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Publicly Insured and Uninsured Patients Are More Likely Than Other Patients to Be Treated Unfairly in Health Care Settings Because of Their Coverage Type

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In an ideal world, the type of health insurance people can or cannot afford should not determine how health care providers and their staff members behave toward patients when they seek care. Yet some patients who are uninsured or have public coverage, such as Medicaid, report experiencing unfair treatment because of their coverage type or ability to pay when seeking health care (Allen et al. 2017; Han et al. 2015; Martinez-Hume et al. 2017; McDaniel et al. 2021; Nong et al. 2020; Tajeu et al. 2015). Experiences of unfair treatment or judgment in health care settings due to insurance type have been associated with unmet health needs (Alcala et al. 2020; Han et al. 2015) that can result in poorer health care quality, undermine patient health and well-being, and contribute to health inequities by race and ethnicity (Institute of Medicine et al. 2003).

Unfair treatment due to health insurance type could have many causes, including bias and discrimination on the part of providers and office staff members. Patients with Medicaid coverage or who are uninsured may encounter providers who have negative perceptions about uninsured and publicly insured people, resulting in providers and their staff shaming, ignoring, or otherwise disrespecting these patients (Arpey, Gaglioti, and Rosenbaum 2017; Hume et al. 2017). Providers may also alter their clinical decisions if they perceive, based on the patient's health insurance type or lack of insurance, that a patient may be unable to pay for services (Meyers et al. 2006). For the uninsured, provider attitudes could be related to concerns about a patient's ability to pay for care, the prospect of providing uncompensated care, or a patient's ability to afford follow-up visits, recommended tests, and prescription drugs (Allen et al. 2014; Allen et al. 2017; Han et al. 2015; Martinez-Hume et al. 2017; Tajeu et al. 2015).

Provider perceptions of or experiences with structural aspects of the Medicaid program may also drive unfair treatment. These aspects include Medicaid's lower provider payment rates relative to those of private insurers and administrative hassles associated with billing and prior authorization that make serving a Medicaid-insured population more time consuming and costly (MACPAC 2021). Patients may also perceive difficulties with finding providers who will accept them as patients, scheduling appointments in a timely way, and requiring upfront payment as unfair treatment; these experiences are more common for publicly insured and uninsured patients than for those who are privately insured (Gotlieb, Rhodes, and Candon 2021; Hsiang et al. 2019; Kenney et al. 2014; Oostrom, Einav, and Finkelstein 2017).

Understanding who is experiencing unfair treatment and patients' perceptions of why they are being treated unfairly is necessary so that policymakers and payers can implement effective policies to prevent such treatment. Our study provides a national picture of the extent to which privately insured, publicly insured, and uninsured patients perceive they are being treated unfairly because of their coverage type and other reasons when seeking care. Drawing on data from the 2021 Health Reform Monitoring Survey (see the Data and Methods section), we assess how the share of nonelderly adults experiencing unfair treatment or judgment because of their health insurance type at a doctor's office, clinic, or hospital (henceforth "health care settings") in the prior year varies by their coverage type (i.e., full-year private coverage, full-year public coverage, and full-year uninsurance). The highlights of our study include the following:

- Adults with public coverage and those who were uninsured were more than twice as likely as adults with private coverage to report that they had experienced unfair treatment for one or more reasons (17.4 percent and 13.9 percent versus 6.4 percent).
- Adults with public coverage and those who were uninsured were also more likely than adults with private coverage to report experiencing unfair treatment because of health insurance *and* another reason.
    - » Among publicly insured adults who reported being treated unfairly because of their health insurance type and another reason, the most common other reasons were income, a disability or a health condition, and race or ethnicity.
- Adults with public health insurance coverage and those who were uninsured were more than five times as likely as adults with private coverage to report that they had experienced unfair treatment or judgment in health care settings in the prior year because of their health insurance coverage type (9.6 percent and 7.4 percent versus 1.3 percent).
    - » After adjusting for observed demographic, socioeconomic, health, and geographic characteristics of nonelderly adults in our sample, differences in the shares of people reporting unfair treatment due to health insurance coverage type remain between publicly insured and privately insured adults and between uninsured and privately insured adults. However, the differences do narrow.[1]

- Having a disability, a physical health condition, or a behavioral health condition was also associated with a greater likelihood of reporting unfair treatment due to health insurance coverage both when adjusting and not adjusting for selected demographic and other characteristics.
- Adults with public coverage were also more likely to report insurance-related hassles than those with private coverage (16.2 versus 11.0 percent), after adjusting for observed differences between privately and publicly insured adults.

Our study finds that adults with public insurance coverage and those who are uninsured are more likely to experience unfair treatment in health care settings than those with private health insurance coverage, which they partly attribute to their health insurance type. Increasing provider payment in Medicaid and reducing administrative barriers that providers face with Medicaid could help reduce these differences.[2] But publicly insured and uninsured adults also indicate that they experience unfair treatment at higher rates than those with private insurance for other reasons, such as their income, disability status, and race and ethnicity. Thus, other factors beyond concerns about payment and administrative barriers appear to be eroding the quality of care Medicaid-covered and uninsured patients receive and their interactions with the health care system and providers. As such, addressing payment and administrative barriers is likely necessary but insufficient for reducing the treatment inequities these patients experience. More exploration is needed to assess the roles insurance-related hassles and differential access to care play in shaping people's perceptions of unfair treatment due to insurance type. Recognizing and addressing the discrimination and bias that underlie experiences of unfair treatment or judgment in health care settings will be important for improving health care services across all insurance types.

Results

Adults with public coverage and those who were uninsured were more than twice as likely as those with private coverage to report unfair treatment due to one or more reasons and to report unfair treatment due to health insurance and another reason.

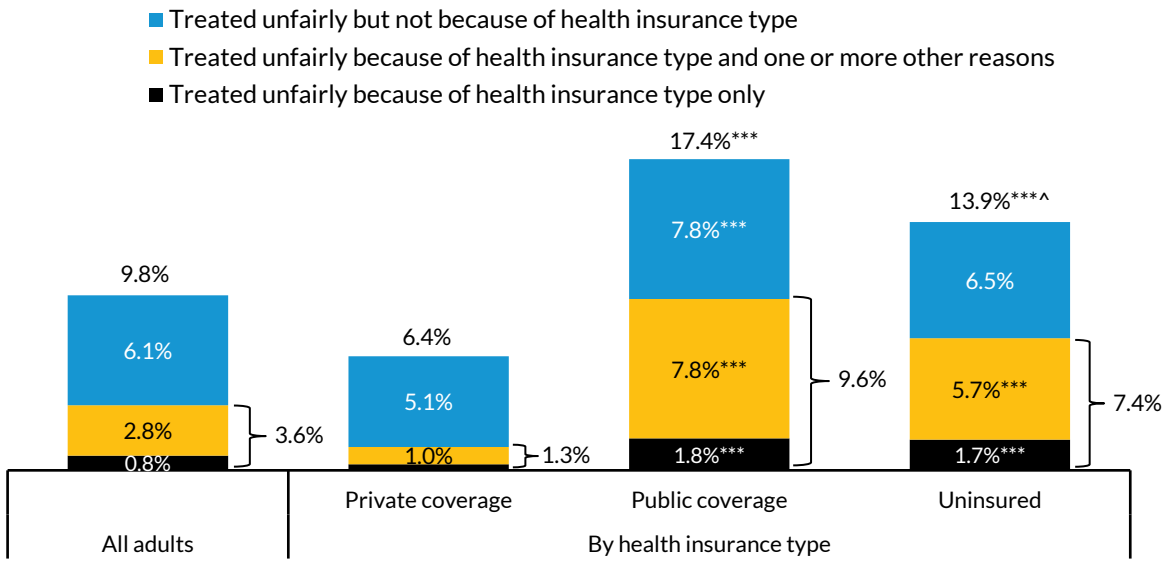
Overall, 9.8 percent of nonelderly adults reported that they experienced unfair treatment in a health care setting in the prior year because of one or more of the following reasons: racial or ethnic background, country of origin, primary language, a disability, a health condition, gender or gender identity, sexual orientation, health insurance coverage type, income level, or some other reason (figure 1). Adults with public coverage and those who were uninsured were more than twice as likely as adults with private coverage to report that they had experienced unfair treatment for one or more reasons (17.4 percent and 13.9 percent versus 6.4 percent).

Among the 9.8 percent of adults who reported unfair treatment due to any reason, roughly one-third (3.6 percent) said they were treated unfairly because of their health insurance type, either alone or in combination with one or more other reasons. This includes 2.8 percent of adults who were treated unfairly because of their health insurance type and one or more other reasons and 0.8 percent who

were treated unfairly only because of their health insurance type. Adults with public coverage and those who were uninsured were more likely than those with private coverage to report unfair treatment due to their health insurance type in combination with one or more other reasons (7.8 percent and 5.7 percent versus 1.0 percent).

FIGURE 1

Share of Adults Ages 18 to 64 Reporting Unfair Treatment or Judgment in Health Care Settings in the Past 12 Months, Overall and by Health Insurance Type, April 2021



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Source: Health Reform Monitoring Survey, April 2021.
Notes: Estimates by health insurance type are based on adults with the same coverage type all year. The shares of adults reporting unfair treatment due to health insurance alone or in combination with another reason add up to the total share of adults reporting unfair treatment due to health insurance. The share of adults with private coverage who reported unfair treatment only because of health insurance is 0.3 percent. Adults could have reported unfair treatment due to one or more of the following: racial or ethnic background, country of origin, primary language, a disability, a health condition, gender or gender identity, sexual orientation, health insurance coverage type, income level, or some other reason.
*/**/*** Estimate differs significantly from that for adults with private coverage at the 0.10/0.05/0.01 level, using two-tailed tests.
^/^^/^^^ Estimate differs significantly from that for adults with public coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

Among publicly insured adults who reported being treated unfairly because of their health insurance type and another reason, the most common other reasons were income (5.9 percent), a disability or health condition (4.6 percent), and race or ethnicity (2.6 percent; table 1).

Adults with public insurance were more likely than those with private insurance and those who were uninsured to report that they experienced unfair treatment because of their coverage type and income level (5.9 percent versus 0.7 percent and 3.7 percent), health insurance and a disability or health

condition (4.6 percent versus 0.5 percent and 1.7 percent), and health insurance and racial or ethnic background (2.6 percent versus 0.5 percent and 1.4 percent).

Among adults with private health insurance coverage, those with family incomes below 250 percent of the federal poverty level (FPL) were more likely than those with higher incomes to report that they experienced unfair treatment because of their coverage type and income level (3.4 versus 0.5 percent), coverage type and a disability or health condition (2.7 versus 0.4 percent), and coverage type and racial or ethnic background (2.9 versus 0.4 percent; data not shown).

TABLE 1

Share of Adults Ages 18 to 64 Reporting Unfair Treatment or Judgment in Health Care Settings Due to Health Insurance Type and One or More Other Reasons in the Past 12 Months, by Health Insurance Type, April 2021

	Health Insurance Type		
	Private coverage	Public coverage	Uninsured
Treated unfairly for the following reasons (%)			
Health insurance and one or more other reasons	1.0	7.8***	5.7***
Health insurance and income level	0.7	5.9***	3.7***^
Health insurance and a disability or health condition	0.5	4.6***	1.7***^^^
Health insurance and racial or ethnic background	0.5	2.6***	1.4*^^
Health insurance and another reason	0.7	3.5***	2.5***
Sample size	**5,369**	**1,517**	**739**

Source: Health Reform Monitoring Survey, April 2021.

Notes: Estimates are based on adults with the same coverage type all year. "Another reason" includes respondents who reported being treated unfairly because of country of origin, primary language, gender or gender identity, sexual orientation, or some other reason.

*/**/*** Estimate differs significantly from that for adults with private coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for adults with public coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

Adults with public health insurance coverage and those who were uninsured were more than five times as likely as adults with private coverage to report that they had experienced unfair treatment or judgment in health care settings because of their coverage type.

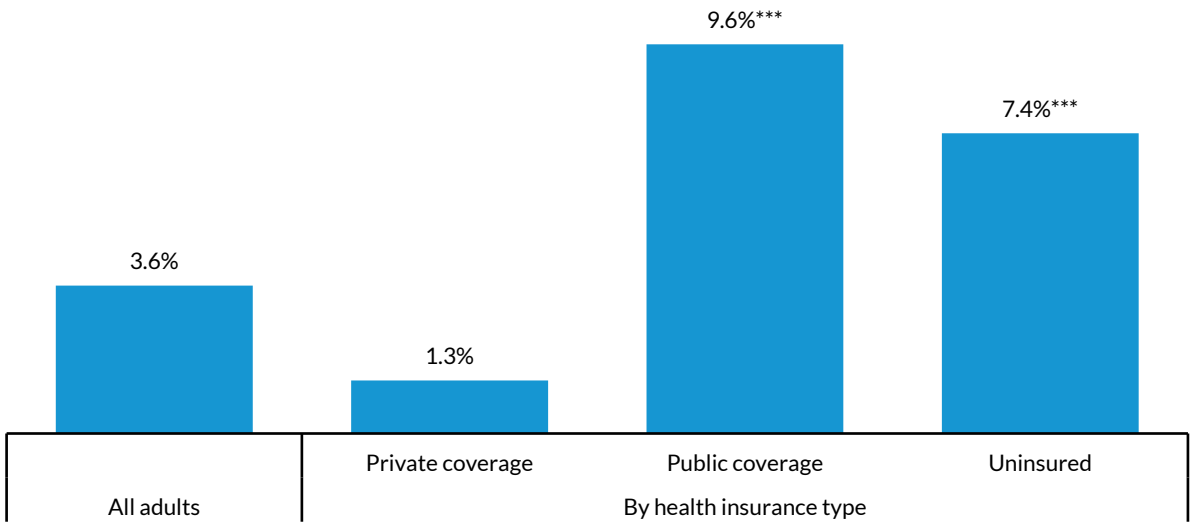
Overall, 3.6 percent of nonelderly adults reported that they experienced unfair treatment or judgment in health care settings in the prior 12 months because of their health insurance type (figure 2). Adults with public coverage and those who were uninsured were more than five times as likely as adults with private coverage to report that they had experienced unfair treatment for this reason (9.6 percent and 7.4 percent versus 1.3 percent).

Adults who were uninsured for part of the year reported unfair treatment due to coverage type at a rate similar to that for adults uninsured all year (8.4 versus 7.4 percent; data not shown). Similarly, adults insured all year but with multiple coverage types reported a similar rate of unfair treatment due to health insurance type as adults with private coverage only (1.9 versus 1.3 percent; data not shown).[3]

When considering only people who sought care for themselves in the past 12 months, we see similar patterns. About 3.8 percent of all adults, 1.4 percent of adults with full-year private coverage, 10.1 percent of adults with full-year public coverage, and 9.7 percent of adults uninsured all year reported unfair treatment due to their health insurance type (data not shown).[4]

FIGURE 2

Share of Adults Ages 18 to 64 Reporting Unfair Treatment or Judgment in Health Care Settings Due to Health Insurance Type in the Past 12 Months, Overall and by Health Insurance Type, April 2021



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Source: Health Reform Monitoring Survey, April 2021.
Notes: Estimates by health insurance type are based on adults with the same coverage type all year.
*/**/*** Estimate differs significantly from that for adults with private coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

After adjusting for observed demographic, socioeconomic, health, and geographic characteristics of nonelderly adults in our sample, differences in the shares of people reporting unfair treatment due to health insurance coverage type remain between publicly insured and privately insured adults and between uninsured and privately insured adults. However, the differences do narrow.

People's coverage types were not the only factor determining whether they felt they had been treated or judged unfairly because of their coverage type. In unadjusted analyses, Black adults with private coverage were more likely than white adults with private coverage to report unfair treatment due to their health insurance type (3.2 versus 0.9 percent; table 2). Privately insured adults with family incomes at or below 138 percent of FPL were more likely to report unfair treatment due to health insurance type than those with higher incomes (4.8 versus 1.1 percent).

TABLE 2

Unadjusted Share of Adults Ages 18 to 64 Reporting Unfair Treatment or Judgment in Health Care Settings Due to Health Insurance Type in the Past 12 Months, by Health Insurance Type and Selected Characteristics, April 2021

	Health Insurance Type		
	Private coverage	Public coverage	Uninsured
All adults (%)	**1.3**	**9.6**	**7.4**
Demographic characteristics (%)			
Gender			
Women^	1.3	10.7	9.5
Men	1.3	7.8	5.1*
Age			
18–34^	1.2	8.8	—
35–49	1.6	11.9	8.9
50–64	1.1	8.5	—
Race/ethnicity			
White^	0.9	9.8	9.1
Black	3.2**	10.0	—
Hispanic/Latinx	1.8	9.4	7.2
Additional races	1.6*	—	—
Socioeconomic characteristics (%)			
Family income			
At or below 138% of FPL^	4.8	9.9	8.2
Above 138% of FPL	1.1***	9.0	6.6
Educational attainment			
High school degree or less^	1.8	8.1	7.1
Some college or more	1.1	12.3**	8.0
Geographic characteristics (%)			
Region			
Northeast^	1.4	6.3	—
Midwest	1.0	10.0*	—
South	1.3	10.5**	8.1
West	1.6	10.4	—
Urban or rural residence			
Lives in urban area^	1.3	10.2	7.4
Does not live in urban area	1.2	6.6*	—
Sample size	**5,369**	**1,517**	**739**

Source: Health Reform Monitoring Survey, April 2021.

Notes: FPL is federal poverty level. — represents estimates suppressed because of sample size restrictions. Estimates are based on adults with the same coverage type all year. People who are Black, white, and additional races are not Hispanic/Latinx.

*/**/*** Estimate differs significantly from that for the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

Among adults with public coverage, those with some college education or a college degree were more likely than those with lower educational attainment to report unfair treatment (12.3 versus 8.1 percent). Adults with public coverage in the Midwest and the South were more likely than those in the Northeast to report unfair treatment due to insurance type (10.0 percent and 10.5 percent versus 6.3 percent). The distribution of Black and Hispanic/Latinx populations likely explains some of these geographic patterns. For example, Black adults, who constitute a disproportionate share of the

Medicaid population, are more likely to live in the South (Tamir 2021).[5] Among uninsured respondents, women reported unfair treatment due to health insurance type at higher rates than men (9.5 versus 5.1 percent).

Among both publicly insured and privately insured adults, those with a disability, a physical health condition, or a behavioral health condition were much more likely than such adults without disabilities or who lacked these health conditions to report that they experienced unfair treatment because of their health insurance coverage type (table 3). Similarly, both publicly insured and privately insured adults in fair or poor health were more likely than such adults in excellent or very good health to report experiencing unfair treatment because of their coverage type.

Uninsured adults with a physical health condition were four times as likely as those without a physical health condition to report experiencing unfair treatment because of their coverage type.

TABLE 3

Unadjusted Share of Adults Ages 18 to 64 Reporting Unfair Treatment or Judgment in Health Care Settings Due to Health Insurance Type in the Past 12 Months, by Health Insurance Type and Selected Health Characteristics, April 2021

	Health Insurance Type		
	Private coverage	**Public coverage**	**Uninsured**
All adults (%)	**1.3**	**9.6**	**7.4**
Disability status (%)			
Has a disability^	6.6	14.8	—
Does not have a disability	0.9***	7.0***	6.7
Presence of physical health condition (%)			
Has a physical health condition^	1.7	12.4	15.4
Does not have a physical health condition	0.9**	4.9***	3.8***
Presence of behavioral health condition (%)			
Has a behavioral health condition^	2.5	14.3	—
Does not have a behavioral health condition	0.9***	5.1***	4.6
Health status (%)			
Excellent or very good^	1.1	6.2	3.4
Good	1.2	9.8	8.5*
Fair or poor	3.1**	12.3***	—
Sample size	**5,369**	**1,517**	**739**

Source: Health Reform Monitoring Survey, April 2021.

Notes: — represents estimates suppressed because of sample size restrictions. Estimates are based on adults with the same coverage type all year.

*/**/*** Estimate differs significantly from that for the reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

When we adjust for observed demographic, socioeconomic, health, and geographic characteristics of nonelderly adults in the sample, we still find that those with public coverage and those who were uninsured were more likely than those with private coverage to report unfair treatment due to their health insurance type in the prior 12 months. But the difference in this measure between those with public versus private coverage decreases from 8.3 to 4.8 percentage points, and the difference between

uninsured adults and those with private coverage decreases from 6.1 to 5.6 percentage points (table 4). This suggests that differences in the characteristics of privately insured, publicly insured, and uninsured adults partly explain the differences in reported unfair treatment due to health insurance type between these groups. However, that differences in reported unfair treatment remain significant even after adjusting for these characteristics suggests other factors may contribute to the discrepancies.

TABLE 4

Regression Coefficients Associated with Unfair Treatment or Judgment in Health Care Settings Due to Health Insurance Type among Adults Ages 18 to 64 Who Were Publicly Insured, Privately Insured, or Uninsured, April 2021

	Treated unfairly because of health insurance type in the past 12 months
Health insurance coverage type	
Has public coverage	0.048***
Is uninsured	0.056***
Demographic characteristics	
Men	-0.005
Ages 18 to 34	0.001
Ages 35 to 49	0.012*
Black	0.011
Hispanic/Latinx	-0.001
Additional races	0.004
Socioeconomic characteristics	
Family income at or below 138% of FPL	0.014*
Less than high school degree	0.002
High school degree	-0.008
Some college	0.003
Bilingual or speaks Spanish	0.009
Health characteristics	
Has a disability	0.050***
Has a physical health condition	0.018***
Has a behavioral health condition	0.029***
Good health status	0.001
Fair/poor health status	0.012
Geographic characteristics	
Midwest	0.003
South	0.005
West	0.009
Lives in an urban area	0.011*
Constant	**-0.026**
N	**7,625**

Source: Health Reform Monitoring Survey, April 2021.

Notes: FPL is federal poverty level. Estimates are based on adults with the same coverage type all year. People who are Black, white, and additional races are not Hispanic/Latinx. Reference groups are adults with private coverage, women, adults ages 50 to 64, white adults, adults with incomes above 138 percent of FPL, adults with a college degree or higher, adults whose primary language is English, adults without a disability, adults without a physical health condition, adults without a behavioral health condition, adults in excellent or very good health, adults living in the Northeast, and adults not living in an urban area.

*/**/*** Estimated association differs significantly from zero at the 0.10/0.05/0.01 level.

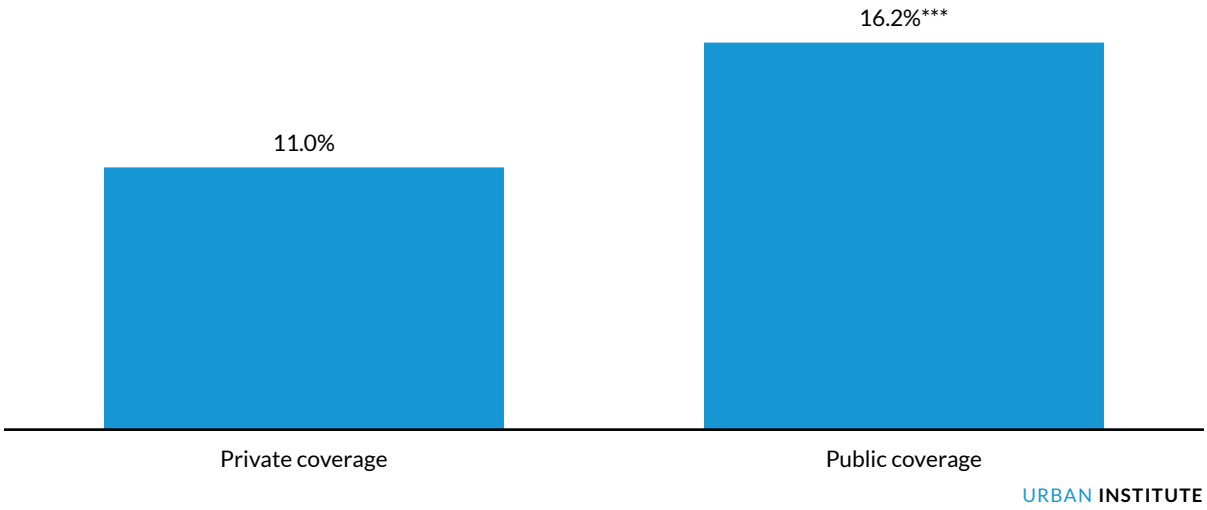
Further, differences in reported unfair treatment between some populations, especially those who may have elevated health needs, remain significant after adjusting for insurance type and other characteristics. For example, people with disabilities were about 5.0 percentage points more likely than those without disabilities to report unfair treatment due to health insurance type. People with behavioral health conditions were about 2.9 percentage points more likely than those without behavioral health conditions to report unfair treatment due to health insurance type. The higher reports of unfair treatment among this population could also be related to the greater number of interactions people with disabilities and health conditions tend to have with the health care system.[6]

Adults with public coverage were more likely than those with private coverage to report that they had an unmet health need because of an insurance-related hassle, even after adjusting for observed demographic, health, and socioeconomic characteristics.

We find that 16.2 percent of adults with public coverage reported having an unmet need for care because of an insurance-related hassle, defined as difficulties getting authorization from a health insurer for care or prescription drugs, finding a doctor or health care provider who is accepting new patients, or finding a doctor or health care provider who would accept their health insurance coverage type, in the past 12 months (figure 3). This share is 11.0 percent among adults with private health insurance coverage. These patterns suggest that, on average, adults experience greater hassles associated with having Medicaid coverage relative to private insurance, which, in turn, could be interpreted by patients as unfair treatment.[7]

FIGURE 3

Share of Adults Ages 18 to 64 Reporting an Unmet Need for Care Due to Insurance-Related Hassles in the Past 12 Months, by Health Insurance Type, April 2021



Source: Health Reform Monitoring Survey, April 2021.
Notes: Estimates are based on adults with the same coverage type all year. Insurance-related hassles include difficulties getting authorization from a health insurer for care or prescription drugs, finding a doctor or health care provider who is accepting new patients, and finding a doctor or health care provider who would accept the respondent's health insurance coverage type.

Estimates are adjusted for respondent gender, age, race and ethnicity, family income, educational attainment, primary language, disability status, presence of physical conditions, presence of behavioral health conditions, health status, census region, and urban or rural residence.
*/**/*** Estimate differs significantly from that for adults with private coverage at the 0.10/0.05/0.01 level.

Discussion

Our study finds that publicly insured and uninsured adults report experiencing unfair treatment or judgment because of their health insurance type at significantly higher rates than privately insured adults. These differences narrow but are not eliminated after adjusting for key health, demographic, and socioeconomic characteristics. Additionally, adults with public coverage or who were uninsured were more likely to report unfair treatment due to health insurance in combination with other reasons, such as race or ethnicity, showing that people with these insurance types are more likely to have other characteristics that place them at higher risk of being treated unfairly. Experiences of unfair treatment could be compounding for these adults, or they could be finding it hard to determine why they are being treated unfairly. Even when controlling for other characteristics, including health insurance type, people with a disability and people with health conditions were more likely to report unfair treatment due to their coverage type. These experiences may reflect negative provider or staff biases toward people with disabilities or particular health conditions, or they could reflect a lack of appropriate accommodations that meet these patients' needs. These populations often have elevated health care needs, but these negative experiences and the resulting lack of trust in the health care system could be deterring them from getting needed care.

There is still much to learn about the nature of the unfair treatment patients experience because of their health insurance type, especially to distinguish between treatment that may be related to aspects of the Medicaid program (e.g., hassles associated with seeking authorization for care or prescriptions) and negative interpersonal treatment at the point of care or when speaking to front office staff. The types of solutions that would target unfair treatment due to insurance type in health care will depend on uncovering these distinctions.

Reducing Administrative, Payment, and Other Barriers in Medicaid

To the extent that administrative hassles, low reimbursement rates for providers who serve Medicaid patients, or patients' inabilities to find appointments in a timely way contribute to perceptions of unfair treatment, then steps that address these issues could reduce unfair treatment due to insurance type. Providers often do not accept Medicaid patients because of the low reimbursement rates associated with the program, the greater complexity required to navigate billing, or the greater cost associated with treating Medicaid patients, who often have more complex medical needs.[8] Physicians in states with greater administrative hurdles in billing for their Medicaid programs are significantly less likely to accept Medicaid patients, and reductions in administrative hassles for providers have been found to increase providers' acceptance of Medicaid patients (Dunn et al. 2021). Reducing administrative hassles and other insurance-related barriers by streamlining payment or other administrative processes and

increasing Medicaid reimbursement rates could help reduce unfair treatment stemming from these issues (Alexander and Schnell 2019; Dunn et al. 2021; Long 2013; Polsky et al. 2015).

Mitigating Provider and Office Staff Bias and Discrimination

To the extent that providers' and their staff members' implicit or explicit biases about publicly or uninsured patients drive unfair treatment due to insurance type, policies to reduce unfair treatment will require counteracting these biases and holding providers accountable for providing culturally competent care, regardless of their patients' identities and socioeconomic statuses. Steps policymakers and other stakeholders can take to make progress on this front include collecting patient satisfaction surveys that incorporate questions about unfair treatment and publishing these results, extending trainings around implicit and explicit biases and cultural competence to include not only health care providers but also their front office and billing staff members, incorporating criteria around providers' and office staff members' abilities to provide culturally competent care into performance evaluations, and being intentional about hiring providers and front office and billing staff members with track records of providing exceptional customer service and culturally competent care (Bleich, Zephyrin, and Blendon 2021).[9] Mitigating unfair treatment by providers and their staff members could help reduce disruptions to care stemming from these experiences (Gonzalez et al. 2022).

Addressing Affordability Issues Facing Uninsured People

Affordability, providers' perceptions of patients' abilities to pay for services, and requirements around upfront payment could be reasons why uninsured or privately insured adults with low incomes experience unfair treatment. For example, unfair treatment may stem from providers' responses to the challenges uninsured patients may experience in meeting their out-of-pocket costs, such as payments for office visits. Reducing the size of the uninsured population could be accomplished by expanding Medicaid eligibility in states that have yet to do so under the Affordable Care Act or expanding eligibility to additional groups of immigrants who are currently ineligible, enhancing subsidies for Marketplace coverage, and increasing enrollment and retention among people who are eligible for Medicaid or subsidized coverage but are not enrolled (Branham, Peters, and Sommers 2021; Buettgens 2021; Buettgens, Banthin, and Green 2022; Lacarte, Greenberg, and Capps 2021; Pollitz, Tolbert, and Orgera 2021). Broadening access to affordable care options by increasing capacity at federally qualified health centers could lower the out-of-pocket costs faced by the remaining uninsured population, which, in turn, could help reduce unfair treatment based on ability to pay (Behr et al. 2022; Lewis et al. 2021; Richards et al. 2014).

Conclusion

Though other studies have explored patients' perceptions of discrimination and unfair treatment by health insurance coverage type, our study is among few to assess these experiences nationally (Nong et al. 2020) and to quantify such experiences (Alcala et al. 2020; Allen et al. 2017; Han et al. 20175; Nong et al. 2020). Learning more about unfair treatment in health care settings and its adverse effects on

patients' care, health, and well-being—especially for populations who have elevated health needs or face systemic disadvantages—is important. Future work should continue exploring these issues to shed light on solutions that would expand patient receipt of high-quality health care regardless of ability to pay or health insurance type.

Data and Methods

Data

We draw on the Urban Institute's Health Reform Monitoring Survey (HRMS), a nationally representative, internet-based survey of adults ages 18 to 64 launched in 2013 to provide timely information on the Affordable Care Act before data from federal surveys are available. HRMS samples are drawn from Ipsos's KnowledgePanel, the nation's largest probability-based online research panel, which includes households with and without internet access. If needed, panel members are given internet access and web-enabled devices to facilitate their participation. The HRMS is currently fielded annually, and 9,067 respondents participated in April 2021. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population, based on benchmarks from the Current Population Survey and the American Community Survey. Participants can take the survey in English or Spanish.

Measures

We examine outcomes by the following health insurance coverage types: full-year private coverage, full-year public coverage, and full-year uninsurance. Public insurance includes Medicaid and Medicare, and about 90 percent of respondents with public insurance reported having Medicaid. Private insurance includes employer-sponsored insurance, Marketplace and other nongroup coverage, and TRICARE or other military coverage.

Having a physical health condition is defined as having been diagnosed with one or more of the following: hypertension; high cholesterol; heart condition; stroke; cancer; diabetes; asthma; chronic obstructive pulmonary disease, emphysema, or chronic bronchitis; arthritis; liver disease; or kidney disease. Having a behavioral health condition is defined as having been diagnosed with one of the following conditions: anxiety, depression, another type of mental health condition, or a problem with alcohol or drug use.

We define unmet needs for care in the past 12 months due to insurance-related hassle as those attributable to difficulties getting authorization from a health insurance plan for health care, getting authorization from a health insurance plan for prescription drugs, finding a doctor or health care provider who was accepting new patients, or finding a doctor or health care provider who would accept the respondent's health insurance coverage type.

Our measure of unfair treatment in health care settings is based on questions that ask respondents whether there was a time in the past 12 months when they felt treated or judged unfairly at a doctor's office, clinic, or hospital because of one or more of the following reasons:

- racial or ethnic background
- gender or gender identity
- sexual orientation
- country of origin
- primary language
- health insurance coverage type
- a disability
- a health condition
- income level
- some other reason (specify)

Approach

We examine perceptions of unfair treatment or judgment due to one or more of the above listed reasons at a doctor's office, clinic, or hospital in the 12 months before April 2021. We first determine the unadjusted share of adults who reported unfair treatment or judgment due to their health insurance coverage type overall and by insurance coverage type. We do not report estimates based on sample sizes with fewer than 250 respondents.

We also assess differences in reported unfair treatment or judgment in health care settings due to health insurance coverage type in a linear probability model that includes coverage type, gender, age, race and ethnicity, family income as a percentage of the FPL, educational attainment, primary language, disability status, presence of physical health conditions, presence of behavioral health conditions, self-reported health status, region, and urban or rural residence. Finally, we assess the share of privately and publicly insured respondents who reported facing insurance-related hassles in the past 12 months.

Limitations

Our study has several limitations. First, though the cumulative response rate for the HRMS is much lower than the response rates for federal surveys such as the National Health Interview Survey and the Current Population Survey, analyses have found that HRMS estimates benchmark well against those from the National Health Interview Survey and other surveys (Karpman and Long 2015; Long et al. 2014). Moreover, we are limited in our ability to characterize experiences of unfair treatment given that these are fully self-reported patient perceptions, and we cannot complement these with measures of provider behavior or intent. In addition, because people with public coverage or who are uninsured are

more likely to have other characteristics, such as a disability or low income, that place them at greater risk of experiencing unfair treatment in health care settings, some respondents may have attributed unfair treatment to health insurance type when they may have been treated unfairly because of a reason overlapping with insurance (e.g., income or disability). Additionally, we cannot determine whether respondents were seeking care for themselves or someone else (e.g., a child) when they were treated or judged unfairly. Further, though we report on key insurance-related hassles, such as providers not accepting a respondent's insurance coverage type, we cannot capture all the factors that could make interacting with public or private insurance difficult for patients. We also cannot determine whether and to what extent reported unfair treatment or judgment is related to administrative difficulties or interpersonal interactions beyond administrative failings.

Additionally, our estimates are subject to underreporting because we asked respondents to report experiences of unfair treatment or judgment in the last 12 months, so we do not capture the experiences of people who may have experienced unfair treatment in a longer time frame or who did not see a provider in the past 12 months. We may also be underreporting experiences of unfair treatment or judgment in health care settings because respondents may not know the reason they were treated unfairly or may hesitate to classify their negative experience as discrimination without evidence (McDaniel et al. 2021).

Further, some respondents, such as those with health care conditions and disabilities requiring frequent medical care, may have more encounters with the health care system. This could increase their chances of encountering unfair treatment relative to someone who interacts less frequently with health care settings. Sample sizes also do not permit us to assess the consequences to health care receipt for people who experienced unfair treatment because of their health insurance type. Further, some measurement error may be associated with reported health insurance coverage type. Finally, the HRMS is only conducted in English and Spanish, so we do not capture the experiences of respondents who do not speak these languages.

Notes

1 See the Data and Methods section for more information.

2 Tiffany N. Ford and Jamila Michener, "Medicaid Reimbursement Rates Are a Racial Justice Issue," Commonwealth Fund blog, June 16, 2022, https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue.

3 Because of sample size restrictions, we do not present analyses for people uninsured part of the year or with multiple insurance types throughout the year in later sections of this brief.

4 We base these estimates on all adults in our sample who sought care for themselves through one or more of the following: a routine checkup, an encounter with a provider or specialist to discuss health, a telehealth visit, or a visit to the emergency department.

5 "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity, Timeframe: 2019," Kaiser Family Foundation, accessed August 9, 2022, https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-

raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] In sensitivity analyses where we control for whether adults sought one or more types of care (see endnote 4 for definition) in the past 12 months, the results do not change.

[7] Adults with private insurance face higher out-of-pocket-spending burdens than those with public coverage. This could introduce access barriers, particularly among adults with low incomes.

[8] Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't," *Health Affairs Forefront*, April 10, 2019, https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/.

[9] Rick Evans, Shari Berman, Esther Burlingame, and Stephanie Fishkin, "It's Time to Take Patient Experience Measurement and Reporting to a New Level: Next Steps for Modernizing and Democratizing National Patient Surveys," *Health Affairs Forefront*, March 16, 2020, https://www.healthaffairs.org/do/10.1377/forefront.20200309.359946/full/; and Vivek Garg, Amberly Molosky, Sandeep Palakodeti, and Sachin H. Jain, "Rethinking How Medicaid Patients Receive Care," *Harvard Business Review*, October 5, 2018, https://hbr.org/2018/10/rethinking-how-medicaid-patients-receive-care.

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