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# Healthcare Financial Experience Study

ONE SIZE
FITS NONE

INTRODUCTION

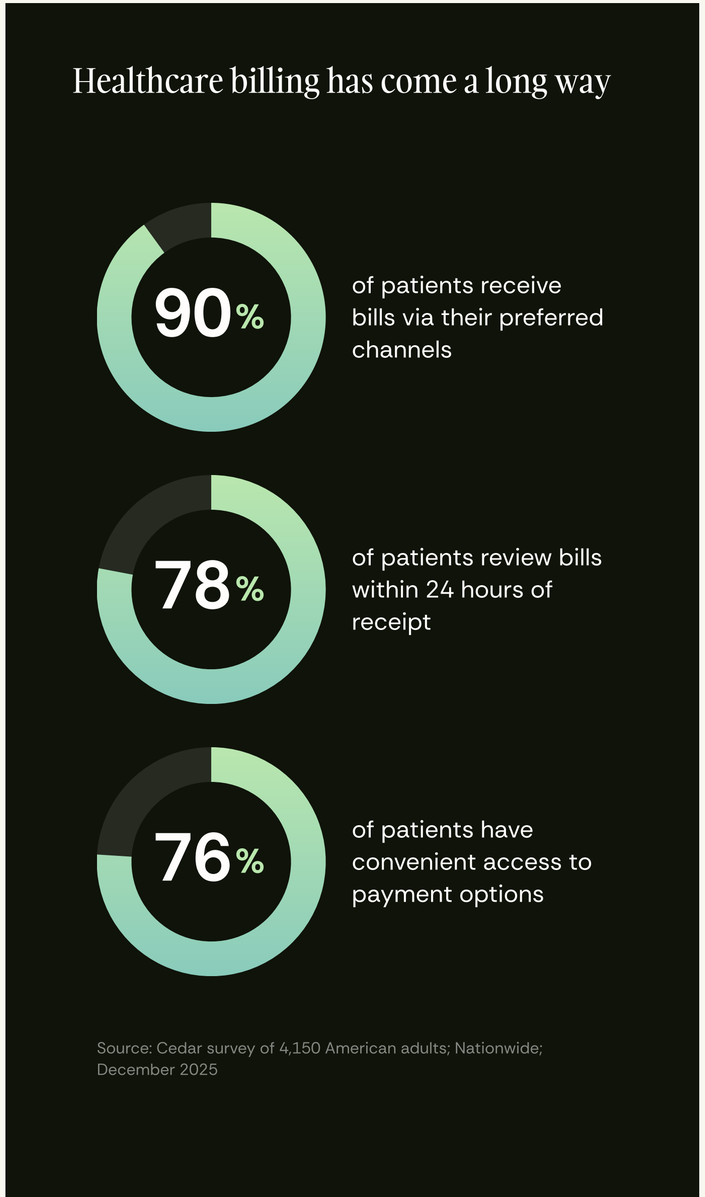
# The patient relationship is more financial than ever before

**More healthcare costs are being pushed onto patients than at any point in history. Out-of-pocket spending[1] is rising faster than wages[2] and inflation[3]—driven in large part by a 65% increase in high-deductible health plan enrollment over the last decade.[4] The cost of care, not food or rent, is now Americans' top financial worry.[5]**

At the same time, providers have made progress modernizing the patient financial experience. Bills are digital and easier to read. Payment is more convenient. But those solutions were designed for financially stable patients—while financial risk is increasingly shifting toward those who aren't.

Across Cedar's platform, nearly 40% of collectible dollars now come from patients without insurance coverage—up 54% in just three years.[6] Twenty million people face premium spikes following the expiration of enhanced ACA subsidies.[7] And Medicaid reforms in H.R. 1, projected to strip 10 million of coverage, haven't even taken effect yet.[8]

What got providers here won't be enough for what's coming. A closer look at today's patient financial experience exposes the gaps.

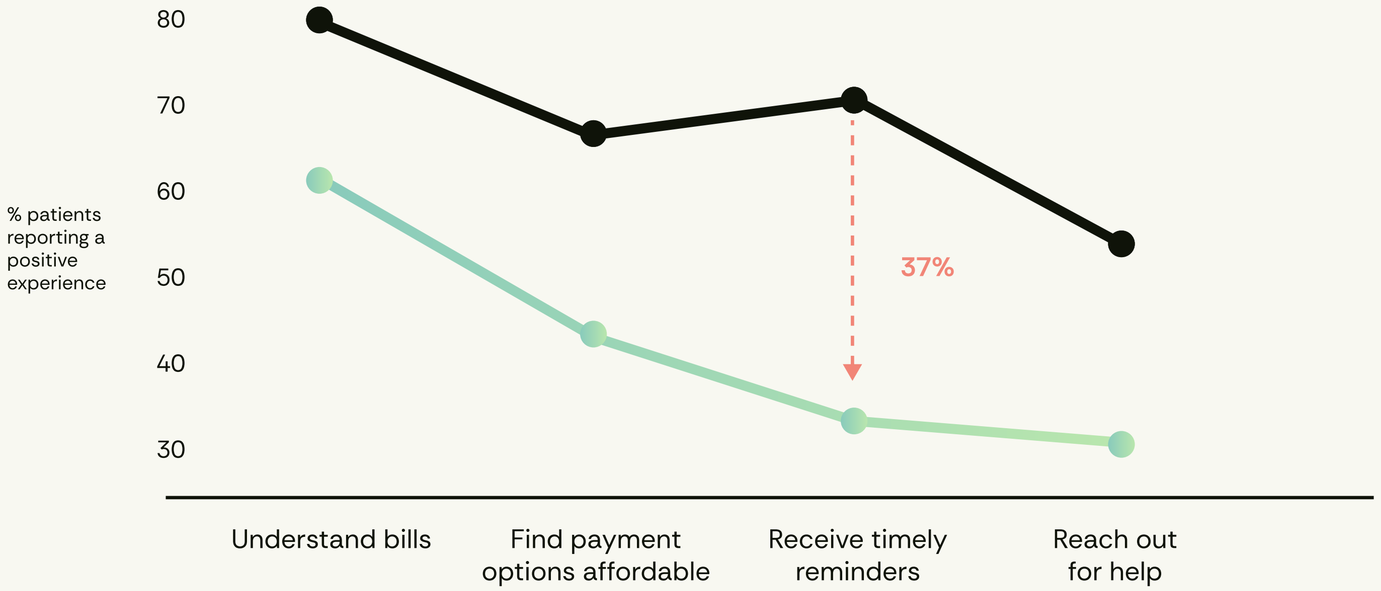



"Technology has definitely helped—with delivering the bill, explaining it. The problem is deductibles and patient out-of-pocket costs keep growing."

**Lawrence Freni**, Chief Financial Officer, Gastro Health

HIGH-CAPACITY VS. AT-RISK PATIENTS

# How experience varies across the financial journey




**Who are high-capacity patients?**

Patients who typically pay bills within six months. The majority earn above $75,000 and tend to live in urban areas.

**Who are at-risk patients?**

Patients who typically delay paying bills for six months or more. The majority earn less than $75,000, living in both urban and rural areas.

Source: Cedar survey of 4,150 American adults; Nationwide; December 2025

At the highest level, our research uncovered two distinct populations: high-capacity and at-risk patients. From bill payment to customer support, the experience gaps between the two groups are significant. So are the implications. At-risk patients are twice as likely to delay payment and report 62% lower satisfaction across the financial journey.

The instinct might be to dismiss these gaps as issues at the margins. But they're not marginal. In Cedar's book of business, 77% of total patient responsibility falls into difficult-to-collect cohorts—balances tied to individuals who are underinsured, uninsured, digitally disengaged, or facing large, complex bills.[9]

> Healthcare's financial experience was designed for patients with capacity. The fastest-growing share of collectible dollars now sits with patients in flux. That's where revenue is being lost—and what this report is all about.

We analyzed insights from 4,150 adults nationwide and 1.5 billion patient financial interactions across Cedar's platform. Three trends reveal who's most at risk, where they're getting stuck, and how providers can help them reach resolution before they fall into bad debt.

## Research methodology

The findings in this report draw from two primary sources.

### Patient survey

Cedar's research team conducted an online survey across 34 U.S. states to understand how patients experience the medical billing process. The survey targeted adults who actively manage medical bills for themselves or others. A total of 4,150 responses were collected in December 2025.

### Cedar platform data

Quantitative survey findings are supplemented by analysis of 1.5 billion patient interactions across Cedar partners and qualitative patient research—providing a real-world behavioral foundation for the patterns identified in this research.

Together, these sources offer a comprehensive view of the patient financial experience that reflects how patients actually engage with the billing process.

# 2026 trends and findings

## 01 Patient financial risk is hiding in plain sight

Insurance coverage and propensity to pay tell providers almost nothing about a patient's capacity and willingness to pay.

## 02 Reminders don't resolve bills—relevance does

Getting the bill to the right place at the right time isn't enough if it doesn't address what's actually preventing payment.

## 03 AI is becoming the first stop for support

Patients want support that's always-on and context-aware, and providers have the informational advantage to give it to them.

01

# Patient financial risk Is hiding in plain sight

**Meet Katie:**

Commercially insured. Stable income. By every traditional measure, Katie—a school teacher diagnosed with breast cancer—had a high propensity to pay.

But propensity to pay models don’t know about her deductible reset. They don’t know that she previously hunted down every possible assistance program when her late husband fell ill. They don’t know that, with her own diagnosis, she lacked the energy to do it all again.

This time, Katie didn’t have to. Novant Health identified risk early and connected her to financial support at the start of her care journey.

WATCH KATIE’S STORY

# Katie isn't the exception

**The categories used to segment patient accounts—commercial, government, self-pay—are no longer reliable predictors of payment behavior. Coverage shifts. Deductibles increase. A patient who was high-capacity last visit may be at-risk today.**

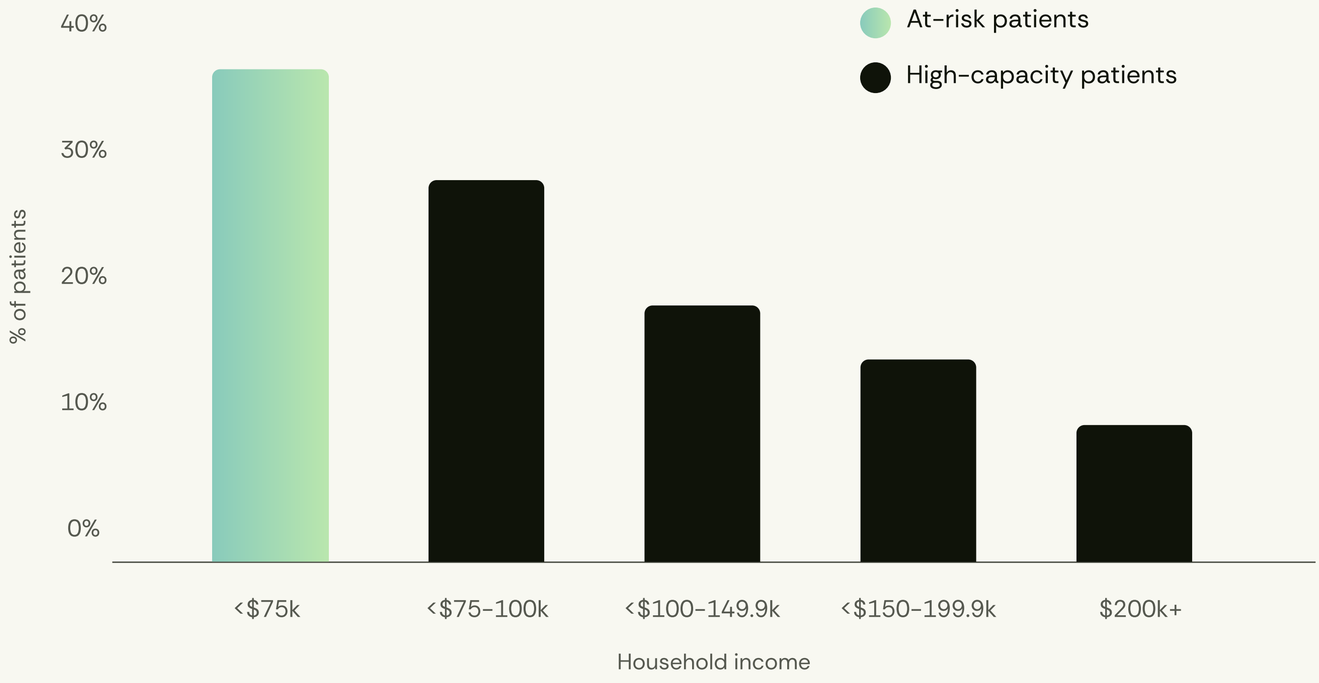
But the options being offered aren't changing to reflect that. Thirty percent of patients say the payment options in front of them are unaffordable—and it's not confined to lower-income households. Four in ten earn $100,000 or more. Even among commercially insured patients, one in four report difficulty paying medical bills.

Part of this is circumstantial. "We're seeing real economic pressures that affect people's ability to pay for the things they need—or want," says Doug Watson, Chief Financial Officer of Allina Health. For patients who've historically had the capacity to pay, that shift can be invisible until it isn't. "If you give someone a choice of paying $1,000 a month and they can't afford to pay $1,000 a month," Watson adds, "that's not a real choice."

It's also a signal problem. The risk models providers rely on to guide collection activity, like propensity to pay, draw on historical payment data and public records. In today's volatile coverage environment, that snapshot becomes outdated fast. The result is a static financial experience applied to dynamic patient circumstances.

**Even patients earning six figures struggle with affordability**

Percentage of patients who perceive existing payment options as unaffordable




Source: Cedar survey of 4,150 American adults; Nationwide; December 2025

# When the signal is wrong, so is the strategy

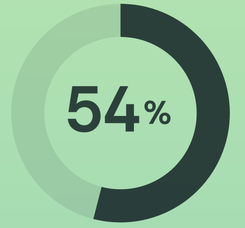
At-risk patients—seven in ten of whom can manage less than $100 per month, including those earning four times the poverty level—might not be offered a payment plan that fits their budget. Patients like Katie may never get connected to coverage or funding that reduces the bill itself.

In some cases, the signal works against patients. A joint federal notice flagged that patients eligible for financial assistance—but with high propensity scores—are sometimes guided toward payment products with deferred interest, potentially costing them more.[10]

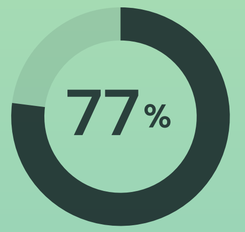
Cedar saw the disconnect firsthand when analyzing external propensity to pay scores across 10 million bills. A patient had paid a $100 copay without issue, then lost Medicaid. Months later, they were labeled as high propensity to pay—for a $330,000 bill.[11]

Propensity to pay reflects who the patient was, not who they are today. When revenue cycle operations are organized around that signal, the best case is misallocated resources. The worst case is bad debt accumulating in the background while the score says everything is fine.

## The highest-scored accounts may be the biggest collection risk




of bills over $50K are scored high propensity to pay




of bills have no propensity to pay score at all

↑ 51% higher yield on bills with no score vs. high score

Source: Cedar analysis of external propensity to pay scores across 10 million bills and $1.5 billion in patient responsibility; 2024

"AR predictability tools help us prioritize accounts and accelerate cash collection. But they're not factoring in unique patient personas or circumstances. There's definitely an opportunity to go deeper."

**Joe Meador**, Chief Financial Officer, Augusta Health

# The takeaway

Segmenting patient accounts by insurance coverage and propensity to pay can be directionally useful. But these methods don't capture the full range of factors that get in the way of payment. And those barriers extend beyond affordability.

A patient who doesn't think their insurance was applied correctly won't pay. A patient who thinks they already paid—not realizing the facility and professional bills are separate—won't pay. A patient who qualifies for assistance but is struggling to fill out the application won't pay. These are trust problems, clarity problems, navigation problems.

But these differences aren't random. They're measurable. And providers that can detect them and pinpoint what's standing in the way right now can intervene early enough to change the outcome.

02

# Reminders don’t resolve bills—relevance does

### Picture this:

A well-insured patient receives a $500 bill. They already pay hefty monthly insurance premiums and don’t think the charge is fair. Grateful for the care and wanting to avoid collections, they pay $75 toward it.

Soon after, they receive an email acknowledging the payment and offering a $40/month, interest-free plan. Clear terms and easy enrollment make the balance feel reasonable, so they sign up. For one Cedar provider partner that tested this approach, collections from patients making partial payments increased 17%.[12]

# Three things had to go right

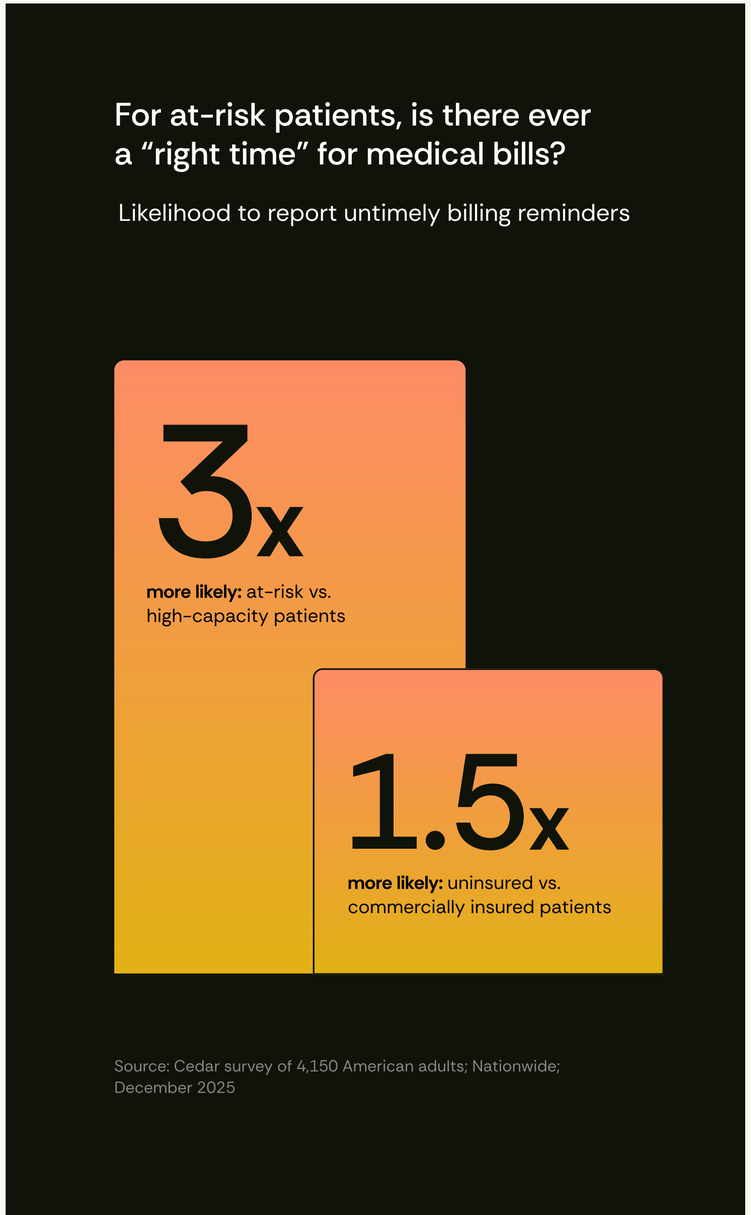
**The message arrived via the patient's preferred channel, which matters—they're twice as likely to pay promptly when bills arrive this way. And it landed before the moment passed: patients who engage within 24 hours are three times more likely to pay on time. But the real differentiator wasn't channel or timing. It was relevance.**

Now imagine the alternative: same channel, same timing, but a generic reminder. *Your bill is due. Please pay your balance.* For a patient who just thought twice about making a $75 partial payment, that message isn't helpful.

The survey data makes this concrete. While just 20% of patients across the panel say reminders arrive at inconvenient times, that number jumps to 45% for at-risk patients. If this were a logistics problem, frustration would be evenly distributed. Instead it clusters among harder-to-resolve accounts.

"The patient with the small balance who has to pay a copay to see their PCP—you need to approach that differently than a patient who has a large bill, easily in the thousands of dollars, and may not easily have the ability to pay."

**Joe Meador**, Chief Financial Officer, Augusta Health



# The problem isn’t when bills arrive, but what they ask patients to do

The same reminder can land very differently depending on the patient and the barrier they’re facing. Three groups stand out—each stuck for entirely different reasons.

**Rural residents** (self-reported) experience more friction at every step of the financial journey. Notably, they’re twice as likely to find payment options unaffordable, compared to those in urban areas. These patients might need flexible payment options surfaced proactively, before they have to go hunting for them.

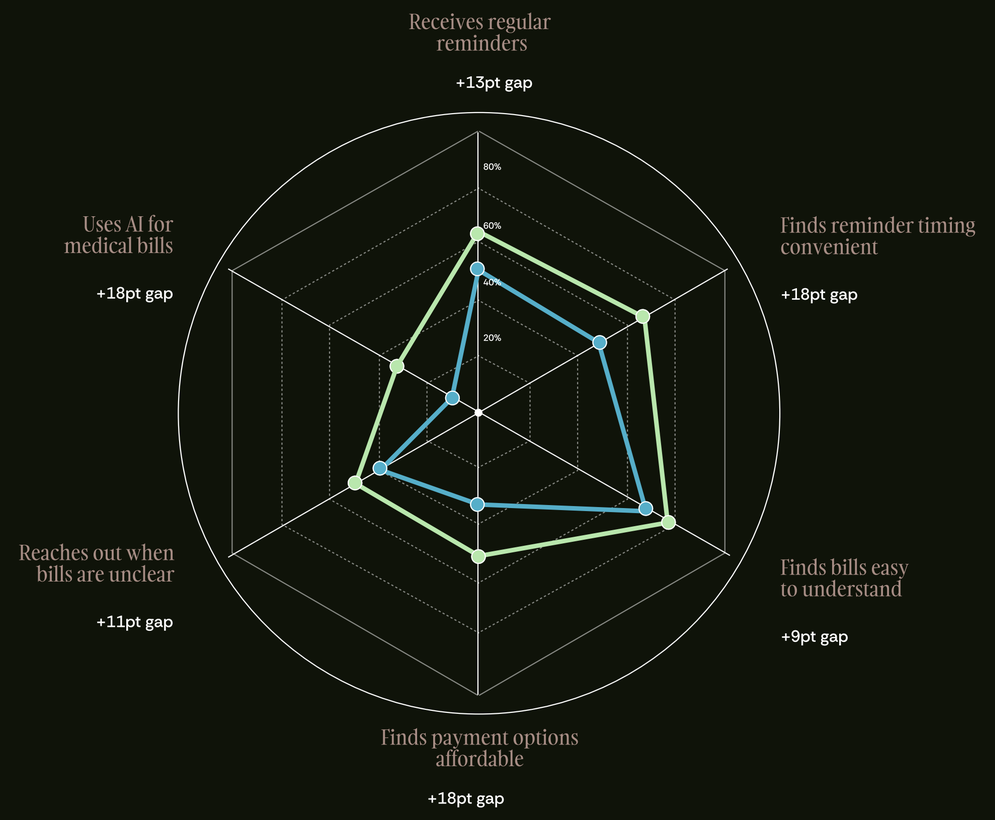
**Uninsured patients** tell a different story. They report the lowest satisfaction with reminder timing of any group—likely not because the timing is wrong, but because the bill itself is the wrong conversation. What this population needs isn’t a nudge to pay. It’s a path to coverage.

**Pre-retirees** represent a third distinct group. At a stage of higher care utilization, they’re often managing more bills than younger patients. But the barrier isn’t always the ability to pay. It can be clarity, reassurance, or friction accessing health savings account (HSA) funds already set aside for moments like these.

These are three generalized cohorts. In practice, the factors that shape patient behavior are even more granular. Balance size, digital literacy, past payment behavior, and more all influence what a patient needs and when.

## A closer look: The rural-urban divide

For rural residents, bills aren’t just inconveniently timed—they’re also less affordable, more confusing, and harder to navigate alone.




Source: Cedar survey of 4,150 American adults; Nationwide; December 2025

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# What the right intervention looks like for different patients

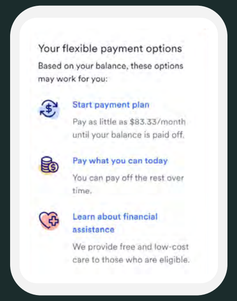
Based on Cedar platform data and controlled experimentation. Cohort profiles and attribute values are illustrative.

## COHORT 01

**Sarah**

- Insurance coverage: 50% (None – High)
- Bill size: 60% (Low – High)
- Bill complexity: 40% (Low – High)
- Digital literacy: 30% (Low – High)
- Income: 40% (Low – High)

### Proactive payment flexibility




**23%**

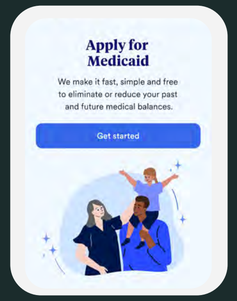
lift in payment rate among target cohort[13]

## COHORT 02

**Sunil**

- Insurance coverage: 0% (None – High)
- Bill size: 80% (Low – High)
- Bill complexity: 40% (Low – High)
- Digital literacy: 30% (Low – High)
- Income: 15% (Low – High)

### Guided Medicaid enrollment




**97%**

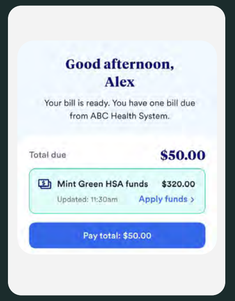
Medicaid application approval rate[14]

## COHORT 03

**Judy**

- Insurance coverage: 60% (None – High)
- Bill size: 80% (Low – High)
- Bill complexity: 40% (Low – High)
- Digital literacy: 60% (Low – High)
- Income: 60% (Low – High)

### HSA/FSA integration




**8%**

lift in collection rate from patients with active HSA funds[15]

"The more we can find the right fit for a patient personally—so they can do what they need to do for their family and still meet their financial obligation—that's just the right thing to do."

**Doug Watson**, Chief Financial Officer, Allina Health

# The takeaway

Identifying risk is only half the equation. The other half is intervening in ways that are both timely and relevant. Yet that runs counter to how patient billing typically works.

Most financial experiences are built around operational workflows, not patient reality. Statements drop. Follow-ups trigger. Accounts escalate. But patients don't experience financial distress on a 120-day billing cycle. They experience it situationally.

The providers that outperform are those that directly address what's actually blocking resolution, in real time. AI can help by continuously learning which interventions work for which patients, when, and through which channel, so the right message reaches the right person at the right moment. Success comes down to knowing when to send a nudge and when to extend a lifeline—and never confusing the two.

# 03

# AI is becoming the first stop for support

## What can I help with?

By the time hospital billing offices open tomorrow morning, almost 300,000 medical billing and insurance questions will have already been answered—just not by them.

“Globally, more than 40 million people are turning to ChatGPT every day for health questions,” says Brad Lightcap, Chief Operating Officer of OpenAI. Seven in ten arrive after hours, when providers aren’t available, but patients finally have time to deal with bills that have been sitting on their counters for weeks.[16]

# Patients are sending a clear message

**They want support that's available when they need it, doesn't put them on hold, and doesn't make them start from scratch with each new interaction. That kind of experience doesn't exist in many billing environments today.**

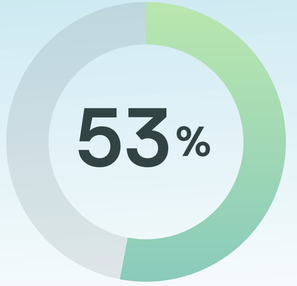
Friction shows up in predictable places. For example, 43% of patients say they have to re-explain their situation every time they contact billing support or get transferred. Patients with balances over $1,000, who are more likely to be under financial strain, report repeating their hardship twice as often.

"The phones are the nemesis of a medical practice. You have staff taking a lot of calls and trying to be patient-focused—while the phones keep ringing."

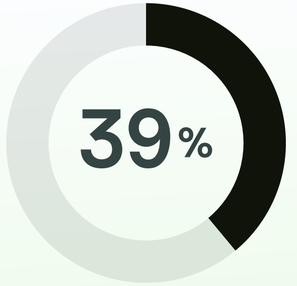
**Lawrence Freni**, Chief Financial Officer, Gastro Health

Facing that friction, four in ten (41%) patients simply don't reach out at all when bills are confusing. This creates a compounding cycle: confusion leads to silence, silence leads to delay, and every unanswered question is a missed opportunity to intervene. The opportunity, as Freni sees it, is to give patients what they want: contextual, always-on support wherever they choose to engage. "This is where AI is absolutely necessary."

**At risk or high capacity, the support experience isn't working for patients**

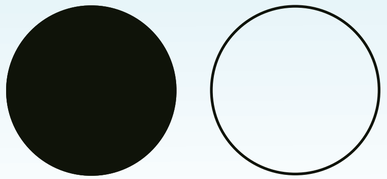



of at-risk patients don't reach out when bills are confusing




of high-capacity patients don't either

Source: Cedar survey of 4,150 American adults; Nationwide; December 2025



**1 in 2 patients** have used AI tools to interpret medical bills and resolve billing challenges

Source: Cedar survey of 4,150 American adults; Nationwide; December 2025

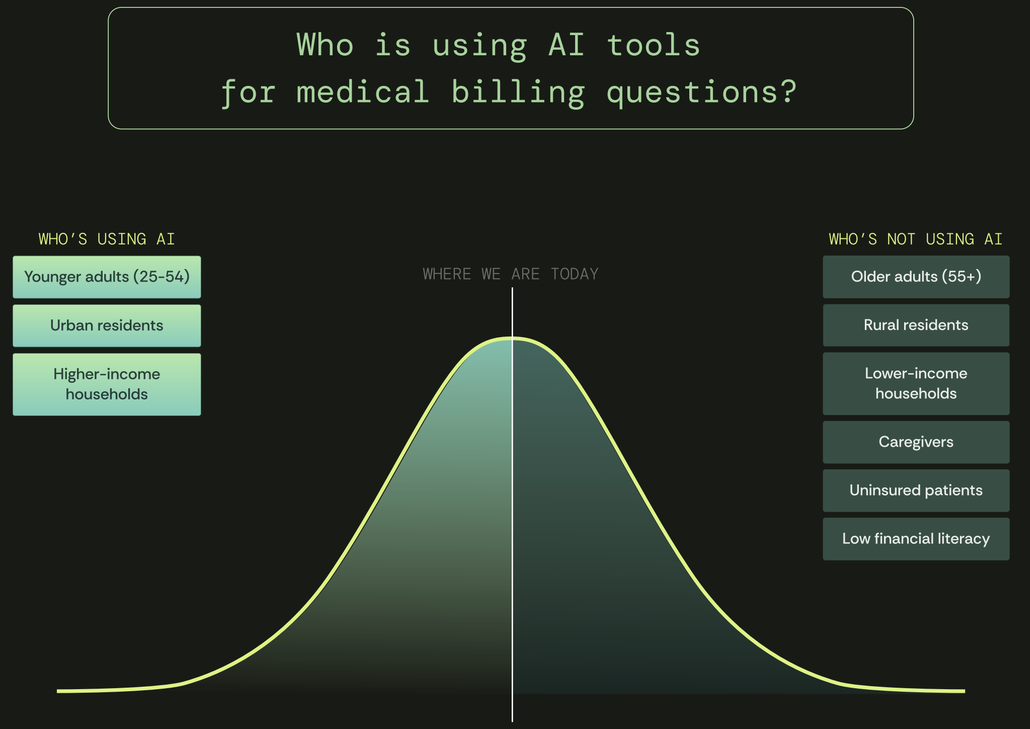
# Patients aren’t waiting for providers to catch up

When one Augusta Health patient received a confusing bill, they turned to a generic AI tool—not just to interpret it, but to find out whom to contact. “It had some inaccuracies, and it got my email wrong,” recalls Meador. But he sees past the rough edges. “I love the promise of these tools and how they’re going to impact people’s understanding of bills. I think there’s a real opportunity there.”

The opportunity, though, depends on context—especially for at-risk patients, who aren’t asking simple questions. They need to know whether their insurance was applied correctly, why a bill was higher than expected, or whether they qualify for financial assistance. Providers have the informational advantage to answer those questions today.

But Watson sees that as the foundation for something more powerful than answers alone. “How do we anticipate what patients are thinking—or not thinking—and give them a full deck of information as they make choices? That’s where AI can help us get smarter.”

For patients who’ve learned that asking for help is more trouble than it’s worth, that proactivity and precision could be what gets them to try again.




Source: Cedar survey of 4,150 American adults; Nationwide; December 2025

"It's the first time that you actually have a system that has a full composite of human knowledge built into it. As the AI gets to know you better, its ability to be precise and specific can be much more significant."

**Brad Lightcap,** Chief Operating Officer, OpenAI

# The takeaway

Most providers are sitting on exactly what patients need: their balance, their coverage, their options, and every interaction they've had along the way. The challenge has been surfacing those answers in a way that's convenient for the patient. At the moment they need them. In the channel they're already in.

AI is the unlock. Every interaction a patient has—a bill viewed, a payment made, a question asked—is a data point that sharpens the next one. Whether through foundation model platforms or purpose-built solutions, what matters is that the AI is built on that context. Not a snapshot. A living picture that gets more useful over time.

Deployed well, support that knows patients can meet them wherever they are—in the bill itself, on the phone, or after hours when they finally have time and headspace to deal with it.

FINAL THOUGHT

# Patients are the payer with the greatest financial upside for providers

**Commercial and government rates are locked in zero-sum agreements. Denials are climbing as payers deploy AI to fight claims. Patients are different.**

They represent the one payer class where providers can influence outcomes—not through harder collection tactics, but through better, personalized experiences. In practice, organizations that can see risk clearly, respond precisely, and support patients proactively will outperform those that can't

That's worth getting right. Not just because the share of outstanding dollars sitting with at-risk patients is growing—but because the financial experience is the last mile of the healthcare experience. When it works, patients can put it behind them and focus on getting better. When it doesn't, the stress of unresolved bills becomes part of the diagnosis.

"The fastest-growing payer isn't Blue Cross. It's not United. It's not Aetna or Cigna. It's the patient."

**Joe Meador**, Chief Financial Officer, Augusta Health

# About Cedar

Cedar is the performance engine for healthcare financial experience, built on AI to solve the growing complexity of patient financial engagement and deliver personalization at scale. Powered by more than a billion patient interactions, Cedar's platform unifies billing, payments, coverage, and support into a single solution that continuously learns and adapts—driving stronger results for providers and simpler, more empathetic, and personalized financial journeys for patients. By connecting over 200+ healthcare and financial partners, Cedar reduces administrative burden, improves margins, and helps patients access the coverage, aid, and payment options they need with confidence.

To learn more, visit **www.cedar.com** and join us on **LinkedIn**, **X**, and **YouTube**.

**58M+**

patients served

**1.5B+**

patient touchpoints

**$13.6B+**

payments processed

ADVANCED METHODOLOGY

# Survey design and sampling

To capture a representative view of the patient financial experience, Cedar's research team conducted an online survey across 34 U.S. states in December 2025, collecting over 4,150 responses from adults who actively manage medical bills for themselves or a family member. Respondents were weighted to reflect variation across income, insurance status, geography, and age.

Online survey methodology captures a wide range of patient perspectives, but tends to over-represent patients who are already digitally engaged. The experiences of patients with limited digital access or low digital literacy may not be fully reflected in these findings.

## Survey respondent breakdown

### Gender

Female - 57%
Male - 43%

### Income groups

Under $25,000 - 15%
$25,000-$24,999 - 24%
$50,000-$74,999 - 16%
$75,000-$99,999 - 12%
$100,000-$149,999 - 19%
$150,000-$199,999 - 10%
$200,000-$249,999 - 2%
$250,000 and over - 2%

### Age groups

18-24 - 2%
25-34 - 12%
35-44 - 31%
45-54 - 17%
55-64 - 15%
65 and over - 23%

### Medical bills per month

1-2 - 72%
3-5 - 23%
6-8 - 3%
9 or more - 1%

### Insurance coverage groups

Employer-sponsored - 33%
ACA marketplace - 10%
Medicare - 21%
Medicare Advantage - 16%
Medicaid - 12%
TRICARE or VA Health Care - 2%
Healthshare / Healthcare Ministry Plan - 2%
Uninsured - 3%
Other - 2%

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[13] Cedar (2025). Based on A/B test results for a flexible payment option intervention for one Cedar health system partner in August 2025.

[14] Cedar (2025). Based on Medicaid enrollment pilot results for one Cedar health system partner in 2025.

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