Insured Isn’t the Same as Covered

What underinsurance costs patients, and the practices that care for them

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A patient walks up to the front desk and hands over an insurance card. By every measure we track, that patient is covered. But that card may not mean what the patient thinks it means, or what the practice thinks it means either.

In 2026, the average deductible for single coverage in an employer plan is $1,955. In the ACA marketplace, it is far higher. Until that deductible is met, the insurance card mostly entitles the patient to the insurer’s discounted price. The patient pays the bill. Or doesn’t.

That gap between insured and covered is one of the least discussed threats to sustainable healthcare. It costs patients their health and their savings. And it quietly costs the practices that care for them.

The size of the problem

The Commonwealth Fund calls these patients underinsured: they have coverage all year, but their out-of-pocket costs are so high relative to their income that care is hard to afford. In its 2024 national survey, 23 percent of adults were underinsured. That is nearly one in four.

This is not mainly a problem of the uninsured or of Medicaid. Two-thirds of underinsured adults get their coverage through an employer. These are working people, with jobs and benefits, who still cannot afford to use them.

And it is getting worse in the individual market. After the enhanced ACA premium tax credits expired at the end of 2025, many enrollees moved to cheaper bronze plans to keep their premiums affordable. The average marketplace deductible jumped 37 percent in a single year, to a record $3,786.

What it costs the patient

The first cost is care not received. Among underinsured adults, 57 percent avoided needed care because of cost. Of the people who skipped or delayed care, 41 percent said their health problem got worse as a result.

The second cost is debt. Forty-four percent of underinsured adults said they were paying off medical or dental debt, and nearly half of adults with medical debt owed $2,000 or more. Those are not catastrophic injuries. Much of that debt comes from ordinary, ongoing care.

I think about what that means in a primary care exam room. A patient with diabetes who stretches out the time between visits. A blood pressure prescription that does not get filled. A lab test that gets postponed until next year, after the deductible resets. Each of those choices makes sense to a family watching its budget. Each of them raises the odds that the next visit is to the emergency department.

What it costs the practice

The practice pays too, in two ways.

First, patient balances are hard to collect. In a 2025 MGMA report, practices collected about 72 percent of copays at the visit but only about 27 percent of other patient balances. A national revenue cycle report found that insured patients' share of provider revenue grew from 6.8 percent in 2024 to 7.3 percent in 2025, while the share of that money providers actually collected fell from 45 percent to 42 percent. Owed more, collected less.

Think about what that means. The plan collected its premium every month. The patient's out-of-pocket share was the part of the bill the plan's design moved off the plan's books. When that share goes unpaid, it lands on the practice as bad debt. The practice becomes the collection agency for a benefit design it did not choose.

Second, deferred care becomes more expensive care. The patient who skips the visit in March often comes back in October sicker, with more to manage and fewer options. For a practice in a value-based contract, that shows up as higher total cost of care and missed quality measures. For the patient, it shows up as a worse outcome. For the system, it is the opposite of prevention.

I have said that if it is not sustainable, it does not serve the patient. Underinsurance is a clear example. A practice that cannot collect what it is owed cannot keep its doors open. And a practice that pressures a struggling family for money it does not have is not serving that patient either.

What practice leaders can do

There is no perfect answer here, but there are better ones.

Tell patients the price before the visit. Check eligibility and estimate the patient's share in advance, at scheduling or check-in. Patients deserve to know what they will owe, and a surprise is harder to pay than a plan. Transparency works at the front desk just as it does at the negotiating table.

Collect with kindness. Ask for the estimated balance at the time of service, explain it plainly, and offer a payment plan when it is needed. Treat the patient the way you would want your mother treated at that counter.

Have a cash price. For patients facing a large deductible, a clear, fair self-pay price for common services can cost them less than running the visit through their insurance.

Protect the visits that prevent the expensive ones. Make sure patients know which preventive services their plan must cover without cost sharing. Reach out to the chronic patients who have gone quiet. A phone call in March is cheaper for everyone than a hospital stay in October.

Consider models built for this problem. Direct primary care, which I will write about next, takes the deductible out of the primary care relationship altogether with a flat monthly fee. It is not for every practice, but it is a real answer for some patients.

The two questions

A benefit design that lowers the premium by raising the deductible can look like a good deal on paper. So ask the two questions. Does it serve the patient? Is it sustainable?

If patients skip the care that keeps them well, it does not serve them. If the unpaid balance lands on the practice, it is not sustainable for the people delivering care. Insured is not the same as covered, and we should stop pretending that it is.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north. That includes the patient standing at the front desk, wondering what this visit will cost.

Sources

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