

The Affordability Mandate: How Leading Health Systems are Strategically Broadening Their Approach

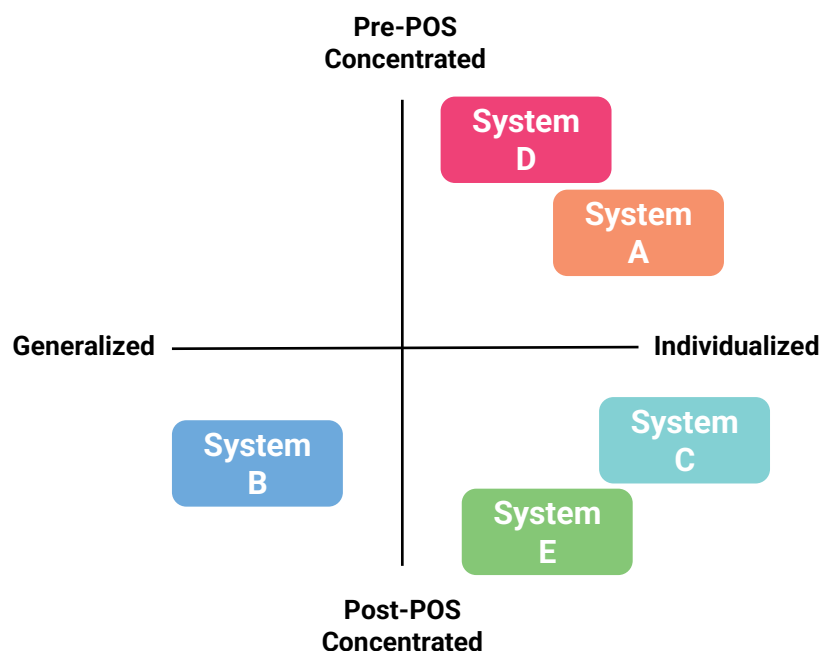
Insurance coverage status is no longer a reliable predictor of whether a patient can pay. Rising deductibles, copays, and premiums keep shifting liability onto patients. Deductibles have climbed 43 percent over the last ten years, and 62 percent of insured adults report concern about affording care before their coverage takes effect.^{1,2} The underinsured population (insured patients whose incomes exceed traditional assistance thresholds but who cannot absorb thousands of dollars in healthcare costs) 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. Cedar data show this shift concentrating in large bills (roughly \$200 or more). At health systems, out-of-pocket (OOP) liability now makes up 49.3 percent of dollars in large, slow-to-collect balances, up from 37.5 percent a year earlier, while the OOP share of small bills is essentially unchanged. As a result, systems face mounting financial strain through underpayment, uncompensated care, bad debt, charity care, and longer days in AR.³

These pressures land on already thin margins; the average not-for-profit health system runs at a 1.3 percent operating margin. Policy changes, including the expiration of enhanced ACA subsidies and looming Medicaid work requirements, are weakening critical financial safety nets.⁴ Patient affordability is no longer just a collections problem; it spans access, growth, strategic pricing, and revenue integrity.

Methods and System Overviews

This research summary draws on a recent case series completed by 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. Despite their different postures, no system has reached an end state of an ideal affordability strategy.

The Strategic Distribution of Profiled Health Systems



Four takeaways recurred across the series, each speaking to what separates a reactive affordability posture from a deliberate one.

1. Patient liability is a fast-growing revenue risk that often gets less attention

Nearly every system in the series reported rising patient liability, driven by high-deductible plans, downgrades to lower-tier exchange coverage, Medicare Advantage cost sharing, and lapsing premium subsidies. Yet several leaders ranked it below payer denials and reimbursement, and some described it as a slow-building pressure largely outside their control. At those systems, post-service workflows often defaulted to statements, agency placement, and eventual write-off. Systems with more deliberate, patient-centered strategies described reductions in bad debt and improved revenue. The tools to intervene largely exist; the opportunity is giving patient liability strategic attention proportional to its growth.

“

In the marketplace, a more significant number 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

2. Individualized, actionable interventions tend to outperform broad educational initiatives, especially when deployed across the patient journey

The strongest results participants described came from approaches built around a patient's specific financial situation. Systems used patient-level information, such as an individual estimate, eligibility and coverage status, or payment history, to decide what to offer, rather than applying the same approach to every patient. These include structured deposit requests tied to an individual estimate, coverage and premium support for otherwise self-pay patients, and payment plans matched to a patient's balance and ability to pay. Systems using these approaches reported financial improvement. These interventions appeared at every stage of the patient journey: estimates and deposit requests before service, assistance screening and payment arrangements at the point of service, and tailored payment plans and financing after billing. As such, a comprehensive affordability strategy offers individualization at each stage, giving each patient more than one path they can reliably manage.

“

Having an intuitive user interface that isn't like a system of record like Epic or Cerner, 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

3. An EHR-native feature does not always equate to a solved problem; as a result, the build, buy, or wait calculus deserves deliberate analysis

Many systems treated their EHR as the de facto answer, whether because of integration burden, vendor fees, or the expectation that the EHR would eventually catch up. While this instinct is often financially reasonable, an available feature is not the same as an optimal one. This case series revealed that EHR-native tools regularly went unused, required years of configuration and dedicated analyst support, or were missed entirely because leaders did not know the functionality existed. In some cases, point solutions offered more robust capabilities than native functionality, helping systems avoid the opportunity cost of waiting. Defaulting to the EHR without an intentional cost-benefit evaluation forecloses the chance to adopt a better-performing option, just as purchasing without it risks paying for duplicative capabilities the EHR already provides.

4. Building, reinforcing, and maintaining organizational agility is more consequential than any one initiative

Affordability strategies lose their effectiveness as markets, policies, and patient behavior change. To protect their results, the profiled systems routinely revisited tools, policies, and partnerships as needs shifted or early assumptions proved wrong. Leadership must also keep a pulse on the broader dynamics surrounding each initiative, treating payer behavior, coverage changes, and regulatory action as early warning signals rather than waiting for their effects to reach patients.

There is no single prescriptive path to an ideal strategy. Approaches that work today will erode as market, organizational, and political forces evolve, and what succeeds at one care site may not translate to another. The true goal is one of organizational agility: recognizing when a strategy needs to change and carrying that change through the organization. Because affordability will keep evolving, the right question is whether a system anticipates shifts or absorbs their cost after the fact.

Even the most advanced infrastructure cannot fully resolve patient affordability; some patients will remain unable to pay, and strategy should minimize the resources spent chasing them. Systems across the series are converging on automation, from virtual agents to AI-enabled self-service, and on pulling affordability upstream through self-service estimates, presumptive charity screening, and earlier payment-plan enrollment. The complete report expands on these themes with five case studies, a framework of four domains that shape each system's strategy (market environment, EHR infrastructure, systemness, and financial standing), and an executive self-assessment.

“

Sometimes tools are behind the rules and regulations, and therefore, we're always playing catch up to a degree... these rules and regulations [are] changing year after year. We're, again, kind of under the gun to adapt and then provide a process that meets those guidelines.”

– Patient Access Administrator,
System C

1. KFF, 2025 Employer Health Benefits Survey, KFF, 2025. <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf>
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. <https://www.kff.org/health-costs/health-policy-101/health-care-costs-and-affordability/?entry=table-of-contents-how-do-high-health-costs-affect-affordability-of-care>
3. Swanson N. National Hospital Discharge Report: January 2026 Metrics. Kaufman Hall 2026. <https://www.kaufmanhall.com/sites/default/files/2026-03/14-18-EHR-Report-January-2026-Metrics.pdf>
4. The Health Management Academy. Q3 2026 healthcare trends: finance and budgeting survey. The Health Management Academy. Published September 11, 2026. <https://theacademy.com/insights/video/archive/q3-2026-healthcare-trends-finance-and-budgeting-survey>