Patient Affordability as a Strategic Imperative:

How 5 Leading Health Systems Are Responding to Rising Patient Out-of-Pocket Costs

October 2026

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Executive Summary

Rising patient liability, thin margins, and shrinking public coverage are converging to make patient affordability a core strategic issue for health systems. Deductibles have risen 43% over the past decade, and a targeted analysis by Cedar indicates that the share of out-of-pocket liability in large, slow-to-collect balances climbed from 37.5% to 49.3% over the course of 2025 alone. At the same time, the average not-for-profit health system operates at a 1.3% margin, and policy changes such as the expiration of enhanced ACA subsidies and looming Medicaid work requirements are expanding the underinsured population that falls between existing assistance pathways. To respond effectively, systems must treat affordability as an enterprise strategy spanning financial access, pricing, and revenue integrity, rather than as a collection function.

This case series, conducted in partnership with Cedar, examines five health systems of different structures and market conditions, drawing on interviews with CFOs, revenue cycle leaders, and operational staff. The central obstacle was not a lack of technical capability but difficulty around centralization. Key gaps across the systems include:

- **Integration and systemness:** Functions are split across teams, reporting lines, and technology stacks, so no one owns pre-service outcomes end to end.
- **Underinsured policy gaps:** Charity and payment-plan policies rarely serve underinsured patients who cannot absorb their expected liability.
- **Upstream data gaps:** Systems lack early, reliable access to eligibility, payer responsibility, and financial information, which keeps payment conversations downstream.
- **Uniform post-service policies:** Collection approaches are not segmented by ability or likelihood to pay, so outreach is either too aggressive or too weak.
- **Underused platform capabilities:** Available tools, such as patient risk scoring, sit enabled but unused in workflows.
- **Estimate accuracy:** Payer-layer complexity makes upfront estimates hard to get right, limiting their value for pre-service collection.
- **Measurement:** Few systems track access outcomes alongside realized revenue and cost-to-collect, so local gains can shift burdens elsewhere unseen.

The systems that performed best shared several traits, including upfront patient cost conversations, presumptive charity screening, coverage discovery before collection, and segmented post-service outreach. Ultimately, the most durable approach treats affordability as a continuous operational capability built on clear ownership, shared metrics that track access alongside realized revenue, and the agility to adjust as pressures change.

Section 1:

Market Context: Patient Liability, Operating Margins, and Political Disruption

"It's going to get harder for patient liability, with all of the things that are happening, it's just going to get harder."

— Chief Revenue Officer, System C

Introduction

Insurance coverage status is an increasingly unreliable predictor of patient payment ability as rising deductibles, copays, and premiums incrementally shift more financial liability to patients. Over the last ten years, deductibles have increased 43%, with 62% of insured adults reporting concern about affording healthcare costs before their insurance takes effect.[1,2] Consequently, the underinsured population, insured patients with incomes above traditional FPL thresholds that cannot absorb thousands of dollars in liability, continues to grow. Faced with prohibitive costs, more patients leave balances unpaid, elect to self-pay, or defer care until they present in emergency settings.

> **"If you couldn't afford your premium, you certainly can't afford your hospital bill."**
>
> — SVP of Revenue Cycle, System A

An analysis of Cedar's aggregated billing data, conducted for this research, shows out-of-pocket (OOP) liability growing fastest where collection is hardest: large bills, roughly $200 or more. At health systems, OOP liability now represents 49.3% of dollars in large, slow-to-collect balances, up from 37.5% in Q1 2025. Total billings in this cohort grew $16M (from $307M to $323M, Q1 2025 to Q1 2026), while OOP liability grew $44M (from $115M to $159M over the same period). Roughly $28M in cost shifted from payers to patients on essentially the same volume of care. On small bills, the OOP share is essentially unchanged. The divergence reflects trended growth in risky benefit designs, specifically high-deductible plans and rising coinsurance models, where patient liability scales with the bill, and coverage protects least where exposure is greatest. As a result, systems experience mounting financial strain through increased underpayment and uncompensated care, growing bad debt and charity care, and longer days in AR.

Broader market conditions further strain the impact of this risk-shifting. The average not-for-profit health system operates at a margin of 1.3%, and absorbs mounting costs that outpace general economic inflation.[3,4] Regulatory actions offer a range of measures that provide limited reprieve or enforce further downward pressure: recent and forthcoming policy changes undermine the safety nets that keep a patient's medical bill from becoming a health system's bad debt. The expiration of enhanced ACA subsidies resulted in a sharp increase in average out-of-pocket premiums and a decline in marketplace enrollment;[5] concurrently, the financial impact of Medicaid work requirements looms. At the state level, legislative action is extending good faith estimates to insured patients, raising charity care thresholds, capping interest on medical debt, and limiting credit reporting.

Amid these market headwinds, regulatory changes, shifting liability, and bolstered cost exposure, patient affordability must be positioned as a comprehensive strategic conversation that encapsulates financial access, growth, strategic pricing, and revenue integrity. Therefore, to intervene productively, health systems must solve a deliberate balance of offering a comprehensive yet individualized infrastructure for patients and payers alike.

Footnotes

1. KFF. 2025 Employer Health Benefits Survey. KFF; 2025.
2. Cox C, Ortaliza J, Wager E, Amin K. Health care costs and affordability. In: Altman D, ed. Health Policy 101. KFF. Published October 8, 2025.
3. Swanson E. National Hospital Flash Report: January 2026 Metrics. Kaufman Hall; 2026.
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About This Research

The Health Management Academy, in partnership with Cedar, produced this case series to understand how five leading health systems of different structures and market dynamics strategically posture to address the broader problem of affordability. Interviews were conducted with system CFOs, revenue cycle leaders, and operational staff; these calls focused on how each system deployed patient affordability as means to mitigate bad debt and charity care. Each case outlines the specific system's broader strategic philosophy, and end-to-end process map, organized by stage of the patient journey (defined below). Additionally, every vignette features an exploration of a distinctive affordability solution employed.

Outlining the Patient Value Journey Stages

Pre-Point of Service

Definition

Activities between scheduling and the patient's arrival, including:

- Eligibility and benefits verification
- Prior authorization
- Cost estimates
- Financial assistance screening
- Upfront deposits

Point of Service

Definition

Activities during the patient's visit, including:

- Coverage confirmation
- Review of estimated costs
- Copay or partial payment collection

Post-Point of Service

Definition

Activities after care is delivered, including:

- Claim adjudication
- Patient statement generation
- Payment plan initiation
- Follow-up outreach
- Collect agency referral
- Bad debt write-off

The stages represent a distinct point-in-time to intervene on a patient balance becoming bad debt; each missed opportunity results in the next one becoming harder and costlier to recover. Despite the revenue recovery implications, most systems engage patients with disjointed efforts across this continuum.

Section 2:

The Case Studies

"Patient affordability.. it's like one of those healthcare terms like 'virtual front door'. The definition can be many things to many different people, depending on from what perspective you're looking at it."

— Chief Revenue Officer, System E

The Case Studies

Across the case series, two contrasting positions toward patient affordability emerged: a largely defensive, passive “status quo” approach and a more deliberate, interventional “ideal state.”

The Status Quo Approach

The status quo characteristics consist of elements that insignificantly influence declining patient repayment. Collectively, these features result in a strategy that dedicates most resources toward payer reimbursement increases and maintains generalized post-service billing processes. A patient affordability strategy that aligns with the status quo simultaneously foregoes collecting recoverable revenues and mitigating avoidable costs.

1. **Overly payer-centric:** Revenue cycle effort concentrates on the payer collection, comparatively leaving patient liability, the fastest-growing share of revenue risk, little strategic attention.
2. **One-size-fits-all patient engagement:** Patient-facing efforts rely on broad interventions, like financial literacy campaigns, instead of offering tailored support for each patient's unique circumstances and ability to pay.
3. **Uneven, siloed engagement across the patient journey:** Intervention effort is bounded within a single stage rather than sustained from scheduling through final payment. Gaps at any stage make recoupment more difficult and costlier.
4. **Symptom-driven cost management:** Cost reduction and efficiency initiatives are deployed to offset reimbursement gaps, treating the symptoms instead of resolving structural deficits. Root causes, like coverage gaps, non-competitive pricing, and inaccurate estimates persist.

The Ideal State

The ideal state is a distinct set of characteristics associated with strategically ambitious affordability approaches. These qualities recurred among initiatives that measurably strengthened performance on patient-responsibility balances, whether by increasing repayment rates, converting self-pay to insured, reducing bad debt, or lowering cost-to-collect.

1. **Patient-centered, individualized assessment:** Affordability is evaluated on a person-by-person basis as often as possible; repayment strategy is built around each patient's coverage, financial circumstances, and ability to pay rather than a broad, uniform policy.
2. **Actionable over purely educational:** Interventions directly change what a patient owes or how they pay, rather than relying on literacy alone. Knowledge rarely changes outcomes when structural barriers remain in place.
3. **Coordinated engagement across the patient journey.** Affordability is addressed continuously, and each stage reinforces the next:
4. **Structurally redesigned and periodically recalibrated:** The affordability strategy is revisited regularly to account for regulatory, social, and economic shifts to address the root causes of affordability gaps rather than how they present.

System Overviews

No system in this series fully realizes *the* ideal approach, but each offers key learnings for others. Importantly, affordability is inherently dynamic; strategies effective today will erode as market, organizational, and political forces evolve. Therefore, the "right" path forward relies on assessment of each system's particular market context, EHR infrastructure, degree of systemness, and financial position detailed further in section 3 of this report.

System A (pg. 9 – 14)

A large, nonprofit academic and multi-specialty integrated delivery system concentrated in one state with some regional reach into contiguous states. Faces mounting pressure from a highly concentrated commercial market, a small-employer-heavy base, Medicaid losses, and strained supplemental funding.

System B (pg. 15 – 20)

An independent, not-for-profit regional referral system of hospitals in a predominantly rural region of a non-Medicaid-expansion state. Its payer mix skews heavily toward Medicare and Medicaid, and is subsequently sensitive to government reimbursement policy.

System C (pg. 21 – 26)

A private nonprofit system serving over one million patients annually across a multi-county metropolitan region, with one of the nation's highest case-mix indices among non-specialty hospitals. It operates in a heavily regulated market with an unusually fragmented, delegated-risk payer landscape.

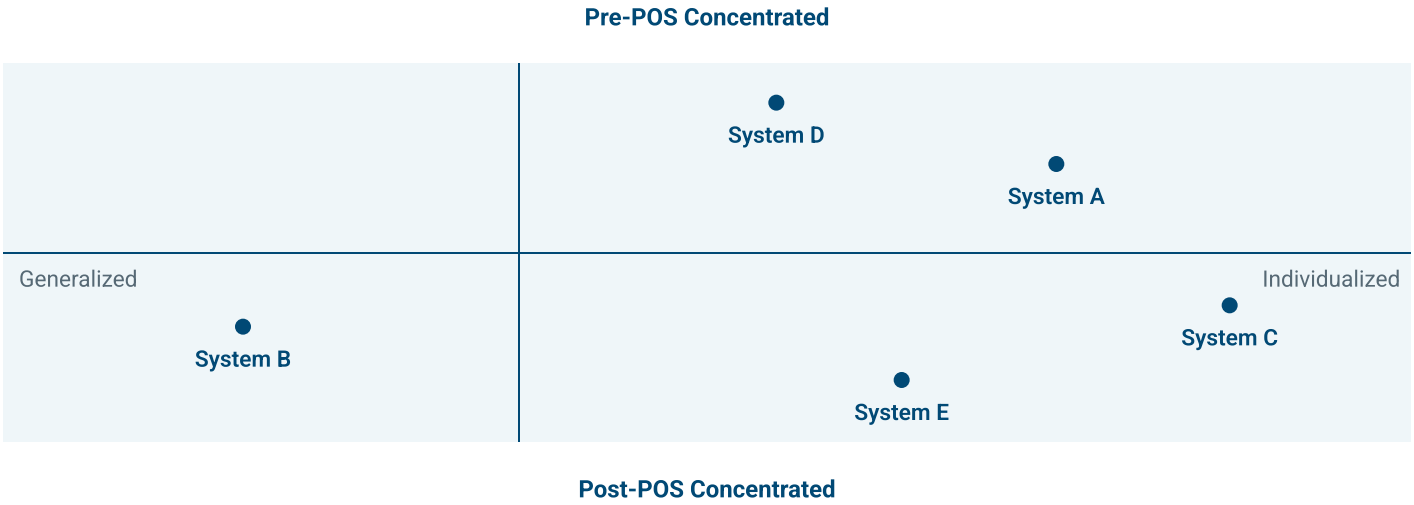
System D (pg. 27 – 32)

A large, not-for-profit integrated academic system anchored in a major metro area of a non-Medicaid-expansion state and home to one of the country's largest transplant programs. With net patient revenue approaching $7 billion, it has grown rapidly through organic expansion and acquisition while carrying a sizable ACA exchange population.

System E (pg. 33 – 38)

A community-owned, not-for-profit integrated system of acute care hospitals serving a roughly 25-county area in a growing southeastern metro of a non-Medicaid-expansion state, with over two million patient encounters annually.

The Strategic Distribution of Profiled Health Systems



Patient Affordability Case Series:

System A

System A: System Overview and Strategic Philosophy

System Overview

System A is a large, nonprofit, academic, and multi-specialty integrated delivery system with deep impact in one predominant state with some regional reach in contiguous states. It serves well over a million patients annually and functions as one of the largest employers in its primary market. The system has grown substantially over the past decade through a deliberate strategy of acquisitions, affiliations, and joint ventures with community and rural hospitals, extending its network across a broad geography. Its commercial market is highly concentrated, and its employer base is fragmented and weighted toward small employers.

The system operates amid intensifying patient-affordability pressures sharpened by its market. The growing unaffordability of insurance premiums, rising patient deductible exposure, and growth in the underinsured and uninsured populations are increasing the share of revenue that must be collected directly from patients. Medicaid eligibility and work-requirement changes impose reductions in public-coverage enrollment, and subsequently, additional coverage loss. Continued pressure on supplemental funding mechanisms, combined with a concentrated market, further limits their leverage and shapes their financial planning. Together, these converging forces require the system to position patient affordability as an increasingly important, though not yet primary, strategic focus.

Executive Leadership Strategic Philosophy

System A frames patient affordability less as a discrete program and more as an inherent outcome of improved operating efficiency and refined consumer transparency. From its perspective, the largest affordability impact comes from delivering similar or better care with fewer resources, while also reducing length of stay, improving throughput, and consolidating physician-preference vendors. As a not-for-profit, the system applies an automatic self-pay discount, offers financial assistance to 200% of the federal poverty level, performs presumptive charity, and forgoes extraordinary collection actions.

Patient out-of-pocket exposure is rising but remains strategically secondary in volume to payer reimbursement, and the system lacks the leverage to reset rates in a concentrated commercial market. Leadership is focused on being paid for demonstrated value as payer-side measures are opaque, shift annually, and disproportionately benefit insurers. Where payers will not partner, the focus turns toward direct-to-employer and direct-to-patient models as a longer-horizon play. The system is preparing to go out-of-network for the first time and plans to elevate payment strategy through a dedicated senior executive. System A also views automation as a promising means of extending patient reach, though scaling remains constrained by staffing and technical capacity.

> ***"Most of our conversations about patient affordability will tie back to becoming more efficient… nearly all of the things that I think have the largest impact on affordability are things that allow you to do similar or better quality care with the same or less resources."***
>
> ***– Chief Financial Officer, System A***

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System A: Front-to-End Patient Journey

Patient-financial processes, including billing, are internally distributed across several revenue-cycle and patient-access teams: an estimate team, a financial-clearance team, and a centralized pricing office. The pricing office is split between an inbound-call function and an internal-consulting team that conducts accuracy research and compliance work.



Pre-Point of Service

Before a patient arrives for an appointment, the system provides extensive patient cost information through a public financial-resource center and the patient portal, including estimates and educational material on financial responsibility, deductibles, coinsurance, and out-of-pocket maximums. Additional programs include a Medicaid application service, presumptive charity determination, and financial-assistance materials translated into locally prevalent languages. System A also has service-line-specific initiatives. For example, infusion and chemotherapy patients obtain manufacturer-funded copay assistance for their out-of-pocket drug costs.

Physicians can also route patient cost questions to the centralized pricing office. The system proactively contacts patients ahead of scheduled services to review expected costs, screen for financial assistance, and offer interest-free payment plans, accepting that not every patient answers or engages with the call. A financial-clearance policy implemented in 2014–2015 requires clearance above a defined dollar threshold before scheduled visits, with clinical carve-outs for medically urgent, pediatric, and oncology care. State-contracted outreach workers also sit on site to support Medicaid enrollment.



Point of Service

At the point of service, staff offer every patient a plain-language summary of the financial-assistance policy. Additionally, billing and financial-assistance policies are published publicly on the system's website.



Post-Point of Service

Following the visit, patients receive statements and phone calls to collect on balances. There are options offered to patients such as interest free payment plans and financial assistance screening. The system presumptively screens uninsured patients who cannot be contacted if their balance remains unpaid after a defined period. Other unresolved balances proceed through first- and second-placement bad-debt vendors before being deemed uncollectible. Customer service staff and the patient portal support billing questions, itemized statements, and in-application messaging.

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System A: Solution Deep Dive - Centralized Transparency

SME Strategic Positioning

Operational and patient-access leaders express a more patient-centered perspective focused on improving comprehension. Proactive patient education is treated as both an ethical obligation and a financial strategy since pre-service collections are more likely to succeed and less costly to secure. Leaders argue that regulatory transparency artifacts hold little meaning for patients who simply want to know what they will owe, and that achieving comprehensible price transparency requires more than just providing machine-readable files. Instead, this system focused efforts on an estimator tool that clearly explains what patients should expect to owe, tailored to the specific service, coverage, and benefits. The No Surprises Act shaped the estimate practice, though proactive estimation predated the regulatory requirement. The strategy highlighted in this case is the system's investment in a robust EHR-native patient-estimate and cost-transparency suite, underpinned by a dedicated centralized pricing office.

The Business Case

Rather than originating as a single strategic decision, the system's estimation and financial-clearance capability evolved over roughly a decade. Prior to its current EHR-based estimator, the system used external tools that relied on historical data to generate estimates. When the EHR's estimator became available, the system transitioned to it, beginning with a limited set of services and expanding over time. Federal price-transparency and surprise-billing requirements broadened and formalized the program by requiring estimates for all scheduled uninsured patients, but the core investment in proactive estimation and financial clearance predated the regulation by several years.

Measured Outcomes

The program has produced measurable gains. Estimate accuracy improved from approximately the low-50 percent range at initial go-live to the 70 percent range, tracked against tightening accuracy tolerances that have moved from a 10 percent to a 5 percent threshold. Pre-service and point of service collections rose to roughly 47 percent of total patient cash, up from the mid-to-high 30 percent range in the prior year. Estimate volume grew from 65,000 in the first full year of EHR-based estimation to just under one million in the most recent complete year, with more than 600,000 generated partway through the current year as coverage expanded to additional service types.

+40% — **Percent gain in estimation accuracy**

47% — **Percent of total patient cash contributed from pre-service and point of service collections**

1M — **Volume of estimates completed in the most recent complete year**

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System A: Solution Deep Dive - Centralized Transparency

Change Management

Implementation depended first on organizational alignment. Executive, facility, regional, and clinical leadership codeveloped the estimate and financial-clearance program, rather than by the revenue-cycle function in isolation; this breadth of buy-in made the clearance policy enforceable across the organization. The rollout was deliberately phased, beginning with radiology and expanding to surgical, laboratory, infusion, and therapy services, and progressing from manually generated estimates to automated generation with human review.

Sustained technical capability was equally essential. The system maintains a close, continuous working relationship with its internal EHR configuration team, including bi-weekly meetings and a constant flow of configuration requests. Leaders emphasize that without the right skilled analysts in place, accuracy improvements stall. A multi-team operating structure supports the effort: an estimate team working from the EHR work queue, a financial-clearance and collections team, and a centralized pricing office whose internal-consulting arm conducts accuracy research and rule refinement.

Beyond internal teams, the system participates actively in the EHR's customer community. Staff have presented nationally on the system's estimation work, been invited to showcase specific tools and techniques, and participate in ongoing estimate-focused user groups with other health systems. This network allows the system to advocate collectively for desired platform features and to learn from peers.

> ***"We know you can have an amazing clinical experience… and have it destroyed by your financial one because you had no idea what was coming."***
>
> ***– Senior Vice President of Revenue Cycle Operations, System A***

Key Challenges and Persistent Gaps

The principal operational challenge with the estimator tool was accuracy. Early difficulties included incorrect service-type mapping and, more persistently, the payer layer, which require substantial normalization and rule-building. Allowed amounts drawn from loaded contracts provide the foundation, but individual benefits demand heavy mapping because of diverging payer service categories definitions and uneven cost-sharing application across hospital and professional billing components. Managed Medicare plans are similarly problematic regarding differing definitions of what constitutes advanced imaging versus simple diagnostic imaging, and copays that may apply to one billing portion but not another. A regulatory requirement to issue self-pay estimates to nominally uninsured patients, many of whom proved to be insured, temporarily impaired accuracy.

Additionally, two structural challenges persist. Staffing limits constrain how many patients the team can reach with upfront education. Second, the system cannot fully account for out-of-network patients who schedule through workarounds (e.g., self-scheduling as uninsured, physician-to-physician referral add-ons, and similar pathways).

Two-to-Three Year Horizon

The near-term roadmap centers on expanding reach through automation. The system has already deployed pre-service automation for infusion services through a separate vendor-based tool. The system is pursuing several EHR automation initiatives for authorizations across surgery, diagnostic testing, and clinic services, including prior authorizations, coverage discovery. Additionally, System A plans to be an early adopter of its EHR virtual agent to support outbound, two-way conversations with patients regarding bill explanation, financial assistance applications, and collecting estimated payments.

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System A: The Bottom Line and Key Takeaways

System A departs from the status quo approach to patient affordability in several ways, most clearly represented by how it engages patients through frontloaded, individualized, and centralized resources. This extensive pre-service engagement is equally matched by an in-house process that combines statements, proactive calls, payment plans, and presumptive charity screening. The impact of this pre-service orientation is undeniable: the system collects nearly half of patient cash before or at the point of service, reflecting a deliberate departure from the status quo, post-POS model that characterizes other revenue-cycle operations. In terms of enhancement, the system would benefit from bolstering their individualization within post-point of service processes. Current practices remain largely threshold-based, reaching patients above a set dollar amount rather than triaging based on a likelihood-to-pay assessment or other personal and financial circumstances.

Notwithstanding a more robust post-service infrastructure, System A's highly individualized, centrally governed, and regularly calibrated affordability approach epitomizes the strategic caliber necessary for long-term success across the patient journey.



Building an extensive patient affordability infrastructure does not necessitate outlining "affordability" as an enterprise-wide strategic objective, which may result in more durable initiatives. System A frames patient affordability primarily through the lens of operational efficiency and value capture, not as a discrete program. Yet the accumulated capabilities constitute one of the most comprehensive affordability architectures observed across this case series. As such, an affordability strategy built indirectly, as a byproduct of efficiency and consumer-experience investment, may prove more durable than one constructed as a standalone initiative vulnerable to competing priorities.



Sustained investment in estimation accuracy, centralized governance, and executive-level alignment promotes higher collection rates at or before the point of service. The system departs from the status quo with more centralized governance, and a pricing office that functions as both an operational unit and an internal consultancy. This consolidates accuracy, compliance, and patient support under a single structure rather than distributing those responsibilities across disparate departments, fostering operational efficacy, precision, and nimbleness.



The accuracy and success of internally built patient-facing affordability tools require continuous operational discipline, not a one-time investment. Maintaining estimation accuracy depends on benefit mapping, plan-level rule-building, and continual refinement as payer-behavior and data rarely arrive in a predictable, usable format. Consequently, when systems opt to build in-house, a skilled internal team with direct organizational decision-making influence is crucial to ensure that the tool continues to be useful to patients in face of wider, macro-level changes.

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Patient Affordability Case Series:

System B

System B: System Overview and Strategic Philosophy

System Overview

System B is an independent, not-for-profit regional referral system anchored by a flagship hospital and two critical-access hospitals; in total, the organization employs approximately 3,900 staff and more than 500 providers across 40-plus specialties. The system serves a predominantly rural region in a non-Medicaid-expansion state, covering primary acute-care for roughly 300,000 residents. Its payer mix skews heavily toward Medicare and Medicaid, with growing Medicare Advantage penetration. As such, the system is particularly sensitive to government reimbursement policy and CMS rulemaking. The system operates in a state that has not expanded Medicaid, which creates a structural gap in coverage for low-income adults, compounding the out-of-pocket burden on patients and bad-debt exposure for the system.

> *"A more significant number [of patients] went from gold plans, silver plans to bronze plans. I fully expect there to be more out of pocket, which ultimately means more bad debt."*
>
> *– Chief Financial Officer, System B*

Executive Leadership Strategic Philosophy

System B positions itself as a "patient taker": it accepts virtually all patients, who rarely exit the system. Because System B does not defer services based on ability to pay, it focuses on maximizing the reimbursement it is entitled to from governmental sources, while also attempting to shield patients from additional out-of-pocket cost.

Leadership is candid about the reasons why. Collecting more from patients instills brand dissatisfaction, creates barriers to access, and opens the door for competitors in an increasingly consumer-oriented market. The system monitors exchange-market shifts closely and has observed a roughly five-percent reduction in marketplace enrollment alongside transitions from gold and silver plans to bronze, and from traditional Medicare to Medicare Advantage. Both trends raise patient out-of-pocket responsibility. At its two critical-access hospitals, the exposure is structurally magnified: Medicare patients owe 20 percent of charges (not the lower allowable amount), so patients pay more while the system collects less from Medicare than its costs would warrant.

According to the CFO, the planning horizon is focused on this year and next as leadership keeps an eye toward anticipated turbulent regulatory changes in 2028–2030. Near-term tactics include converting clinics to hospital outpatient departments to optimize reimbursement. Similarly, operational leaders share a pragmatic view that patient payment behavior is largely fixed: those who intend to pay will respond to a simple reminder, while patients who do not will not respond regardless of delivery channel or effort level.

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System B: Front-to-End Patient Journey

System B runs its revenue cycle on a single enterprise EHR platform and consolidates all patient billing, issuing one bill and providing one customer-service contact point across its sites of care. The system's key initiative is its transition to 100-percent electronic paperless billing through the EHR's patient portal and electronic communication tools.



Pre-Point of Service

Financial conversations begin at the point of scheduling, well before the patient arrives. The system provides cost estimates that are produced, reviewed, and communicated during the scheduling call for all patients. At the same time, staff initiate collection conversations and may attempt to collect payment before the service date. This practice predates federal good-faith-estimate requirements by several years.



Point of Service

When patients arrive for care, they receive a printed copy of the estimate and sign an acknowledgment that the information was explained. Staff again attempt point-of-service collections. Uninsured patients receive a 40-percent discount on charges, with an additional 10-percent discount if they pay at the time of service, though leaders report that the incremental discount does not materially change uninsured patients' payment behavior. Per state mandate, staff review and document all available coverage options with uninsured patients at the time of service, including financial assistance, exchange plans, Medicaid, and payment plans. Patients referred by area free clinics receive services at no cost.

The system's financial assistance program applies only to uninsured patients and operates on an all-or-nothing basis: applicants are either approved at 100 percent or denied, with no tiered reduction. For insured patients with catastrophic out-of-pocket exposure, a separate catastrophic assistance plan can reduce balances when the outstanding amount represents a large share of the patient's annual income.



Post-Point of Service

After the service encounter, the system pursues several parallel tracks. A contracted Medicaid eligibility firm screens inpatients and outpatients (above a dollar threshold) for Medicaid qualification and assists with applications, including SSI disability filings and appeals. The enterprise EHR scores patients on prior payment history to gauge collection risk, though leaders acknowledge this scoring is enabled but not actively managed as a decisioning tool; collectors may reference it during patient conversations, but it does not drive workflow routing or payment-plan auto-enrollment.

Patient-facing billing is now fully electronic. The system moved to 100-percent paperless billing, communicating with patients through the EHR patient portal and, for those without portal access, via text message to any available cell phone number. Additional EHR-based tools pull HSA balance data into the patient portal so patients can see available funds and pay directly. Eligibility-response data from payers populates outstanding deductible and coinsurance information, reducing inbound customer-service calls. Outbound collections are handled by an outsourced EBO on a contingency fee basis. The EBO sends paper letters, makes phone calls, and recently began text-message outreach. The system negotiated a reduction in its EBO contingency fee in exchange for permitting the text-message channel.

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System B: Solution Deep Dive - Electronic Paperless Billing

Identified Challenges

The system acknowledges its nascent front-end approach, recognizing the inefficiency and expense that would otherwise be avoided with better upstream processes. At the critical-access hospitals, the 20-percent-of-charges coinsurance structure penalizes both patient and system while the government pays less than cost. While leadership would prefer lower charges so that more reimbursement flows from government payers and less falls on patients, charge-based commercial contracts with major insurers make across-the-board price reductions self-defeating.

SME Strategic Positioning

Operational leaders view electronic billing as a natural extension of how patients prefer to communicate. The initiative aligns with what the EHR vendor considers baseline functionality, and leaders see the primary value as meeting patients on their preferred channel while reducing collection costs. Overall, their strategic instinct is to keep capabilities within the enterprise EHR rather than adding bolt-on vendors. As one leader described it, vendors seek opportunities where the EHR does not yet meet needs, but the EHR typically catches up, and waiting avoids the cost and operational burden of external integrations that are difficult to manage and expensive to unwind.

The Business Case

Two key factors underpinned the business case: aligning with the shift toward electronic communication in patients' daily lives and reducing the cost of producing and mailing paper statements. Importantly, increasing patient payment rates was not the primary expected benefit. Leadership understood that patients inclined to pay would respond to any reasonable reminder, and that moving to electronic billing would not convince non-payers. The expected economic benefit was therefore in cost avoidance. If patient collections hold steady while the cost of billing falls, the net margin on patient receivables improves.

Measured Outcomes

The clearest measurable result is the reduction in statement production costs. Monthly statement expenses fell by approximately 62.9 percent, from $35,000 to approximately $13,000, after the system committed fully to electronic billing. Outside of cost-to-collect, the system reported patient satisfaction improved, and patient payment percentages rose, though absolute patient-payment dollars remained flat. Revenue cycle leaders frame the outcome in cost-avoidance terms: holding collections steady while cutting billing expenses by more than 60 percent.

63%

Percent reduction in monthly statement generation expense

> *"We want to meet patients where they're at. If electronic billing is their preferred method, then we certainly want to make sure that we are keeping up with their preference, giving our patients as many choices as possible."*
>
> *– Director of Revenue Cycle, System B*

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System B: Solution Deep Dive - Electronic Paperless Billing

Change Management

The rollout was system-wide rather than piloted. The team launched an education campaign using printed flyers, then auto-enrolled all patients into paperless billing with an opt-out mechanism. Patient pushback was limited; the system serves a rural population that includes patients with limited literacy, and staff worked with those patients individually to ensure they received billing in an accessible format. The operational leader's advice to peers considering a similar transition: lead with patient education and offer multiple communication channels to match individual preferences.

An alternative vendor was evaluated approximately two years before the transition to e-billing. While at the time this vendor's platform was slightly more advanced, the system bet on its EHR closing the gap; This decision reflected a broader institutional preference to avoid external bolt-on systems that add IT complexity and create switching costs.

Key Challenges and Persistent Gaps

One operational challenge emerged after go-live. The system initially reverted delinquent patients to paper billing, reasoning that an additional physical reminder might prompt payment. Over time, the cost savings from paperless billing eroded significantly as delinquent accounts accumulated and paper billing costs rebounded. Leadership concluded that non-payers would not pay regardless of the billing channel and abandoned the reversion policy, keeping all patients on electronic billing.

A persistent strategic gap is the underutilization of the EHR's patient-scoring capability. The system has scoring enabled, and the EBO also offers its own scoring data, but neither is used to drive collection workflow, auto-enroll patients in payment plans, or differentiate outreach strategy by risk segment. The team acknowledges the gap but views the scoring as secondary given its non-deferral philosophy: since no patient is turned away based on ability to pay, the urgency to stratify is reduced.

Two-to-Three Year Horizon

In the near term, the system is expanding self-service tools within the EHR, pulling HSA balance information into the patient portal, and auto-populating deductible and coinsurance data. Both capabilities reduce inbound customer-service volume and give patients greater visibility into their financial obligations.

Additionally, the system has discussed building an internal collection agency but shelved the idea, concluding that dialer systems and staffing costs would likely exceed the cost of the current outsourced EBO arrangement. The downstream aspiration centers on the locus of control: leaders would prefer to manage collections internally if the economics justified it.

> *"Today we do not defer services, if a patient can't pay, doesn't pay, we don't defer their services, we still provide their care… we do try to do point of service collections, but we put forth the same effort to collect from everyone."*
>
> *– Director of Revenue Cycle, System B*

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System B: The Bottom Line and Key Takeaways

As a non-deferring “patient taker” in a non-expansion state, System B's strategy understandably aligns mostly with the status quo. Despite these constraints, however, the system provides estimates to all patients at scheduling (implemented prior to the No Surprises Act mandate), offers catastrophic assistance to over-income patients with outsized balances, and proactively surfaces HSA funds and payer benefit data for patient self-service.

System B primarily approaches affordability with a payer-focused orientation, generalized patient-facing support, and a bias toward post-service activity rather than preemptive, individualized action. Executive strategy centers on maximizing non-patient payment. Patient-facing tools and financial support are applied uniformly: every patient receives an estimate, every patient auto-enrolls in paperless billing, assistance is uninsured-only and all-or-nothing. As a result, the system has no systematic way to tailor collection approach, payment-plan offers, or counseling to a patient's risk profile.

System B employs an efficient but generalized patient affordability program that targets cost-to-collect and not recovery rate effectiveness.



Uniform collection policies leave substantial unrealized on both ends of the patient ability-to-pay spectrum. Systems with rigid recovery procedures risk unnecessarily aging balances to agency collections from patients who could otherwise pay, resulting in high contingency fees. Conversely, patients without the means to pay receive costly, largely unsuccessful outreach attempts, and the activation window to connect them with coverage assistance shrinks. By stratifying patients using payment history, benefits, or balance relative to income data, systems can more effectively route patients to appropriate payment arrangements while also connecting vulnerable individuals to available resources.



A tech-stack first strategy works best when paired with a dynamic working partnership between the system and the EHR. When assessing how to implement its e-billing initiative, System B decided against another external vendor in favor of working with their EHR’s technical staff to match and exceed the desired capabilities, avoiding the resulting financial and administrative burden. The system’s leadership identified that they lacked visibility into the full scope of the EHR’s evolving functionality, illustrating a consequential failure point for EHR-first organizations. To maximize the capabilities of existing investments, a function must be responsible for responsibility for their continuous inventory and activation.



Before the go-live, systems must robustly model exceptions to new patient affordability policies. Initially, System B moved to fully paperless billing for all patients, immediately reducing statement generation costs. Shortly after the go-live, the system reverted to sending delinquent accounts paper statements to encourage payment. This reversal gradually eroded the system’s initial lift, requiring another policy shift to rebound cost-to-collect. Exception scenarios must be modeled before go-live, as discovering them post-launch only undermines savings and forces operationally costly policy reversals.

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Patient Affordability Case Series:

System C

System C: System Overview and Strategic Philosophy

System Overview

System C is a private nonprofit health system operating four acute care hospitals. The enterprise consists of two flagships, two community facilities, and more than 100 outpatient clinics across a multi-county metropolitan region. The system serves over one million patients annually and maintains one of the highest case-mix indices among non-specialty hospitals in the country. A distinguishing feature of this system lies within its structure: its flagship hospitals do not have emergency departments. Therefore, virtually all patients admitted to the campuses are financially cleared before arrival, with most complex cases arriving via inter-facility transfer.

The system uses a non-dominant EHR platform, which shapes its vendor strategy and constrains access to patient-facing tools available to peers on Epic. Its payer market features an unusually high degree of fragmentation and delegated risk: a single insurer may subcontract risk across multiple downstream entities, complicating authorizations, claim routing, and financial clearance at scale.

Regionally, the system operates in a PSA under high regulatory oversight and risk, especially regarding affordability. The region features several state-level bodies and policies enforcing additional requirements for good faith estimates, out-of-network coverage and access, and staffing ratios, among others, which provide additional rigidity and complexity to the system's cost and access model.

Executive Leadership Strategic Philosophy

Leadership ties growing affordability pressure to two converging trends: first, the expansion of underinsured patients (e.g., high-deductible health plans); and second, federal policy expected to intensify financial exposure among low-income populations. While payer reimbursement challenges remain the most immediate financial concern, the organization continues to view patient affordability as a strategic priority and has invested significantly in tools, payment options, and patient engagement solutions designed to reduce financial barriers to care.

Nonetheless, the system's affordability work is deliberate. Structurally, annual charge-master reviews benchmark rates against local competitors and internal peers across all four hospitals. Across the payment journey, the system invests through vendor partnerships: Cedar, a patient payment platform for statements and digital billing; FinThrive, a pre-service estimation tool; and PayZen, an extended-payment-plan partner. Leadership views affordability and patient education as inseparable, and believes a purpose-built patient-engagement interface, distinct from an EMR bolt-on, meaningfully improves collection rates within their specific patient demographic.

> ***"Having an intuitive user interface that isn't like a system of record… but is actually custom built for patient engagement, does impact collection rates. I think it would be silly to think that it doesn't."***
>
> ***-- Chief Financial Officer, System C***

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System C: Front-to-End Patient Journey

System C's affordability infrastructure spans the full patient financial journey through a mix of internal teams, EHR-native tools, and vendor partnerships. While the enterprise EHR serves as the system of record for billing and patient accounting, it is not the intended patient-engagement layer. A patient payment platform vendor (Cedar, the key initiative detailed) manages electronic and paper statements, a patient portal, and payment plans for both hospital and physician balances. A separate pre-service estimation tool provides good-faith estimates, and an extended payment plan partner supports patients needing more than twelve months to pay outstanding balances.



Pre-Point of Service

A centralized pre-arrival team performs financial clearance for all scheduled hospital patients and many clinic patients. This team verifies eligibility and benefits, determines authorization requirements, and validates authorizations through the date of service. When authorization is not secured, non-emergent patients are deferred. Given that the quaternary-care hospital and transplant programs draw patients from a wide geography, the pre-arrival team also negotiates an unusually large volume of letters of agreement with payers, including noncontracted insurers.

Patient estimates are currently produced manually through the pre-service estimation tool. A planned iteration through FinThrive will allow patients to generate their own estimates and pre-pay using the payment platform, addressing a gap left by the EHR's lack of native self-service estimate functionality.



Point of Service

Registration areas maintain collection targets, pairing manual estimates with a collection attempt of part or all of patient liability at the time of service. The two community hospitals operate EDs; for non-contracted ED patients who are clinically stable, staff work with payers to transfer patients in-network or negotiate an LOA.



Post-Point of Service

The back end is where the system has made its most distinctive investments. The patient payment platform combines hospital and physician balances onto a single statement despite separate billing systems. Cedar generates statements and manages standard payment plans (typically <12 months), with collection rates on these plans reported as strong. For larger hospital balances, the system is adding PayZen, an extended payment plan partner that purchases balances and manages the patient plan at zero interest, accelerating cash to the system.

Separately, financial counselors at community-hospital EDs screen uninsured patients for the state Medicaid program or charity care. On the roadmap: integrate flexible spending and health savings account data into billing systems, and enable an AI tool to help patients self-service their billing questions and set up payment plans.

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System C: Solution Deep Dive - Cedar and PayZen Partnerships

Identified Challenges

Obstacles concentrate in two areas. First, regulatory requirements such as self-pay estimate deadlines and annual insurance plan changes routinely outpace the enterprise EHR's capabilities, leaving a small internal team to manage high volume while, "always playing catch up." A forthcoming state mandate requiring charity screening before the first patient billing statement further exemplifies the continued need to monitor and address regulatory actions. Second, a single payer may delegate financial risk to ten downstream entities without disclosure. As a result, authorization routing is heavily dependent on institutional knowledge held by individual staff. With over four thousand plan configurations in the system, leaders describe a continually ambiguous situation where "you just honestly don't know who is actually paying the claim."

SME Strategic Positioning

Revenue cycle leaders frame Cedar as foundational infrastructure, not merely a billing tool. The addition of the extended-payment-plan partner is viewed as a natural extension of this relationship, supporting patients with large balances who need more than twelve months. Leaders also cite a social benefit to the partnership. Patients can extend payment timelines through a self-service digital channel rather than face-to-face conversation, reducing stigma.

The Business Case

Payment plans had been growing steadily, pushing out days in accounts receivable. The further balances aged, the greater the risk patients would stop paying. State law prohibits the system from reporting patient medical debt to credit agencies, removing a traditional collection tool and necessitating a different approach.

PayZen, introduced through the existing Cedar relationship, offered an additional mechanism for near-term cash acceleration. Post-rollout, the system tracks ROI on its broader platform contract across cost to collect and collection rate and reports measurable collection-rate increases.

Measured Outcomes

Over the five-year platform relationship, hospital billing collection rates rose from approximately 50% to 70%, against a health system benchmark of 54%, a 39% relative increase. Patient satisfaction scores reached 91% (benchmark: 89%), and among digitally notified patients, 88% engage with the platform (benchmark: 76%). Self-service collections account for 81% of total collections (benchmark: 66%). Payment-plan recovery rates stand at 82% (benchmark: 76%), with approximately $33 million collected on plans. Leaders attribute gains to the platform's purpose-built interface, its single view of hospital and physician liability, and the self-service capability. The system is awaiting post-rollout outcome data related to the extended-plan partner.

+39% — **Percent gain in billing collections rates**

81% — **Percent of collections from self-service accounts**

$33M — **Volume of dollars collected from payment plans**

> ***"We tracked that ROI on our [Cedar] contract… For us, it's definitely both cost to collect and collection rate."***
>
> ***– Chief Financial Officer, System C***

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System C: Solution Deep Dive - Cedar and PayZen Partnerships

Change Management

Executive sponsors drove the decision, centered on cash acceleration and patient experience. An incremental rollout occurred: phase one moved all self-pay balances from a sunsetting legacy patient accounting system to the extended-plan partner, with approximately 60% of legacy-account patients opting in. Phase two, now underway, covers the larger current-state AR. The extended-plan solution runs through the patient payment platform, requiring no separate integration. Within the payment portal, patients are presented with various options algorithmically: pay in full, enroll in a standard plan (up to twelve months), or if the balance and payment history meet certain thresholds, enroll in an extended plan. Patients without identifiable financial history are excluded from the extended plan offer and routed toward charity screening.

System C advises peers not to overlook key change management considerations, including seemingly simple decisions, like payment-plan parameters (e.g., duration, payment amount, and offer thresholds), to other larger political factors. At the system, the professional-billing dynamic created friction. The system bills patients on a combined hospital-and-physician statement and applies payments to physician balances first. Initially, the physician department objected to the extended-plan partner purchasing a balance at a discounted rate, because it was accustomed to full reimbursement under the existing arrangement. The resolution was a CFO-approved policy decision: the hospital absorbs the discount on the physician share. Leaders noted this issue is not unique to their EHR, as any system with a single-statement model and physician-first payment policy will encounter it, including those on Epic's single-billing-office configuration.

Key Challenges and Persistent Gaps

Three unresolved issues remain. The system cannot yet use patient risk scores to proactively offer a payment plan during bill estimation; it must wait for the first bill to generate. Next, the state charity-screening mandate will require a new build of either the payment platform or the upstream billing system. Finally, unwinding dollars when a patient enrolled in an extended plan is subsequently approved for financial assistance remains an open process question, along with algorithm accuracy; a misrouted offer to a patient who should be channeled to charity carries financial and reputational risk.

Two-to-Three Year Horizon

The near-term roadmap centers on three fronts. Upstream, the system is deploying a new tool that will enable patient self-service estimates within the payment platform for advance payment. The team is also building front-end presumptive charity screening for state-program and exchange-plan patients. On the authorization front, a partnership with a reporting and workflow vendor aims to build a "Division of Financial Responsibility" capability to identify which downstream entity a payer has delegated risk to for a given service and plan. If successful, this would reduce pre-operative denials caused by routing claims to the wrong payer. Leaders are also in preliminary conversations with AI-focused revenue cycle technology vendors.

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System C: The Bottom Line and Key Takeaways

System C's affordability strategy is highly individualized but largely backloaded, with its most developed patient-facing capabilities concentrated after the point of service. Its post-POS ecosystem matches payment options with each patient's circumstances, and accounts for balance size, payment history, and charity care eligibility in determining whether to offer an extended, zero-interest plan.

Earlier in the patient journey, System C aligns more with the status quo. Although patients are financially cleared before admission, the process appears built around securing payer coverage (e.g., verifying eligibility, validating authorizations, and negotiating LOAs with non-contracted insurers) rather than assessing what the patient will ultimately owe. Planned investments in self-service estimates, along with the need to address a forthcoming state mandate, positions System C to elevate the individualization it has achieved downstream to earlier stages of the patient journey.

Overall, System C falls closer to the ideal state, deploying robust post-POS capabilities, however, process gaps in the pre-service stage largely leave its impact confined to confirming coverage.



Investment in affordability initiatives can transpire without being a top strategic priority, especially if embedded within revenue-cycle operations and justified by enhanced cash-acceleration and reduced cost-to-collect. Senior finance leadership at this system illustrates the overarching perspective among interviewed CFOs: that affordability is acknowledged as a tangible, growing threat, but payer revenue integrity commands more bandwidth because of the size of the recovery potential. Despite this, System C has built a uniquely comprehensive consumer-facing post-point-of-service payment infrastructure, underpinned by patient experience and hard ROI realization.



System C's EHR lacks the patient-facing tools natively available to other EHR platforms; this constraint likely resulted in an incrementally more innovative, effective affordability approach. Cedar serves as the connective tissue across multiple downstream functions while FinThrive, PayZen, and other workflow partners fill gaps that their EHR does not address. Point solutions exist because they can deliver more specialized functionality and customization than the enterprise platform offers. There may be a corresponding tendency among systems using EHR platforms with extensive native capabilities to assume that because a capability is offered it is sufficiently solved, but this does not inherently translate to the problem being adequately addressed.



Existing downstream affordability infrastructure can extend upstream for pre-service individualization, rather than requiring a net-new initiative. Cedar and PayZen provide rich data on how patients select payment terms and qualify for assistance. System C's leadership wants to pair risk indicators with pre-service estimates to start payment and assistance conversations before the initial bill. Achieving this requires pulling estimates, charity screening, and coverage discovery upstream. This suggests that mature back-end infrastructure can establish the foundation for proactive, front-end customization if the supporting pieces are operationalized in a flexible manner.

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Patient Affordability Case Series:

System D

System D: System Overview and Strategic Philosophy

System Overview

System D is a large, not-for-profit integrated academic health system operating 11 hospitals (fully owned or managed through joint ventures) and more than 575 care locations, employing over 25,000 staff and more than 4,000 physicians. Anchored in a major metropolitan area in a non-Medicaid-expansion state, it functions as the region's most comprehensive academic medical center with net patient revenue approaching $7 billion. Its payer mix (gross patient revenues) trends 40-50% across their flagship facilities, with 30-40% commercial/managed care, 5-10% Medicaid, and 5-10% Self-Pay/Other.

The system has expanded rapidly through organic growth and recent acquisition, and its transplant program now ranks among the largest in the country. Its payer mix includes a sizable exchange population, and its state's non-expansion status limits Medicaid eligibility while concentrating uninsured and ACA-enrolled patients.

Unique to this system's region, the majority of its exchange-covered population was previously subsidized, forming a substantial coverage cliff following the expiration of ACA premium subsidies. Affordability and price sensitivity remain a growing concern, favoring a diverse and saturated community provider market. To improve their competitive posture, this system is undergoing broader, strategic pricing initiatives; they have also undertaken significant efforts to improve systemness, governance, decision-making efficiency, and patient access procedures across sites of care.

Executive Leadership Strategic Philosophy

System D frames patient affordability primarily as a pricing and payer-strategy problem rather than a collections gap. Historically, its services are billed at hospital-based rates (specifically, a percentage of charge), but leadership is working to deliberately set prices on shoppable services (e.g., diagnostic radiology and common procedures such as a colonoscopy) to be comparable to freestanding facilities; the system has negotiated with payers to avoid applying a hospital-based deductible on those services and, in some cases, to have hospital-based services reimbursed off the physician fee schedule. Leaders are explicit that pricing strategy is the primary lever for minimizing what patients owe, and that patient communication, while essential, cannot solve a patient's underlying high-deductible exposure. Notably, the system continues to target a net rate growth of 3–5% to support financial sustainability.

As a not-for-profit, the system maintains a financial assistance policy and takes no extraordinary collection actions like credit-bureau reporting, liens, or wage garnishment. Candidly, leadership acknowledges that a patient who refuses to pay will face no meaningful consequences, which informs how the system emphasizes working with patients and negotiating with payers upstream. Recent AR growth is attributed primarily to payer behavior rather than patient non-payment, a conclusion supported by a reduction in the fatal denial rate from approximately 7 percent to roughly 2 percent over two years. A defer/delay/cancel policy exists for patients who do not meet pre-service financial requirements, but its implementation is limited.

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System D: Front-to-End Patient Journey

System D runs its revenue cycle on a single enterprise EHR platform and issues one bill across its hospitals and physician practices. This EHR integration is central to its access strategy, with patient scheduling operating with a "call center mentality," getting the patient an appointment quickly and chasing clinical and financial clearance afterward. External partners include Experian for real-time eligibility and coverage discovery, Curae for ACA marketplace enrollment assistance and premium sponsorship, and a contracted collection agency for post-service accounts. The system also has an existing patient-financing arrangement with CareCredit.



Pre-Point of Service

At System D, the pre-service financial-clearance activity is extensive and screening-driven. After scheduling, a pre-registration team follows up on referrals, authorizations, and benefit verification. The team also meets with departments seven days before service regarding at-risk patients that lack an authorization or referral. The staff use a scripted deposit request based on the patient estimate, negotiating downward from the full amount (100% to 50% to 25%, then "what can you pay?"). This approach has generated an additional $2 million per year in pre-arrival collections.

A consolidated team centralizes system-wide financial assistance and now conducts more aggressive pre-service screening. First, staff assess patients for Medicaid, then for charity care using Experian real-time eligibility data to drive determinations. In early 2026, the system expanded its charity income limit from 225% to 350% of the federal poverty level, shifting an estimated $100 million from bad debt to charity on the rationale that patients in that gap were not paying regardless. For self-pay patients, the system implemented a process to evaluate ACA marketplace eligibility and provide premium sponsorship and delinquency support. Additional pre-service assets include a drug program for the under- and uninsured funded partly through 340B.



Point of Service

Point-of-service practices largely vary across departments and sites of care. While the information exists in the EHR, staff inconsistently discuss cost-sharing or deposits with patients. This variance partly results from their structure: many registration staff report into the clinical departments they serve without a line to revenue cycle, creating misalignment in scripting, policy, and collection practices as a result. Leadership is evaluating whether to shift reporting relationships for high-volume registration areas, such as laboratories, under revenue cycle oversight.



Post-Point of Service

After the appointment, the system sends statements and makes phone calls to patients for 120 days. Those who do not respond to or agree to a payment plan are referred to a collection agency; if unsuccessful, outstanding balances return as uncollectible and written off after 6 months.

System D emphasizes patient communication and education post-service and heavily relies on its patient portal for electronic statements and patient collections.

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System D: Solution Deep Dive - Curae Partnership

Identified Challenges

Two principal obstacles emerged. First, payer friction has intensified; payment speed has slowed, administrative hurdles have multiplied, and denials use more sophisticated tactics. In response, the system has implemented real-time eligibility cleanup, including query chaining and payer-plan mapping to reduce false positives, but characterizes the challenge as structural and ongoing. Second, the fragmented registration structure destabilizes point-of-service collection standardization, creating an operational gap between the tools available in the EHR and the staff behavior.

SME Strategic Positioning

Operational leaders closest to the Curae partnership view the vendor as filling a specific gap in the system's financial assistance pathway. The internal team screens for Medicaid and charity; Curae adds a layer by evaluating self-pay patients for ACA marketplace eligibility and, critically, by sponsoring premiums for those who enroll. Revenue cycle leaders see the initiative's value less as an IT capability and more like a funding mechanism that converts self-pay patients into insured patients whose care is then reimbursed by ACA plans, yielding higher collections.

> *"All the information is in [the EHR] and available for them, and it's all teed up. But a lot of those people don't actually report into revenue cycle…so we're really relying on people outside of our direct control, surely within our influence, but outside of our control."*
>
> *– Chief Revenue Cycle Officer, System D*

The Business Case

The Curae partnership ensures patients receive appropriate financial assistance opportunities, particularly those within the system's exchange-eligible population. Financially, the business case centers on converting self-pay patients to ACA-covered patients through two mechanisms. First, marketplace enrollment assistance, in which Curae identifies self-pay patients eligible for exchange plans and helps them enroll. Second, premium assistance and delinquency support, where Curae sponsors premium payments or intervenes when existing ACA-plan members fall behind on premiums to prevent coverage lapses.

Operationally, the system provides Curae with a daily data file of its self-pay population, including diagnostic information; Curae processes patients and targets those eligible for sponsorship or delinquency support. Real-time alerts in the EHR automatically trigger a financial assistance case for outreach when a patient is identified as eligible.

Measured Outcomes

Early results exceed initial projections. Curae enrolled approximately 350 patients against a first-year projection of roughly 200 to 225, leading to approximately $10 to $12 million in ACA-plan payments that would otherwise have been self-pay.

350 — **Patients enrolled in Curae during the first year**

$12M — **Amount collected from Curae-sponsored ACA plan payments**

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System D: Solution Deep Dive - Curae Partnership

Change Management

The system launched Curae across the entire enterprise simultaneously, going live in November to coincide with open enrollment; on-site counselors were placed at some hospitals. According to leadership, the implementation was a relatively light lift: Curae gave clear specifications for its technical teams, and the system provided data files.

The more significant change management challenges proved organizational. Initially, referral volumes were low because internal staff did not consistently direct patients to Curae. Correcting this required in-person training of financial counselors, case managers, and patient access leaders. Targeting high-yield clinical areas like transplant and infusion, where patient populations are most likely to benefit, produced stronger results than broad education.

Key Challenges and Persistent Gaps

Vendor overlap transpired as a principal operational challenge. With multiple partners touching Medicaid applications and exchange enrollment, the system sequenced outreach carefully to prevent patient over-contact from different programs simultaneously. Separately, an exclusivity clause with an existing patient-financing vendor prevented the system from adopting Curae's non-recourse financing product, limiting the scope of the partnership.

Two-to-Three Year Horizon

Several expansions are on the near-term roadmap. Once another vendor contract expires, the system intends to adopt Curae's non-recourse patient financing product. It also plans to activate Curae's alternate-funding-source discovery capability, which identifies foundations, government programs, and grants that may offset patient costs based on diagnosis. Leaders are engaging Curae about broadening the scope of patients eligible for premium sponsorship as self-pay volumes grow. Longer-term, leadership aspires to move beyond ad hoc pricing adjustments to a "true strategic charge process" and to reduce reliance on regulatory requirements that force services to be hospital-based. They see automation as essential to staying ahead of increasingly AI-enabled payer behavior.

> *"We're not seeing denials, we're seeing recoupments… As we put things in place to kind of tackle all of that, what's going to change next week?"*
>
> *– VP of Revenue Cycle Management, System D*

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System D: The Bottom Line and Key Takeaways

System D addresses patient affordability head-on, positioning rising bad debt as a convergence of pricing, payer strategy, and patient coverage. The Curae partnership exemplifies a structural intervention; rather than solely improving the collection or communication of bills, the system converts uninsured patients into insured ones to inherently reduce their risk exposure. Additionally, repricing shoppable services and negotiating to remove hospital-based deductibles further reinforces proactivity.

System D demonstrates high levels of efficacy and sophistication within pre-service processes; however, the post-visit consumer-facing financial experience is comparatively underdeveloped (e.g., varying strategies based on likelihood to pay, patient circumstances, or tailored engagement).

Overall, System D concentrates its effort on upstream, payer-oriented initiatives, with comparatively softer focus on post-point of service patient-facing financial individualization.



Robust coverage screening before pursuing payment, and sponsoring that coverage, when necessary, reduces the volume of patients who ever enter the collection cycle. System D sequences Medicaid screening, charity determination, and ACA marketplace enrollment before any collection activity begins, and through Curae, also sponsors premiums for patients who qualify for exchange plans. This allows staff capacity to shift from chasing low-yield balances to working accounts that are more collectible. For systems with a high proportion of exchange-eligible patients, this model fundamentally changes the boundaries of affordability intervention.



An academic medical center can compete on price with freestanding facilities, but only if it restructures pricing in tandem with the underlying cost model. System D repriced shoppable services to match freestanding alternatives and negotiated with payers to remove hospital-based deductibles on those services. This is a departure from the standard AMC approach of accepting hospital-based rate structures as a given. While System D's financial positioning gives it more room to reprice than most others, the approach highlights a broader point: the price gap between hospitals and freestanding competitors is partly strategic, especially as patient price sensitivity grows.



Reducing out-of-pocket liability exposure does not necessitate a radical redesign. By introducing a standard script that moves from requesting the full estimated amount down incrementally to an open-ended ask, System D generated approximately $2 million per year in additional pre-arrival collections. This small change improved cash flow through organizational alignment without new technology, staffing, or infrastructure.

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Sources: THMA research and analysis.

Patient Affordability Case Series:

System E

System E: System Overview and Strategic Philosophy

System Overview

System E is a community-owned, not-for-profit integrated health system anchored in a growing metropolitan area in a southeastern non-Medicaid-expansion state. The system operates nine acute-care hospitals and a behavioral health facility across a roughly 25-county service area, supported by more than 90 physician practice locations and over 11,000 employees, affiliated physicians, and volunteers. It simultaneously functions as the dominant employer and healthcare provider in its home market, recording well over two million patient encounters annually. The system was formed in the mid-1990s through a merger of two legacy hospital organizations and has since grown through facility acquisitions, physician group expansion, and service-line development.

As of FY25, the system's payer mix, net of explicit/implicit concessions and discounts, is approximately 42% Medicare, 22% Medicaid (managed Medicaid), 34% commercial/managed care, and 2% uninsured; gross charges are approximately 55% Medicare, 9% Medicaid, 31% commercial, and 5% uninsured. The system's most recent consolidated financial performance indication in 2026 is stable, reflecting a ~3% operating margin (8.5% EBIDA), with consistent YoY increases in utilization, particularly in outpatient volumes, ER volumes, and surgical volumes (inpatient and ASC). The system's market is aging, as evidenced by a growing share of early- and late-stage retirees. Additionally, as a result of the state's decision not to expand Medicaid, there remains a strong, structural coverage gap for low-income adults, concentrating out-of-pocket exposure on both uninsured and underinsured populations.

Executive Leadership Strategic Philosophy

System E frames patient affordability as a rising strategic priority driven by payer-mix pressures that leadership ties to broader macroeconomic forces. The share of commercial coverage is falling as ACA marketplace subsidies expire, the state's Medicaid program is tightening eligibility, and the system's retiree-heavy destination market accelerates migration to Medicare. Moreover, the reimbursement landscape remains incredibly rigid. The net effect is growing self-pay volume from both uninsured and underinsured patients. Leadership describes this shift as putting pressure on the uninsured population "more than ever," making affordability "more in focus."

Executive leadership views upstream affordability processes (financial-assistance policy, good-faith estimates, charity-care policy, and price transparency) as table stakes for a mature health system. In this view, the differentiating question is collectability. As self-pay rises, traditional bill-and-collect mechanisms will increasingly lose efficacy, and systems will need a deliberate strategy as a result. System revenue cycle leaders complement this perspective by emphasizing the tension between consumer-friendliness and AR discipline. Given extending payment plans ages receivables, establishing an organizational "payment plan tolerance" requires explicit strategic attention. They stress the importance of engaging patients early, when the patient has a motivated interest in resolving cost because they need the service, and describe affordability in part as involving the patient in their own financial decision-making.

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System E: Front-to-End Patient Journey

System E's EHR is limited regarding access to certain native front-end automation tools. Patient billing flows through Cedar, its post-service digital billing and collections partner, which consolidates hospital and physician-group bills into a single patient-facing platform. Additional external partners include a benefits-eligibility vendor for inpatient self-pay screening and an extended business office (EBO) for true self-pay collections. The key initiative explored is the Cedar partnership to modernize post-service billing, collections, and payment-plan administration.



Pre-Point of Service

Pre-service activity centers on scheduling-time discovery and a patient conversation about out-of-pocket options. When an elective service is scheduled, the registration team verifies demographics, policy numbers, and insurance coverage. Closer to the service date, a registrar contacts the patient to discuss out-of-pocket responsibility, using a risk-stratified collection grid to guide how much to collect up front (e.g., a quarter or half of the estimated balance). The conversation typically occurs by phone, however, for low-dollar or short-timeline cases, cost information may be sent via text or email. To accommodate the rise of price-shopping and self-pay discount utilization, patients may elect to be self-pay even if insured, signing a waiver acknowledging they are declining insurance filing. In non-acute settings such as infusion centers, financial counselors are embedded at the point of scheduling and surface pharmaceutical discounts for chemotherapy and other high-cost drugs.



Point of Service

At the point of service, affordability initiatives are relatively standard. The system rarely accepts 100 percent of a patient's balance at risk except in extraordinary circumstances, relying instead on the pre-service grid to establish partial upfront collection. No additional financial-assistance conversations or payment-plan enrollment occur systemically at the point of care beyond what was initiated during scheduling.



Post-Point of Service

After service, patients receive consolidated digital statements through Cedar and can self-serve balances, set up payment plans, and make payments. Cedar uses over 80 patient attributes to individualize payment-plan offerings to optimize yield. The platform predicts a patient's risk profile and routes them into a personalized program rather than defaulting everyone into the same plan.

The system co-develops tiered self-service options with Cedar, establishing guardrails for what patients can configure online versus what requires a phone call. Remaining balances follow a six-month cycle: three AR statements, then transferred to an internal bad-debt collection process for three additional internal statements, and finally placement with an external collection agency.

True self-pay patients route through the EBO. For inpatients identified as self-pay, a contracted benefits-eligibility vendor initiates contact attempts and works to enroll the patient in available coverage.

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SME Strategic Positioning

Revenue cycle leaders closest to the Cedar partnership view it as having evolved from a patient-experience investment into an economic one as the payer-mix shift toward self-pay intensified. Operational leaders see Cedar's data-driven patient risk cohorting as a way to optimize payment-plan design without aging AR unnecessarily, and they stress vendor-scope discipline: with multiple vendors in the revenue cycle environment, clear boundaries on what is in-scope for each are necessary to prevent double or triple commission payments.

Identified Challenges

Two key areas define the gap within the system's approach to affordability. The first is financial assistance policies. Without presumptive eligibility or upfront charity conversations, the system cannot make assurances further upstream in the patient journey; as a result, their charity-approval process is backlogged on the back end, largely because patients seldom supply the documentation needed to approve their applications. Leadership describes this as the issue that "keeps me up": the risk of a patient needing care and having no way to quickly confirm whether they qualify for assistance.

The second involves timing and system constraints in real-time eligibility and collections. A long lag separates the point at which the system can estimate a patient's responsibility from the point at which it can bill or initiate a payment plan after full insurance adjudication. Clean claims take approximately 20–25 days, and denials and resubmissions can stretch adjudication to several months, during which the system has already absorbed the full cost of care. Underlying this obstacle is the difficulty of producing an accurate upfront estimate when the scope of a procedure may change intraoperatively, with reimbursement shifting accordingly. This challenge is rooted in fundamental data access and analytical barriers across the revenue cycle process. Ultimately, missing this patient activation window is considered a key systemwide challenge among leaders.

The Business Case

The move to Cedar was driven by the limitations of the prior vendor, whose platform was confined to paper statements sent monthly on a running-code schedule, with no digital self-service, no electronic patient communications, and no payment-plan functionality. As self-pay volume grew, leadership recognized that traditional bill-and-collect mechanisms would not scale and that a personalized collection strategy was required.

Cedar addressed two fronts. First, it offered a consolidated digital billing experience. Since System E runs on Cerner, patients previously received split bills (separate professional and hospital bills), creating a fragmented experience. Cedar provided a single portal where patients could see and pay all balances. Second, Cedar brought a cross-market payment database and patient-attribute modeling that could solicit payment in ways calibrated to individual patient profiles, improving both yield and cost-to-collect.

Measured Outcomes

The system tracks a defined set of metrics: average speed to pay, total collections, lift since inception, and call-abandonment rate. Collection-rate uplift is measured by payer class against pre-Cedar historical rates and is reviewed on a monthly cadence with an additional quarterly strategic deep dive.

Since implementation, total revenue lift is $18.7 million, driven by increased collections and a reduction in bad debt. Qualitatively, staff and leadership unequivocally endorsed the change, with patient self-service and control identified as the other significant wins.

$18.7M **Total revenue lift since implementation**

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Change Management

Implementation was deliberate and phased. The hospital side launched first in November 2023, beginning with two smaller facilities alongside a flagship hospital; the physician group came on approximately a year later. The system used a phone-tree setup recommended for scaling and conducted extensive multi-scenario test-script validation, tracked through a detailed spreadsheet covering every conceivable billing scenario. Each test case was evaluated as pass or fail and routed to the system's IT team or Cedar for resolution. Advance patient notifications were sent via mail, and the rollout was staged to control risk. The CFO speaks quarterly with Cedar's executive leadership about the vendor's strategic direction and the system's role within it.

Key Challenges and Persistent Gaps

The operational team characterized the go live as complex. Despite planning and advance notifications to patients, call volume surged and the call-abandonment rate collapsed for approximately three months. Discrete technical issues (e.g., charges added to an account not flowing correctly) were identified and resolved through the test-script process.

Several gaps remain unresolved. Cedar was configured hospital-first, which limited customization for medical group-specific requirements (such as displaying the account number on patient statements). This created operational friction for the physician-group side that the hospital does not experience, though patient satisfaction reportedly has been unaffected.

Two-to-Three Year Horizon

Near-term, the system orients its strategic roadmap around moving affordability activity to the front of the patient journey using presumptive eligibility, upfront charity conversations, and risk-stratified payment plans. A marquee aspiration is tying an early estimate to an automated payment-plan setup (a deposit plus monthly payments that adjust after insurance) to collect a substantial share of patient liability before final adjudication. Downstream, the system is evaluating whether to adopt a financing loan vendor, re-envisioning the role of their EBO now that Cedar has lowered collection costs, and considering further integration of Cedar's platform capabilities.

> ***"At times they have disruptive income… their income spikes and their medical bills are spiking… How do we smooth that out so they can at least put that in their budget and make those payments."***
>
> ***– Chief Financial Officer, System E***

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System E: The Bottom Line and Key Takeaways

System E's patient affordability initiatives epitomize the middle ground approach on the status-quo-to-ideal strategy continuum: personalized but not consistently preemptive. Patient-level risk cohorting and likelihood-to-pay segmentation robustly informs post-service plans, which surpass typical education-focused interventions with limited potential for behavior change. Additionally, ad hoc offerings within certain service lines, like infusion, individualize pre-service support with dedicated financial counselors. This sophistication, however, does not yet extend through the full patient journey. System leadership has discussed but has not yet implemented core upstream capabilities like presumptive eligibility, automatic charity screening, and upfront payment plan enrollment.

Overall, System E limits bad debt effectively post-service, but lacks the front-end infrastructure that could abate it in the first place.



Post-service collection investment delivers measurable financial returns, but systems must account for potential implementation costs that extend past go-live. System E reported a multimillion-dollar revenue lift since partnering with Cedar. Even with a phased rollout, however, others pursuing a similar investment should expect operational hurdles, like a temporary surge in patient call volume. To curtail similar post-implementation friction, systems should plan for extensive scenario testing, adequate FTE support, and customization for each care setting.



Prioritizing what affordability investments to deploy requires a thorough assessment of flexibility; as system-level priorities and macro-conditions shift, the right solution compounds in value. According to System E's CFO, the Cedar partnership started as a consumerism initiative to fix a fragmented split-bill experience. As self-pay volume began to rise, the system expanded its use case through tailored payment solicitation, becoming a primarily economic lever. Looking ahead, as exchange-related coverage shifts push more patients toward self-pay, a focus on collectability will be increasingly imperative.

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Section 3:

How Systems Approach Patient Affordability

"You've done all that work. How then, on the back end, do you recoup those payments?… That's where I think a lot of systems are just kind of using their traditional mechanisms, and they're going to find as self-pay increases, you're going to need a strategy."

— Chief Financial Officer, System E

How Systems Approach Patient Affordability

This case series identified persistent market challenges, operational gaps, and cultural dilemmas facing health systems as affordability pressures intensify. External market conditions and internal capabilities shape each system's preparedness and their financial/operational insulation from these pressures across patient populations.

Three key observations stood out across participating systems:

1. **The critical gap lies in integration and systemness, not technical capability.** In-house capabilities or market solutions exist for most technical revenue cycle challenges. The more persistent difficulty is coordinating them across teams, technology, and reporting structures at the pace the market is changing.
2. **Systems are least prepared to support the underinsured population.** Patients with coverage who cannot absorb their expected liability fall between established pathways, and the policy questions they raise extend well beyond what Revenue Cycle can support.
3. **Broadly, leaders agree on direction but differ in approach.** CFOs aligned on widening the scope of affordability strategy and on the need for a more concerted, multi-stakeholder effort. However, the methods and urgency to get there depends on each system's market, infrastructure, structure, and financial position.

Where Leadership Teams' Focus is Concentrating

Historically, payer tactics and constrained rate growth anchored the affordability discussion. CFOs and Revenue Cycle SMEs alike described limited ability to keep pace with growing operational complexity, predominantly pre-point of service, alongside government payer rate pressures that shape wider market economics. As a result, affordability efforts remain focused on the following recurring operational questions:

Payer Strategy

- How do we get ahead of denials upstream?
- How do we more effectively compare payer contractual requirements with actual remittance, act on those findings, and hold our partners accountable?

Operational Efficiency

- How do we communicate estimates more effectively and improve collection rates at POS?
- How do we streamline discovery/eligibility functions and payment-plan/assistance enrollment? How do we manage the growing portion of AR in patient payment plans (PAPs)?

Strategic Direction

- How do we continuously improve both the value our mid-cycle investments create and the value we actually capture from them?
- How do we improve overall collections, and cost to collect, while maintaining patient experience?

Financial Model

- How do we align cost with acuity across sites of care to maintain margin amid site-neutral shifts?
- How do we maximize margin opportunities in high-performing service lines to offset necessary loss-leading services?

Certain foundational questions remain unresolved or are rarely addressed comprehensively across relevant leadership and stakeholders (i.e., outside of the revenue cycle department):

- How do we streamline revenue cycle/integrity operations and technology across fragmented teams and reporting structures, complex fund flows, and organizational bottlenecks?
- Are our investments collectively making it easier for patients to understand, access, and pay for care, and ensuring patient responsibility is accurate before they are billed? Where complexity persists, do we need to realign on the outcomes we are trying to achieve and how we measure progress?
- Are our infrastructure, policies, and procedures, historically built for more clear-cut definitions of affordability and access, equipped to serve a growing population of underinsured, price-exposed, and financially strained consumers?
- As patients become more financially-exposed, how does our pricing compare with alternatives in the market? Where should we reconsider strategically pricing to preserve access and competitiveness while maintaining financial viability?
- Culturally, how do we adjust access policy accordingly when must care proceed over when may it be deferred? How do those decisions affect clinical relationships and economic models built on productivity?

Across participating systems, leaders acknowledge the need to establish a coherent strategy. Each of these foundational questions returns in a more specific form in the section that follow, where we connect it to a stage of the patient journey or a dimension of organizational readiness.

Regardless of system archetype, three strategic imperatives emerged as areas of broad CFO alignment:

Expand the definition of "affordability strategy" and which patient populations it applies; Payer accountability and revenue integrity, patient out-of-pocket exposure, care-model affordability, and cost efficiency are interdependent components of a wider strategy.

Develop a data-centric, digital platform approach that enables coordinated, yet personalized execution to keep pace with innovation, payer tactics, and regulatory/legislative change.

Define success in terms of patient access as well as financial results, and measure it across the full patient journey so that improvements in one area do not shift burdens to another.

The remainder of this section examines findings across the patient journey, including operational gaps, challenges, and potential solutions within each segment. These tactical opportunities should be assessed in the context of the broader strategic imperatives outlined above.

Pre-Point of Service

Pre-POS remains the most mature and complex segment of the patient financial journey. A clean divide between what constitutes pre- vs. at-POS services does not always exist (i.e., pre-POS is essentially an extension of services at POS to streamline registration, access, and collections). Services covered in our discussions with systems included, but are not limited to: eligibility verification, coverage discovery, good faith estimates, financial clearance and counseling, Medicaid and charity screening, deposit collection, payment-plan discussions, and service-line-specific assistance. Regardless, CFOs and Revenue Cycle leaders consistently identified the need for further proactive investment as financial exposure and administrative complexity increase.

Pre-POS complexity fosters substantial organizational inertia

Increasingly complex care pathways and payer requirements necessitate specialized resources and local workflows. But the number of teams involved, compounded by variation across facilities and reporting structures, creates substantial organizational inertia when implementing enterprise changes.

Profiled leaders emphasized the time required to implement new workflows, particularly point solutions outside the EHR stack. Beyond technical integration, deployment requires extensive workflow redesign and change management across already stretched staff, often with multiple layers of committee and legal approval, with some citing enterprise digital integrations taking 10–12 months before go-live. Similarly, systems also described the tension between preserving local expertise and centralizing functions for scale. Specialized financial support addresses meaningful differences in treatment and coverage, while variation in how facilities organize these functions can duplicate work and slow deployment of centralized solutions.

As systems move more work upstream, accountability for pre-POS outcomes is distributed across multiple reporting structures. Some functions report directly to Revenue Cycle, while others fall under facility or service-line leadership with competing operational priorities. Revenue Cycle leaders rarely indicated full visibility into performance and challenges across this environment. This fragmentation of ownership makes it difficult to establish shared priorities and hold the overall process accountable, leaving teams responding to immediate issues rather than advancing a coordinated pre-POS strategy.

The opportunity is to clarify where local specialization adds the most value and which operating-model enables faster enterprise implementation. Leaders must consider:

- Which pre-POS functions (e.g., financial counseling, estimates, service-line advisors) require local expertise, and which could be centralized without compromising patient support?
- Where does workflow variation reflect differences in care needs versus historical organizational practices? Where resources remain local, what shared infrastructure and decision authority would improve enterprise implementation?
- Which pre-POS outcomes (e.g., clearance rates, estimate accuracy, assistance enrollment) are owned by teams outside Revenue Cycle, and does anyone see their combined performance?

Upstream data gaps limit what is possible digitally in the near term

Systems frequently discussed good faith estimate accuracy, real-time eligibility/discovery, authorization, and financial clearance as separate challenges. Many shared an underlying constraint: access to patient and financial information early enough, with sufficient reliability, to support the next step in the workflow. Beyond the work inefficiency and redundancy, these gaps also limit systems' ability to move payment arrangements and assistance enrollment further upstream. Today, engaging patients on financial matters largely still depends on information resolved later in the encounter.

Payer complexity compounds this issue. In certain regions, delegated risk arrangements and unclear payer liability make it difficult to move these services upstream without greater payer accountability and visibility. Task-level automation alone cannot resolve dependencies on incomplete information or repeated manual investigation.

A useful starting point is identifying which information gaps keep financial engagement downstream and where shared data could eliminate repeated work:

- What information gaps prevent earlier alignment on patient responsibility, assistance, or payment arrangements?
- Where are teams repeatedly obtaining or validating the same information, and what would enable its use across encounters and service lines?

Policy gaps for the underinsured are the biggest growing risk

Systems described relatively mature pathways for uninsured and very-low-income patients, alongside established processes for insured patients. The growing underinsured population falls between these models; earlier identification of liability does not resolve the underlying affordability challenge when available assistance and payment options remain insufficient. In response, systems are reconsidering FPL thresholds and charity eligibility, payment-plan duration, discounts, financing, and presumptive-assistance criteria. These decisions involve significant tradeoffs, namely deferring cash realization. Participants also acknowledged that these policy questions require alignment beyond Revenue Cycle. Decisions about proceeding with or deferring care affect clinical relationships and productivity expectations, requiring agreement on how access commitments translate into financial policy and operational practice.

The central policy question is whether existing assistance and payment options provide a viable path to care for this population, and how leadership will resolve the tradeoffs when they do not:

- Where do assistance policies exclude insured patients who cannot reasonably absorb their expected liability?
- When does extending a payment plan support access, and when does it prolong an unsustainable obligation?
- When should lower collection expectations be accepted to preserve access, and who has the authority to make that call?

Point of Service

At the point of service, affordability policy transforms to an access decision

At-POS extends the operational requirements identified pre-POS, particularly consistent policies, integrated data, and actionable financial-assistance pathways. The growing underinsured population tests whether those capabilities support patients with verified coverage who cannot meet expected payment obligations and may fall outside traditional assistance thresholds. Finance, revenue cycle, clinical, and facility leadership must align on when care proceeds, when financial review is required, and when a nonurgent service may be deferred. These parameters must reconcile financial-clearance expectations with clinical priorities and productivity models.

Policy ownership and frontline operations often sit in different places

As in pre-POS, enterprise Revenue Cycle may own the policy while frontline staff report through facility leadership and exceptions are resolved locally. Clear decision rights, escalation pathways, and reporting on local exceptions support consistent implementation.

Frontline staff need practical tools as well as policy

Integrated financial information, practical scripting, and authority to activate appropriate options help ensure sensitive access decisions do not depend too heavily on individual judgment and local practice.

The priority at this stage is translating affordability policy into explicit front-desk decision rules:

- When an insured patient cannot meet their expected responsibility at the front desk, what options can staff offer in the moment, and what happens when none apply?
- Are finance, revenue cycle, clinical, and facility leadership aligned on when care proceeds, when it may be deferred, and who can authorize an exception?
- Are front-desk exceptions reported back to policy owners, and how are they reviewed?
- Can frontline staff apply these policies seamlessly and respectfully, with clear scripting, actionable options, and timely escalation support?

Post-Point of Service

The post-POS toolkit is well understood, but prioritization varies.

Systems generally understand the available post-POS levers: digital billing, consolidated statements, self-service, payment plans, segmentation, automated/AI outreach, financing, and collection workflow optimization. The larger distinction is how urgently leadership prioritizes these capabilities and incorporates them into affordability strategy.

Financial position shapes the timing of these decisions

Systems with less financial insulation must address patient collections and cost-to-collect as immediate operating concerns. Better-insulated organizations have more latitude to defer these decisions or separate collections from affordability discussions. A reasonable question is whether that latitude remains an advantage as patient exposure and the cost of managing outstanding balances increase. Additionally, PAP balances also represent a growing share of AR across systems, which calls for a deliberate strategy.

As such, the objective should be to resolve remaining patient obligations in a way that minimizes burden but maximizes efficiency and economic sustainability. This necessitates a level of personalization and consumer-centricity hard to build when systems have intentionally kept their distance from collections. Payment terms, assistance pathways, and outreach must primarily support the consumer as a vehicle to support the system.

Mission-driven collection limits make personalization more important

Some participants described their limited collection enforcement as a deliberate choice to reflect their mission and commitments to their communities. Within those boundaries, these systems pursue more personalized post-service engagement to improve collectability and mitigate the financial impact. This requires a deeper understanding of patients' ability and likelihood to pay, including whether unresolved balances reflect financial hardship, confusion, or payment terms that do not fit their circumstances.

At post-POS, the priority is managing outstanding balances, including the growing PAP, as a segmented portfolio: matching outreach, terms, and assistance to why each balance remains unresolved. To conceptualize, ask the following:

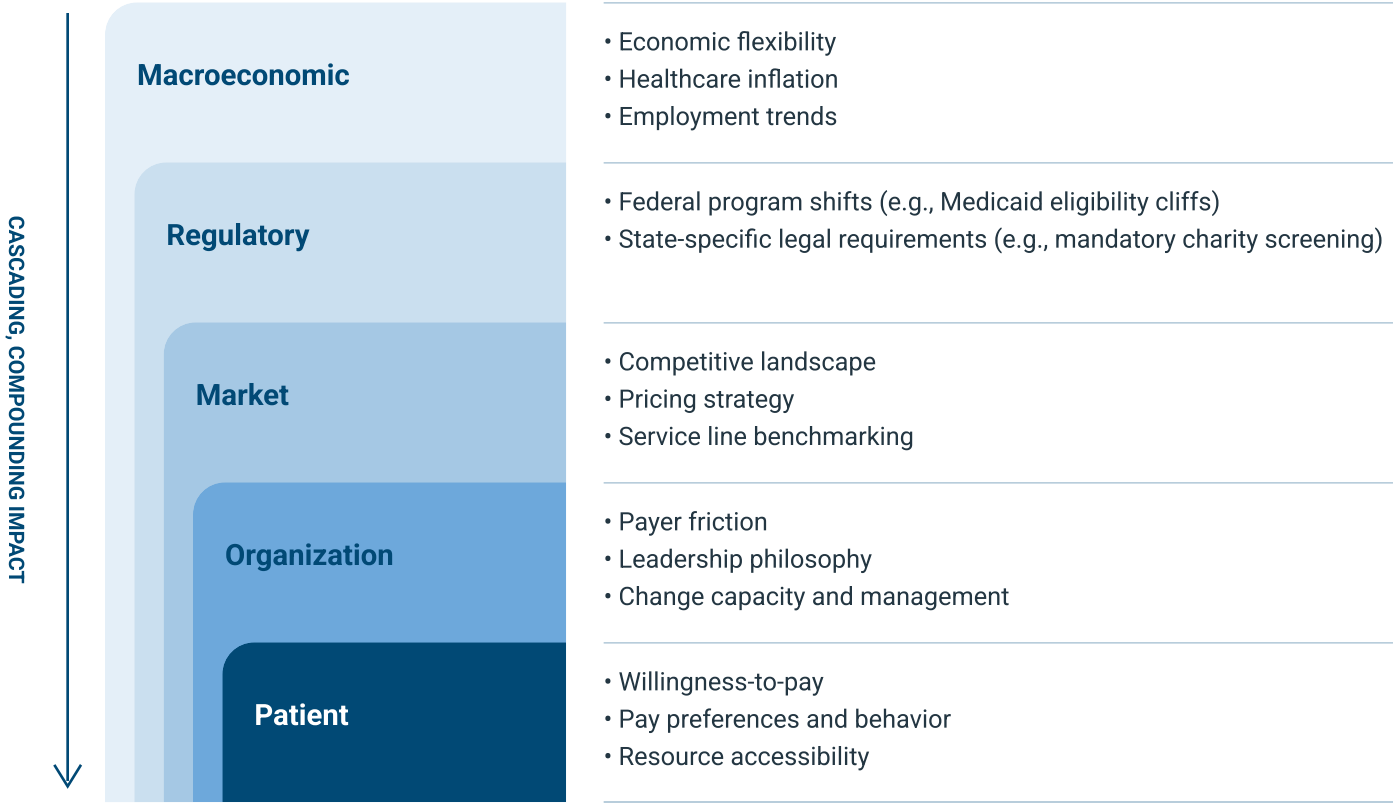
- Can we distinguish patients' ability to pay from their likelihood of paying, and do post-service workflows route them accordingly (to clarification, assistance, or different payment terms) within our collection policies?
- As PAP balances grow, are we tracking cash realization, completion and default rates, and servicing costs alongside enrollment?
- What signals (e.g., missed payments, extended duration) trigger reassessing a payment-plan strategy, and is that reassessment automatic?

A framework for assessing and grounding your affordability strategy discussion.

While patient affordability strategy largely depends on system-unique circumstances, this research identified four dimensions that shape what a strategy must account for: market environment, digital infrastructure, systemness, and financial standing. This framework distinguishes between assessing a system's circumstances and assessing the quality of its response. A well-capitalized system is not necessarily more mature, nor is a centralized system or one with more technology. The four dimensions establish what the organization must account for and what it can execute; the subsequent ideal-state assessment considers how effectively it responds.

1. Market environment: Can you reliably and regularly recalibrate your strategy to address regulatory shifts, organizational changes, and social trends?

Leaders expect current pressures to persist. Affordability reflects a mix of macroeconomic, political, and organizational factors, further shaped by patient sentiment and repayment behaviors that extend beyond healthcare. Across participating systems, leaders recognized that the pressures described earlier reflect a changing economic model, with limited expectation of returning to prior conditions. Therefore, the discussion is whether the system's strategy and operating model are prepared, and whether its investments are positioned for that environment.



This market assessment will differ by market. Payer mix, competitive position, and population needs influence both the urgency of change and the options available. How those realities translate into decisions today, particularly where sustaining current operations competes with investments needed for future viability, is the most acute decision-point. To work through that tradeoff, leaders should consider:

- Where do our financial plans depend on reimbursement or collection assumptions that are becoming less reliable?
- How will growth in underinsurance change demand, realized revenue, and the cost of supporting access?
- Are our service-line and site-of-care investments aligned with where patients will seek care and what they or their payers can sustain?
- Where could strategic pricing or earlier, deliberate loss-leading investments improve access while reducing more costly underpaid or unpaid care?
- Which parts of our operating model require structural change, and are we allocating sufficient resources to make that transition?

2. Digital infrastructure: Where does your existing vendor stack aid in achieving strategic affordability goals?

Platform choices involve tradeoffs in both directions. Participants described a Sisyphean tension for leaders: at what point does the opportunity cost and narrowed strategic scope outweigh seeking a solution outside the EHR? EHR-native tools offer advantages in workflow continuity and vendor management, while point solutions provide functionality or depth that the native platform does not yet support. The assessment is whether the current architecture can deliver the system's affordability objectives, and where waiting for additional functionality carries an operational or financial cost.

This requires looking beyond whether capability exists. An estimate, payment-plan offering, or propensity-to-pay model may be available without providing the accuracy, flexibility, or personalization the strategy ultimately requires. Conversely, selecting a more sophisticated solution does not resolve the implementation constraints described earlier. Its value depends on access to underlying data and the organization's ability to incorporate it into workflows across the enterprise. The decision to build, buy, or wait requires solving an ever-evolving calculus. While no standard answer exists, key questions can assist in narrowing down optionality:

- Which affordability objectives can our current platform support adequately, and where are capability gaps limiting outcomes?
- Where are we accepting functional limitations or manual workarounds to remain EHR-native, and what is the cost of continuing or waiting?
- What incremental value would a point solution provide, accounting for implementation demands and ongoing operating costs?
- Which of the upstream data gaps identified in pre-POS can our current platform close, and which require integration or payer cooperation?
- When we last added a capability, did it make the next deployment faster or slower, and what evidence supports that?

3. Systemness: Does your affordability vision require the health system to move as an enterprise?

A shared strategy depends on shared decision-making, not only shared structure. The ownership and coordination challenges noted across the patient journey raise a broader question about whether the system can execute a shared affordability strategy across its organizational structure collectively. The assessment is whether current arrangements support the intended strategy and provide sufficient authority to act across the enterprise. This starts with leadership alignment on what affordability is intended to accomplish. Finance, revenue cycle, and clinical leaders may support the same broad goals while differing on acceptable collection expectations or when financial barriers warrant deferring care. Without agreement on those decisions, enterprise policies leave substantial interpretation to individual facilities and teams.

Systemness involves more than centralizing functions. It also requires clarity about which decisions are shared, where local discretion is appropriate, and who owns outcomes spanning multiple functions. Leadership also needs visibility into whether local performance improvements translate into better enterprise results or shift costs and unresolved work elsewhere:

- Where do leaders differ in their affordability priorities, and how are those differences resolved in policy and investment decisions?
- Who decides which functions are standardized or centralized versus kept local, and how often is that decision revisited?
- Does accountability for affordability outcomes come with the visibility and authority to change workflows across the teams involved, including those outside Revenue Cycle's reporting structure?
- Can we measure the combined effect of our interventions across the patient journey, including whether local improvements create downstream burdens?

4. Financial Standing: Do you have the financial resources to invest in and sustain an evolving strategy?

Each system's capacity to absorb its access commitments differs. Systems' financial positions are shaped both by their investment horizons and how directly they engage with patient affordability and collections. Some described deliberate limits on collection practices consistent with their mission and community commitments. Others had sufficient financial insulation to give patient collections less strategic urgency. Systems facing immediate operating pressures exhibited less flexibility to absorb unrealized revenue or defer improvements.

Tactically, leaders must choose what degree of strategic distance remains sustainable as patient exposure grows. A deliberate choice to limit collection enforcement still carries financial and operational consequences. Longer payment terms, continued manual support, and unresolved balances require capacity, even when they reflect an intentional commitment to access. While financial standing determines how much of that burden a system can absorb, investment priorities determine whether it becomes more manageable over time.

This tension calls for an assessment of whether the organization has the financial and staffing bandwidth to continue current practices. It also requires distinguishing what leadership has explicitly chosen to subsidize from costs and revenue losses that persist without clear ownership or review:

- Where have we deliberately limited collection efforts, and do we understand and accept the financial consequences of those decisions?
- Does our current financial position allow us to sustain that approach as patient responsibility and assistance needs grow?
- Do we have the staffing and cash-flow capacity to support current payment terms and manual workflows at anticipated volumes?
- Which investments could reduce the cost of maintaining our access commitments, and is our financial cushion funding those investments or postponing them?
- Where are near-term return requirements preventing investments needed for longer-term viability, and how are those tradeoffs being resolved?

Assessing the Ideal State

The four dimensions establish the circumstances shaping a system's strategy. The following characteristics describe an ideal state for systems to work toward, serving as a waypoint for affordability strategy. While the path and pace will differ based on each system's circumstances, these dimensions provide a shared basis for setting priorities and assessing progress, and they build on the strategic imperatives outlined previously.

1. **An enterprise strategy with clear ownership:** Leaders agree on affordability objectives and acceptable financial tradeoffs. Common functions are standardized where scale adds value, while specialized resources remain local where patient needs warrant them. Accountability extends across reporting structures.
2. **A comprehensive digital platform strategy:** EHR-native capabilities and point solutions operate within a shared architecture that supports data continuity and streamlines integration across the POS chain. Technology investments reduce duplicative workflows and make new capabilities easier to deploy across the enterprise.
3. **Individualized support that leads to action:** Patient circumstances inform coverage, assistance, and sustainable payment arrangements. Those arrangements carry through the patient journey, with clear responsibility for unresolved barriers.
4. **Defined and measurable success:** Leadership evaluates whether patients can access care and manage their obligations, alongside realized revenue, and cost-to-collect. Shared measures reveal whether individual interventions improve the overall process or shift burdens elsewhere.
5. **Structural improvement as market conditions change:** Performance findings inform changes to pricing, care delivery, and financial policies. Leadership reassesses the underlying operating model when incremental improvements no longer adequately address affordability pressures.

Conclusion

Even the most advanced infrastructure cannot fully resolve patient affordability; a subset of patients will invariably remain unable to pay, and revenue integrity strategies must evolve in tandem. As a result of this work's ongoing nature, no single, prescriptive route to the ideal state of patient affordability exists. As rising patient liability, thin margins, and contracting coverage continue to erode financial affordability, this issue will increasingly span across financial access, growth, strategic pricing, and revenue integrity.

While no health system exhibited a fully realized ideal affordability strategy within this case series, the most pervasive overarching issue is a lack of organizational agility. This nimbleness hinges on the four interdependent dimensions examined in the previous section. Leaders must assess whether they can recalibrate ahead of market shifts rather than react to them, where their digital platforms advance or constrain affordability goals, which processes warrant enterprise standardization versus local expertise, and whether their financial position supports long-term investment or withstands short-term headwinds. Systems in the series pointed to barriers such as fragmented reporting structures and limited visibility into EHR functionality, demonstrating how a shortfall in any one dimension stalls others already prioritized.

Across this series, the profiled systems' roadmaps converge on a shared set of next steps. Many are turning to automation, from virtual agents to AI-enabled self-service, to extending patient outreach beyond what staffing alone allows. Those strongest after the point of service are pulling affordability upstream through self-service estimates, presumptive charity screening, and earlier payment-plan enrollment. Others are widening the pathways available to resolve remaining balances, such as tailored payment plans, patient financing, and expanded self-service tools. A robust platform strategy speeds execution; in a connected digital ecosystem, each stage of the patient journey can inform the next, easing the integration burden and vendor overlap that slows new initiatives and allows systems to adapt as conditions change.

However deliberate, strategic interventions will be regularly tested by macroeconomic pressure and regulatory changes. This volatility results in a dynamic "ideal state" of affordability and further underscores the necessity of strategic flexibility. Ultimately, patient affordability is not a one-time fix but a continuous operational function—and this organizational agility is what enables systems to get ahead of the next shift rather than responding to the pace set.

Methodology Overview

The Health Management Academy in partnership with Cedar. The work draws on interviews with CFOs, revenue cycle leaders, and operational staff at five leading health systems, examining how each approaches the ever-broadening issue of affordability. The systems differ in scale, market, payer mix, and EHR infrastructure, but each was assessed on the same two questions: how individualized its affordability approach is, and where in the patient journey (before, at, or after the point of service) its efforts are concentrated.

About The Health Management Academy

Since 1998, The Health Management Academy has cultivated the premier community of influential changemakers in healthcare. Our members are aligned around a common goal of improving health for all, and a core belief that partnership will accelerate progress. Our member community includes Leading Health Systems – the approximately 150 innovative integrated delivery systems with over $2B in total operating revenue – and innovative Industry Partners that are working alongside health systems to drive health forward. We power our members by building our community and fostering connections through executive peer learning. We support professional growth through talent and development. We accelerate understanding by delivering timely and actionable data and insights on key challenges. And we catalyze transformation by building alliances in areas where the power of the collective is greater than the power of one.

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About Cedar

Patients are healthcare's fastest-growing payer class, but most billing infrastructure was built to collect from insurers, not individuals. Cedar closes that gap. Powered by more than 1.5 billion patient interactions, Cedar's AI-driven technology meets patients where they are, across billing, payments, and financial assistance, with outreach and payment options built around how people pay today. Cedar has processed over $13.6 billion in payments and supported more than 63 million patients nationwide. Health systems collect more, at lower cost, from a payor class legacy systems were never built for. To learn more, visit www.cedar.com.