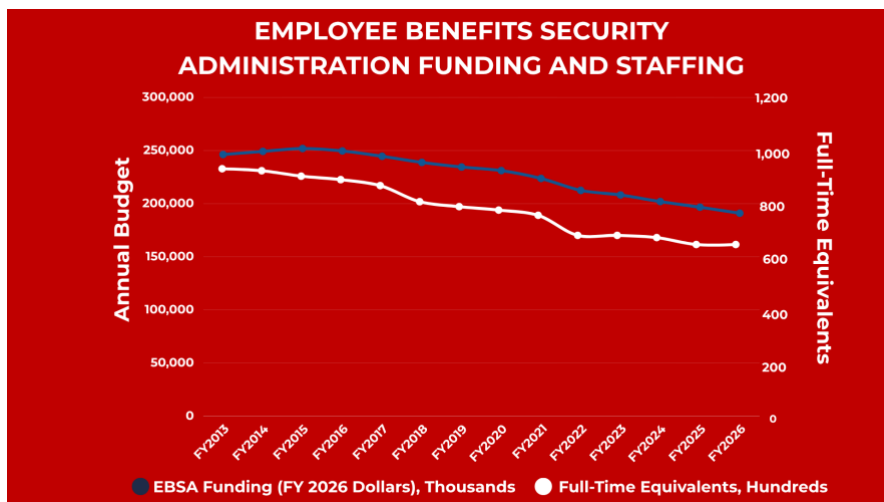
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FEDERAL ENFORCEMENT IS UNDERFUNDED, AND THE TRUMP ADMINISTRATION PUSHES TO FURTHER WEAKEN THE U.S. DEPARTMENT OF LABOR

As described above, ERISA provides consumers with several important protections relating to the review of their claims by group health plans. However, without robust enforcement by EBSA against plans and insurers, the law is rendered a mere suggestion.

EBSA's enforcement powers include the authority to conduct investigations, audit plans, and mandate the submission of reports, books, and records,^{ciii} as well as the authority to enjoin acts or practices that violate the statute or to obtain other appropriate equitable relief with respect to violations.^{civ} Conversely, there are certain unnecessary statutory restrictions on EBSA's enforcement, such as a prohibition on enforcement of group health plan standards directly against insurers^{cv} and a lack of authority to impose civil monetary penalties for violations of the Claims Procedure and Internal Appeals & External Review regulations. But, even more constraining, EBSA is hamstrung by the severe lack of resources available for its vast jurisdiction.

Between 2013 and 2021, EBSA's base budget remained generally flat while operating costs dramatically increased and staffing declined.^{cvi} Since 2021, beyond a one-time lump sum appropriation that expired at the end of 2024 for the implementation of surprise billing protections, EBSA's budget has lagged far behind the overall inflation rate.^{cvi} In addition, since taking office for his second term, President Trump has embarked on a campaign to eviscerate the federal workforce, including at EBSA.



In 2025, the Trump Administration devastated EBSA's workforce through its "deferred resignation" program and early retirement offers, which alone resulted in a sharp drop in the agency's staff count by more than 20 percent.^{cvi} A former senior EBSA official stated that the "agency ha[s] lost 40 [percent] of its investigators since the end of fiscal year 2024."^{cix} Moreover, the Administration called for even more cuts to EBSA in its Fiscal Year (FY) 2026 Budget request, which would have



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resulted in an effective cut of nearly \$30 million.^{cx} While Congress rejected the Trump Administration's drastic proposal, the agency was flat-funded—without any adjustments for inflation—for the fourth consecutive year in FY 2026.^{cx}

To put the agency's capacity in context, ERISA governs 2.8 million health plans, as well as 837,000 retirement plans and 521,000 other employee benefit plans.^{cxii} In 2024, then-Assistant Secretary of EBSA, Lisa Gomez, testified before the Committee on Education and the Workforce that the agency had “less than 1 investigator for every 13,900 [health, retirement, and welfare] plans.”^{cxiii} Over a year into the second Trump Administration, EBSA's bandwidth has become even more dire, with a January 2026 DOL Inspector General report stating that the agency had “roughly 1 investigator for every 21,400 plans.”^{cxiv}

Statutory responsibilities have also grown in recent years with the enactment of major, bipartisan legislation, further stretching investigators.^{cxv} A shrinking budget and staff, with a responsibility of protecting over 130 million consumers, makes it virtually impossible to hold group health plans and insurance companies accountable when they wrongfully deny workers' health benefits. The low probability that the agency will investigate and pursue a case will only embolden noncompliance and fail to deter future violations. Furthermore, the emergence of new industry practices, such as the increasing use of artificial intelligence to review claims,^{cxvi} necessitates an agency that is able to keep pace with insurance practices and protect consumers.

The Trump Administration is not only targeting EBSA's enforcement capacity, but they are also weighing in on behalf of the interests of large companies. In recent months, the Republican leadership at DOL and EBSA has filed numerous amicus briefs in favor of plan fiduciaries over workers, supporting companies such as JPMorgan Chase, Siemens, and Honeywell International.^{cxvii} EBSA is also shifting its enforcement policy from accountability for consumers to leniency for companies. In July 2025, DOL announced several “self-audit programs” that preemptively offer plan fiduciaries and administrators safe harbors from enforcement actions for ERISA violations.^{cxviii}

With ballooning denial rates and new and expansive tactics to reject coverage becoming more prevalent, policymakers must act urgently to protect the lives and livelihood of millions of workers and their families. However, legislative reforms cannot be the sole focus. EBSA needs more resources and higher staffing levels to effectively implement the law and crack down on bad actors; otherwise, any legislative changes, as is the case with current requirements, will continue to be ineffective in addressing the claim denial crisis.



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CONCLUSION

Over 70 percent of Americans believe that our health care system is failing them.^{cxix} For too long, working people have dealt with a broken health insurance system where even the coverage they are owed is not provided. As health care grows more expensive, every wrongful claim denial bears a greater burden on workers and their families who are already struggling to get by. However, the crisis of claim denials within the largest source of health coverage in the nation—employer-sponsored health insurance—has received scant attention.

This report fills that void by outlining the harms and pervasiveness of improper claim denials and industry tactics as well as the current legal rights and protections for consumers. The report also addresses current challenges such as the significant limitations on claim denials data, the lack of awareness by consumers of their rights, and the underfunding and under-resourcing of enforcement to hold health plans and insurance companies accountable when violations occur.

It is incumbent on Congress to act to curb improper claim denials and uphold the promise of health insurance for working people by legislating bold and important reforms, providing adequate funding to federal agencies, and performing meaningful oversight of the implementation of laws intended to protect consumers.

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