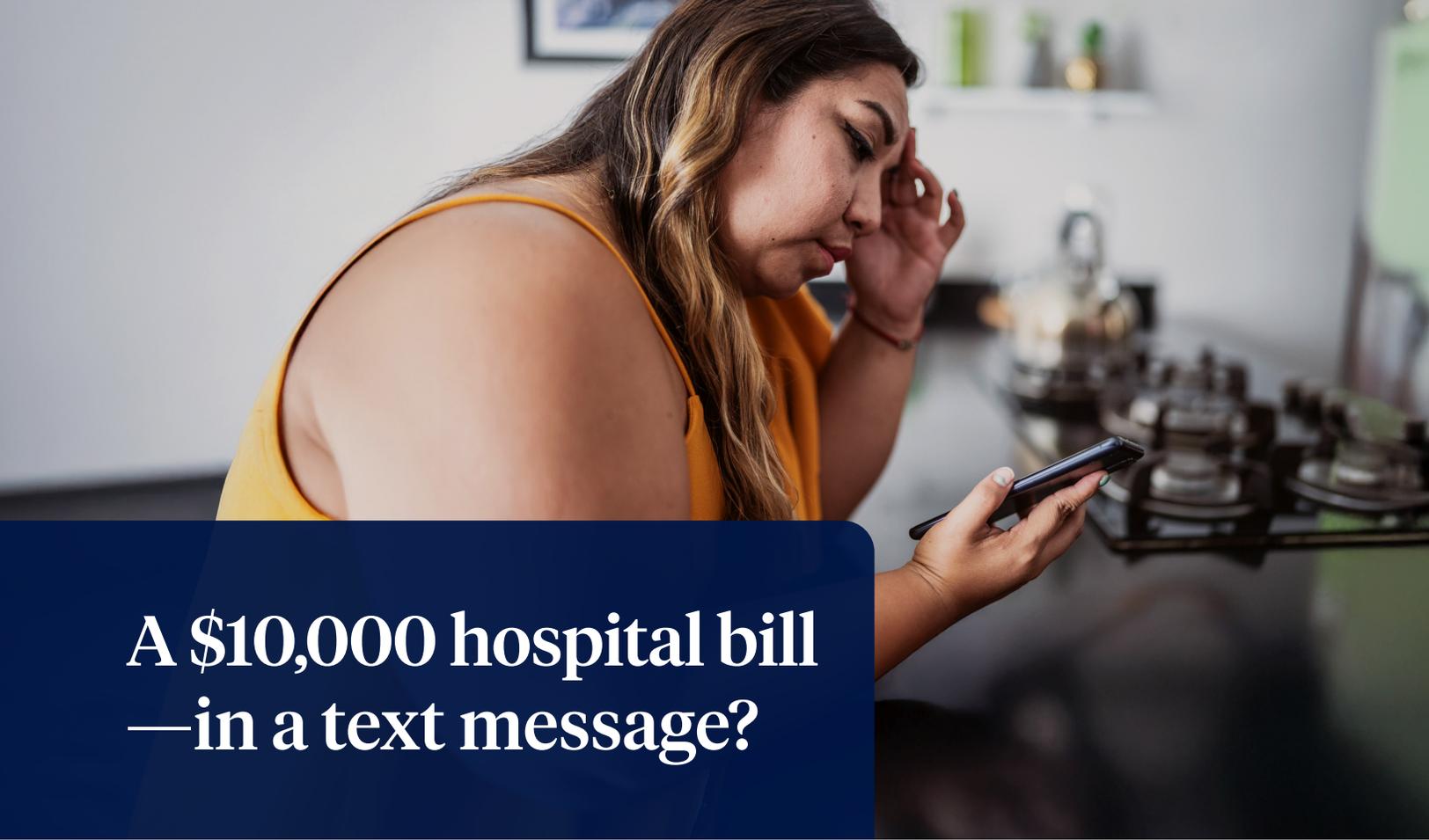




# Better billing won't solve healthcare's affordability crisis

Why connecting patients to billions in untapped assistance matters now more than ever—and what providers can do to support.





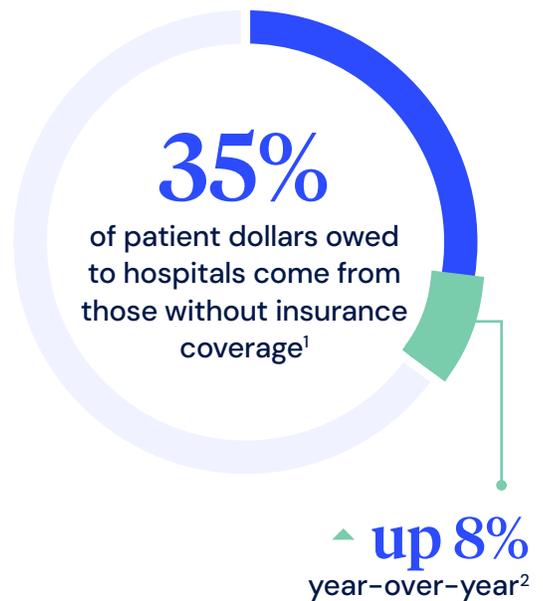
# A \$10,000 hospital bill —in a text message?

**That's more likely to net a headline than a dollar, especially at a time when there is a boiling over of consumer frustration regarding the cost of care.**

Yet the industry keeps optimizing billing—while patients increasingly face larger medical bills with no coverage at all. Without insurance, a hospital stay can easily result in balances of \$10,000, \$20,000, even \$50,000. And for those amounts, a text payment reminder isn't just irrelevant. It's absurd.

Instead of chasing patients for money they don't have, we should be connecting them to resources they don't know exist. That's what this paper is about. We make the case for putting financial assistance and support at the center of the patient experience, and shine a light on who you might be missing.

ACCORDING TO CEDAR'S DATA:



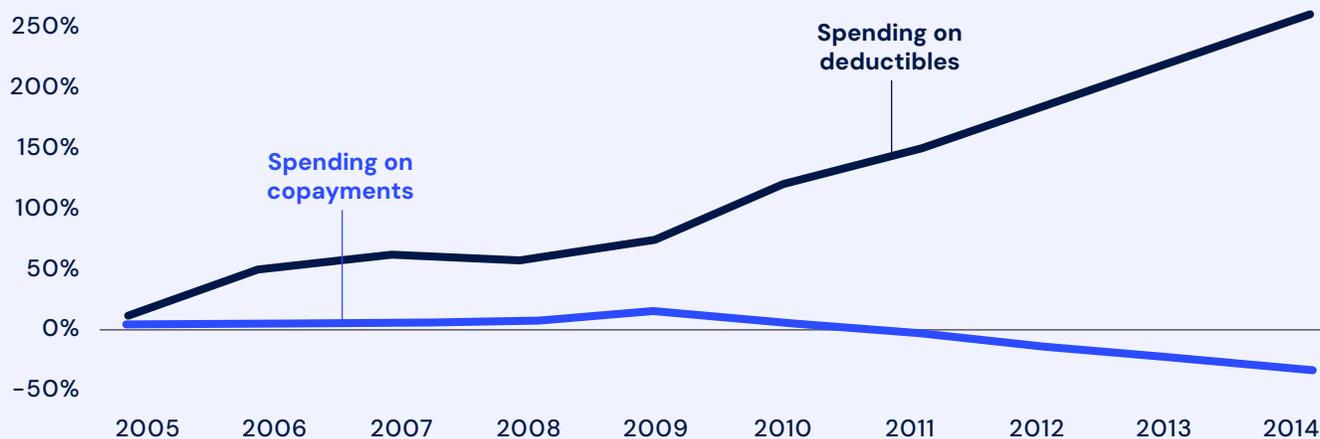
**But first, how did we get here?**

# It started with the \$10 copay

For decades, the copay defined the American healthcare experience. It was predictable, manageable, and transactional—a simple exchange at the point of service, no different from paying for a meal or a cab ride.

Then came the rise of high-deductible health plans. What was once a \$10 copay at check-in became a confusing bill arriving weeks after a visit. Patients didn't just owe more; they owed unexpectedly. Providers, once just caregivers, became debt collectors. Patient collections became an unavoidable part of patient engagement.

RELATIVE GROWTH IN TYPE OF PATIENT OUT-OF-POCKET SPEND, 2005–2014<sup>3</sup>



## IN RESPONSE, THE INDUSTRY PIVOTED.

Billing technology improved. Payment plans became more flexible. Personalized outreach helped providers recover more of what patients owed. But just as providers adapted to the reality of high deductibles, a new crisis is already unfolding.



**This time, it's not about billing. It's about affordability. Why?**

# Because insurance doesn't equal financial protection

Turns out, high-deductible health plans never really delivered on the promise of consumer-driven healthcare. Instead, they've left millions underinsured<sup>4</sup>—forced to navigate a system where *having insurance doesn't mean being covered*.

## The problem

These plans were designed to curb utilization and lower premiums, not to make care more affordable.

They overlooked three simple realities:

- 1 People inevitably need care, planned or not.
- 2 Half of Americans can't afford an unexpected \$500 medical bill without going into debt.<sup>5</sup>
- 3 Patients often don't feel empowered to advocate for themselves (e.g., seek assistance).<sup>6</sup>

When insurance doesn't actually cover care, patients act as if they don't have it—delaying visits, skipping treatments,<sup>4</sup> and waiting until small problems turn into costly emergencies. It stands to reason, then, that underinsured patients are, in effect, uninsured.



I try to avoid having to seek medical attention as much as I possibly can unless it's an emergency.

A PATIENT ON A HIGH-DEDUCTIBLE HEALTH PLAN

## PERCENTAGE OF AMERICAN ADULTS BY INSURANCE STATUS, 2024<sup>4</sup>

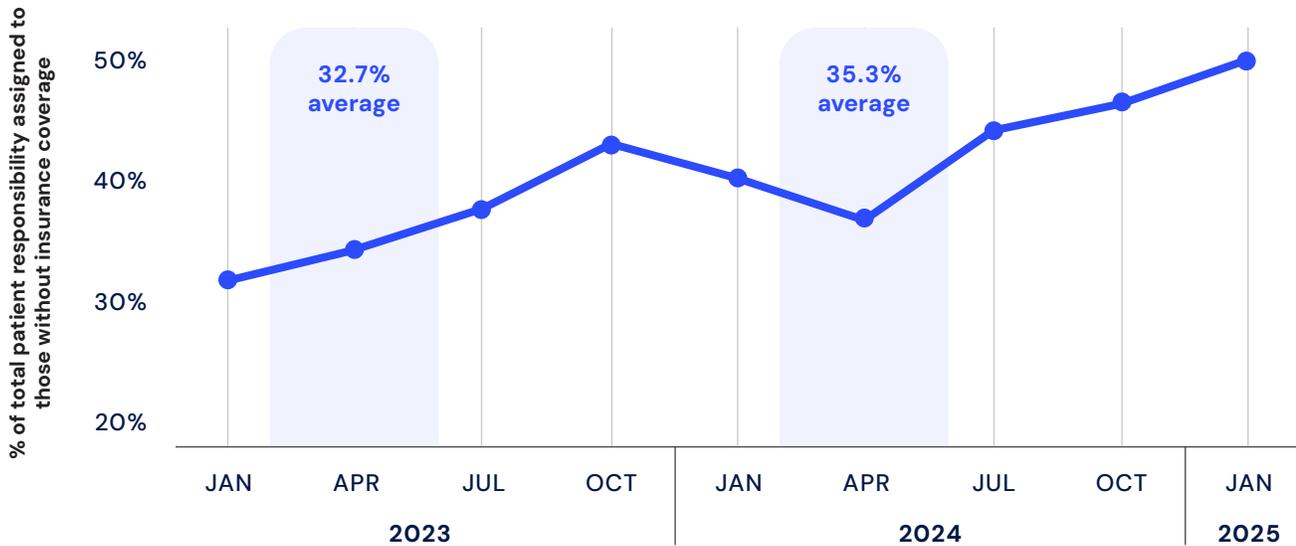


That's almost half (44%) of patients potentially one medical bill away from financial hardship—and at high risk of nonpayment. **And our data suggests the crisis is deepening.**



# More bills are now piling up with no insurance

PATIENT RESPONSIBILITY WITHOUT INSURANCE COVERAGE  
ACROSS CEDAR CLIENTS, 2023-2024<sup>7</sup>



# Policy headwinds could only accelerate the trend

Medicaid disenrollments and medical inflation have already strained the system. Now imagine that pressure multiplied by these looming policy changes:

 <b>Policy change</b>	 <b>Patient impact</b>	 <b>Provider implication</b>
<b>Enhanced subsidies for marketplace plans expiring end of 2025 (absent action)</b>	Premiums surging by as much as 75%, <sup>8</sup> resulting in an estimated 3.8M people losing coverage annually 2026–34. <sup>9</sup>	Significant deterioration in payer mix quality as patients either become underinsured on Bronze plans, or uninsured.
<b>Proposed budget resolution with potential implications for Medicaid funding<sup>10</sup></b>	Tightened eligibility and reduced benefits due to a lower federal Medicaid match rate, block grants, and a per capita cap.	Lower reimbursements create margin pressure, while fixed funding limits the ability to scale coverage during downturns.
<b>Possible work requirements for able-bodied Medicaid beneficiaries</b>	Working Americans with unstable jobs might face coverage gaps, cycling on and off Medicaid due to administrative hurdles.	Operational burden of verifying eligibility and supporting enrollment for each visit, creating front- and back-end friction.

# For providers, this means collecting less per dollar billed

To put this in perspective, we modeled how a sustained shift toward uninsured patients could impact cash collections—holding all else constant. **In reality, the impact could be even greater.**

## IN OTHER WORDS:

**A 10% mix shift represents more than a month of lost patient collections**

Putting more pressure on balance after insurance collections to sustain cash.

**For a \$3B system, that's enough to fund a new ambulatory surgery center**

Or multiple primary care practices to grow market share for a smaller one.

**Inevitably, this leads to more bad debt write-offs and a higher cost to collect**

Especially as more patients seek care through the Emergency Department.

**What's more, uninsured patients need entirely different engagement strategies**

Ones that could overwhelm staff with manual outreach and enrollment tasks.

### POTENTIAL CASH IMPACT OF A SHIFT TO PATIENT RESPONSIBILITY WITHOUT INSURANCE COVERAGE\*

Scenario	% uninsured patient responsibility (\$)	EXPECTED CASH	
		\$1B health system	\$3B health system
Control	35%	\$27.0M	\$81.1M
2% shift in mix	37%	\$26.5M	\$79.4M
4% shift in mix	39%	\$25.9M	\$77.6M
6% shift in mix	41%	\$25.3M	\$75.9M
8% shift in mix	43%	\$24.7M	\$74.2M
10% shift in mix	45%	\$24.2M	\$72.5M

\*Numbers are illustrative. Control scenario assumes 35% of patient responsibility has no insurance coverage. Patient responsibility is assumed to be 10% of annual net patient revenue. Expected cash calculated using 37% collection rate for balances after insurance<sup>11</sup> and 8.5% collection rate for balances without insurance coverage.<sup>12</sup>



**The business case for promoting affordability is clear. But the best way to do that? Not so much.**

THE REASON

# Financial hardship isn't just some group over there

In fact, it affects more people than you might realize—those who earn above the Federal Poverty Level but not enough to make ends meet (let alone unexpected medical bills).

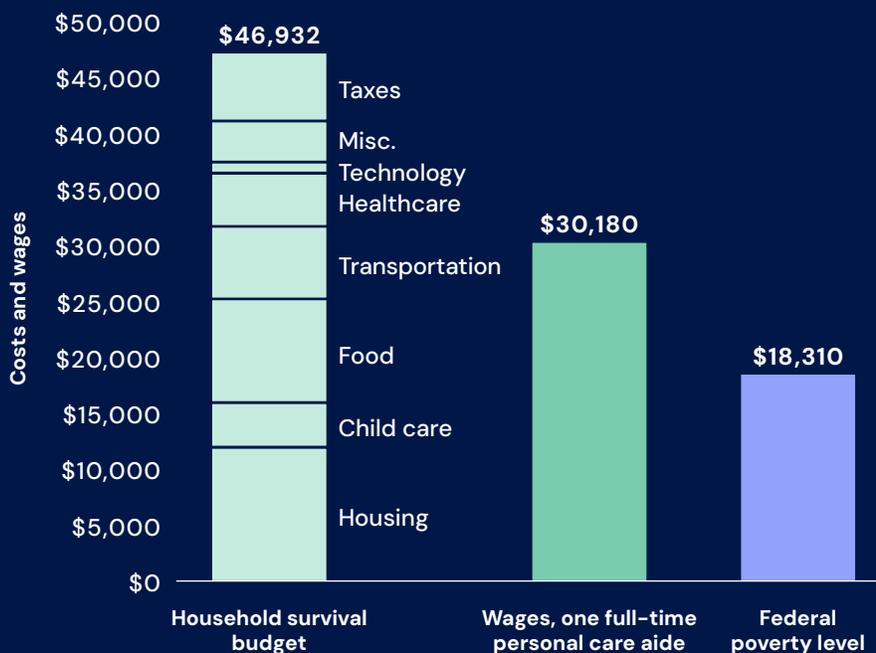
United Way calls this group ALICE, which stands for Asset Limited, Income Constrained, Employed. And they're not an exception—they make up nearly a third of American households, growing twice as fast as all others since 2010.<sup>13</sup>

For this population, healthcare affordability and access is a moving target. They're not always uninsured—but they're frequently underinsured. One month they qualify for marketplace subsidies, the next they don't. Too "well-off" for public assistance programs like Medicaid, they're often caught in a cycle where a single care encounter can force impossible choices.

“I was working 60, 70 hours a week. It was either keep the electric on and the baby in diapers and pay the insurance premiums, or not even make it.”

A NEW MOTHER IN BANKRUPTCY DUE TO MEDICAL DEBT

EXAMPLE OF COSTS AND WAGES FOR AN ALICE HOUSEHOLD: INCOME BARELY COVERS BASIC EXPENSES<sup>14</sup>



Understanding ALICE is critical because it exposes major gaps in how the industry defines financial hardship—and the systems meant to support patients through it.



**We see ALICE juggling multiple jobs, part-time work, side hustles—but those often don't come with the medical insurance they need.**

**So they're trying to get it from the marketplace and then something drops or their family eligibility changes.**

**It's a constant process of navigation when you're already navigating food on the table and rent and bills.**

ASHLEY ANGLIN, PHD  
Director of Research and Strategic Analysis  
United for ALICE, United Way of Northern New Jersey<sup>15</sup>

# Truth is, our healthcare system wasn't built for ALICE

And by extension, almost half the U.S. population. Because no matter one's income or insurance status, navigating the system is hard—and it's easy to fall through the cracks.

## Here's why:

**Financial screening is a snapshot when ALICE lives in flux**

Point-in-time assessments assume stability ALICE doesn't have. Patients may appear financially secure, but one medical bill can push them into ALICE status. Meanwhile, financial assistance thresholds often miss expenses like childcare or car repairs.

**Support systems can't scale to ALICE's growing numbers**

Financial counselors provide crucial help in emergency settings, but can't be everywhere at once. While one counselor assists a patient with forms, another waits on hold. When they do connect, patients often hesitate to share struggles due to shame.

**Resources that can help ALICE aren't where they're needed**

ALICE has options—HSA dollars, medication assistance, and affordable coverage pathways. But accessing them means jumping through hoops and making phone calls between shifts, with these resources nowhere to be found in the EHR patient portal.

“They look and see ‘well this is how much this person makes a year’ but they don’t ask you about daycare.”

A PARENT ON NAVIGATING MEDICAL FINANCIAL ASSISTANCE

THE RESULT

# Billions in financial assistance go unused each year



**\$123B**

sitting in health savings accounts across the U.S.<sup>16</sup>

**35%**

of accountholders forget they even have an account<sup>6</sup>



**\$4.5B**

in flexible savings account funds forfeited annually<sup>17</sup>

**50%**

of accountholders lose funds each year<sup>17</sup>



**\$5B**

spent annually on pharmaceutical assistance programs<sup>18</sup>

**97%**

of eligible patients don't use these benefits<sup>19</sup>



**6.4M**

uninsured Americans are likely eligible for Medicaid<sup>20</sup>

**5M**

more for essentially free ACA marketplace plans<sup>21</sup>



## Let's take a step back

We've established that the combined uninsured and underinsured population is large and growing, placing increasing financial pressure on providers.

We also know that vulnerable populations like ALICE have diverse needs and challenges that today's healthcare system struggles to address—even though resources to help them are available.



**So, where do we go from here?**

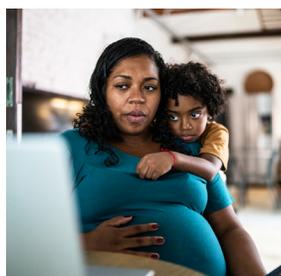
# Start by getting to know your patients better

## What if financial hardship isn't who patients are, but what happens to them?

Forget income brackets. Forget insurance status. Our research shows that the line between stability and crisis isn't drawn by just demographics—it's often marked by specific, identifiable moments.



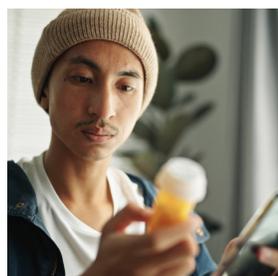
Home repair expenses due to a natural disaster



Separation or divorce from income-earning partner



Loss of benefits when switching to contractor status



Change in prescription for a more costly medication



Aging out of a parent's insurance plan at age 26

### FOR ALICE, FINANCIAL STRAIN ISN'T AN IDENTITY—IT'S A TURNING POINT.

Many can pinpoint the exact event that changed everything. And when you look at enough of these stories, patterns emerge. Not just anecdotes, but data.

These patterns offer a new way to understand and support patients. By identifying which events typically destabilize specific ALICE segments, you can intervene proactively—addressing affordability at its root.



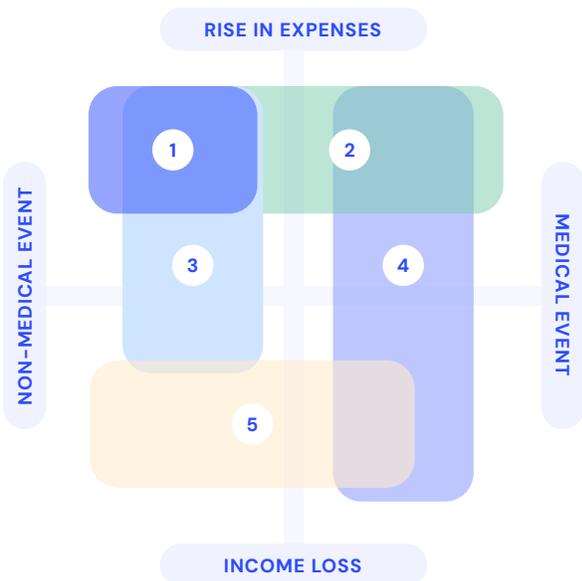
This is where archetypes come in.

# Archetypes show us when and how to support

Traditional assistance programs ask: “Who qualifies for help?” While important, our archetypes attempt to answer more actionable questions: “When will they need support?” and “What resources will actually help?”

We identified five distinct archetypes that show different ways patients could become ALICE, defined by two key dimensions: the nature of triggering events and their financial impact.

## FIVE ALICE ARCHETYPES IN HEALTHCARE



### METHODOLOGY

Between 2022 and 2024, Cedar conducted in-depth interviews with patients facing healthcare financial challenges using an online research platform.<sup>22</sup>

- **1 Cost burdened**  
Patients whose basic expenses have increased without matching income growth.
- **2 Caregivers**  
Patients managing their own care and that of dependents, with limited resources.
- **3 Gen Z builders**  
Young adults newly navigating healthcare with limited income and experience.
- **4 Treatment drained**  
Patients with medical costs that gradually or quickly deplete their savings or income.
- **5 Suddenly self-pay**  
Patients who unexpectedly lost insurance coverage or income due to life changes.

# So, what does this look like in practice?

	 <b>Treatment drained patients</b>	 <b>Caregiver patients</b>						
<b>Situation</b>	<p>When a patient faces a cancer diagnosis or begins treating a chronic condition, they aren't just managing the initial hospital bills—they're entering a long-term cycle of specialist visits, treatments, and medications.</p> <p>Then there are the expenses people don't think about: parking fees for frequent visits, specialized clothing to accommodate medical devices, and home modifications, among others.</p>	<p>Financial hardship often coincides with big life transitions. The birth of a child, caring for an aging parent, or supporting a family member with special needs creates a dual financial burden.</p> <p>While these guarantors may have stable employment and insurance, the combined weight of new healthcare costs, childcare, and lost work hours can quickly erode a family's financial stability.</p>						
<b>In practice</b>	<p>A provider identifying a patient with a new cancer diagnosis can take immediate action before financial toxicity sets in, analyzing oncology procedure codes and prescription data on claims.</p> <p>This proactive approach allows providers to connect patients to manufacturer assistance programs for high-cost chemotherapy drugs, disease-specific foundation grants, and pharmaceutical copay cards.</p>	<p>When caring for an uninsured expectant mother, providers can proactively help her enroll in Medicaid by leveraging higher thresholds available for pregnant women—reaching nearly 400% of the Federal Poverty Level in some states.<sup>23</sup></p> <p>Providers can also support enrollment of newborns in Children's Health Insurance Program (CHIP), even when parents' income exceeds Medicaid limits, to secure immediate coverage for vulnerable infants.</p>						
<b>Indicators to track</b>	<table border="1"> <tr> <td>Number &amp; frequency of medical bills</td> <td>Specific CPT codes</td> </tr> </table>	Number & frequency of medical bills	Specific CPT codes	<table border="1"> <tr> <td>Household size</td> <td>Number of dependents</td> <td>Patient age</td> </tr> </table>	Household size	Number of dependents	Patient age	
Number & frequency of medical bills	Specific CPT codes							
Household size	Number of dependents	Patient age						
<b>Potential solutions</b>	<table border="1"> <tr> <td>Medication assistance</td> <td>Discounts applied to existing bills</td> <td>Extended dunning</td> </tr> </table>	Medication assistance	Discounts applied to existing bills	Extended dunning	<table border="1"> <tr> <td>Children's Health Insurance Program (CHIP)</td> <td>Pregnancy-related Medicaid</td> <td>Dual-eligibility for Medicare &amp; Medicaid (older dependents)</td> </tr> </table>	Children's Health Insurance Program (CHIP)	Pregnancy-related Medicaid	Dual-eligibility for Medicare & Medicaid (older dependents)
Medication assistance	Discounts applied to existing bills	Extended dunning						
Children's Health Insurance Program (CHIP)	Pregnancy-related Medicaid	Dual-eligibility for Medicare & Medicaid (older dependents)						

“Even with the HMO coverage, the financial aid program was the only thing that saved me.”

# Financial preventive care is now possible—at scale

Just as we invest in early clinical interventions to avoid harmful and costly health outcomes, we can apply the same approach to financial assistance and support—using technology to address affordability issues before they start.

## Here's how:

### IT STARTS WITH CONNECTION

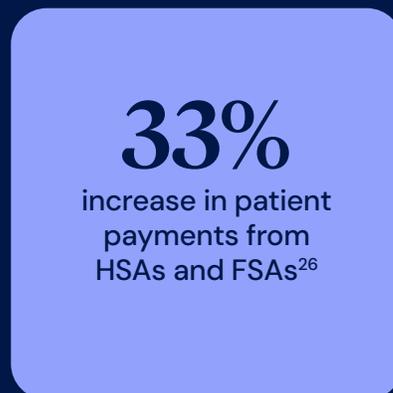
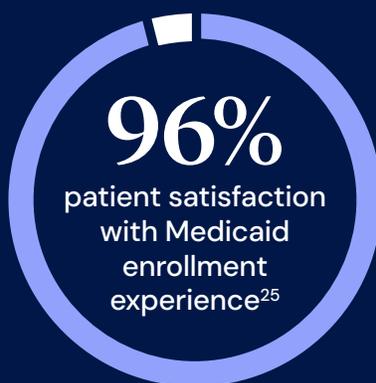
Bringing together scattered resources across the healthcare ecosystem into one, integrated platform. Connections with payers, Medicaid agencies, HSA banks, and medication programs make these resources visible and accessible at the right moment.

### THEN COMES CURATION

Intelligently matching patients with relevant resources based on their specific circumstances. AI tools can analyze traditional measures like income alongside more nuanced indicators (e.g., archetype-specific) to identify the best path forward.

### AND THE IMPACT IS REAL

Organizations that take a technology-driven approach to financial preventive care are already seeing results with Cedar:





## Final thought

# Connecting patients to billions in untapped assistance is one of those rare opportunities in healthcare

**A break from the zero-sum game where mission and margin finally align.**

It might just be the key to restoring trust in the system. Because trust is built when patients know the system is on their side—not just caring for their health, but for their financial well-being, too.

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## About Cedar

Cedar helps healthcare providers connect patients with the financial resources they need to access and afford care. We combine AI-powered technology with human-centered design to create personalized financial journeys for every patient. With deep revenue cycle expertise and a focus on intuitive user experiences, Cedar has served more than 50M patients nationwide and processed over \$10B in payments.

**Cedar has proven to increase collections, maximize reimbursement, and lower operational costs—all while improving patient satisfaction.**

LEARN MORE AT [CEDAR.COM](https://cedar.com)

