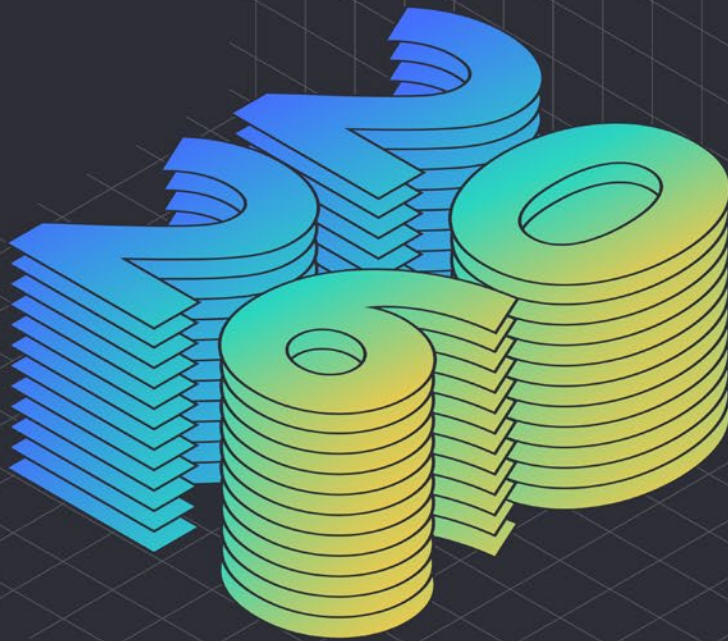


State of Healthcare Affordability: The Provider Perspective

PATIENT AS THE PAYER REQUIRES A NEW BLUEPRINT



Patient as the Payer Requires A New Blueprint

01 Designed for Copays. Broken by Deductibles.

The average patient can only afford \$82 a month toward medical bills, yet most health systems cap in-house payment plans at 24 months. That math leads to defaults. And 72% of systems surveyed do not know their default rate.

02 Engage Earlier or Collect Less. The Data Is Clear.

Systems with a pre-service payment policy collect 2x more pre-service than those without one. Engaging earlier matters. So does offering patients affordable options when you do.

03 AI Started with Denials. The Patient Is Next.

One in three health systems is already using generative AI in the revenue cycle, mostly for denials and coding. The patient financial journey is the next frontier, and the experiments are already underway.

Letter from the CEO

The healthcare financial system was not built for this moment.

It was designed for an era of predictable copays and manageable out-of-pocket costs. When patients were secondary payers, the financial conversation could wait until after care was delivered. That era is over. In just one year, the **number of health systems ranking patient balances as their top priority nearly doubled**. Patients are now increasingly the payer. And health systems across the country are designing a new blueprint for this reality.

This second annual report is based on a survey of 205 healthcare revenue cycle leaders nationwide, conducted in partnership with the Healthcare Financial Management Association (HFMA). It continues our commitment to building one of the most comprehensive datasets on patient affordability and financial performance in healthcare.

What we found this year is a system in motion. Health systems are reassessing their priorities, rethinking their tools, and recalibrating when and how they engage patients financially. The direction is clear, even where the execution is still catching up.

The tools most health systems rely on today were built for a different era. **Most in-house payment plans cap out at 24 months**, far shorter than what most patients can realistically manage, especially with high deductible health plans. And **72% of revenue cycle leaders told us they don't know their own default rates on those plans**. The gap between what patients can afford and what health systems offer is structural. Closing the gap starts with understanding it deeply.

The clearest path forward is earlier engagement. Health systems that connect with patients financially before care is delivered consistently outperform those that wait. Pre-service payment adoption is rising across the industry.

But pre-service collections are only making modest gains. The systems closing that gap aren't just adding a policy. They're rethinking the entire conversation.

Generative AI is beginning to accelerate that shift. **One in three health systems is already using AI in the revenue cycle, and interest among the rest is nearly universal**. Most of that activity today lives in denials and coding. But **the patient financial journey is the next frontier**. The experiments underway now will rewrite the blueprint for patient financial care.

At PayZen, our vision is to make care affordable and accessible to every patient. We believe the data is where that work begins. This report exists to help health systems move faster, serve patients better, and build the blueprint this era demands. We're grateful to the revenue cycle leaders who contributed their perspectives and made this report possible.



Itzik Cohen, CEO of PayZen

Methodology

The survey explored key areas including financial performance, patient financing plans, pre-service practices, and patient billing, payments, and balances.

The second annual Provider Perspective Report 2026 is based on a 35-question online survey conducted in partnership with the Healthcare Financial Management Association (HFMA), capturing insights from **205 healthcare revenue cycle leaders** across a diverse range of health systems nationwide.

The 2026 survey results reflect increased participation among higher-revenue health systems. While the 2025 study included a varied range of sizes, including many in the \$100M to \$200M NPR category, this year's data is more concentrated on organizations with \$200M or more in annual revenue. Because the participant mix has evolved, year-over-year comparisons should be viewed as directional markers of where the market is headed.

All data reflects self-reported responses. In some cases, conditional survey questions resulted in smaller sample sizes for specific metrics.

2nd

annual report

35

questions

205

healthcare revenue leaders

<\$200M-\$25B+

NPR Range

01

PATIENT AS THE PAYER REQUIRES A NEW BLUEPRINT

Designed for Copays. Broken by Deductibles.

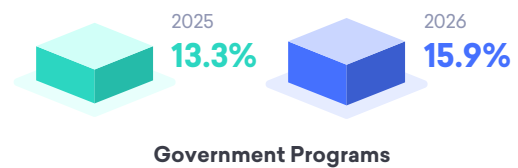
Priority Shifts Reflect A New Financial Reality

Patients are shouldering a growing share of the cost of care. Rising costs, higher premiums, high-deductible health plans, and stricter Medicaid eligibility have made that burden heavier every year. And health systems are feeling it in the revenue cycle. The patient, once a secondary payer, is now at the center of most financial conversations.

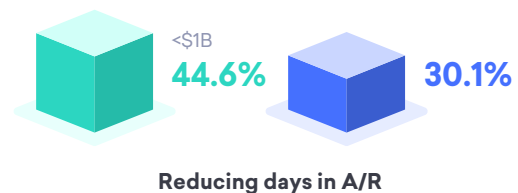
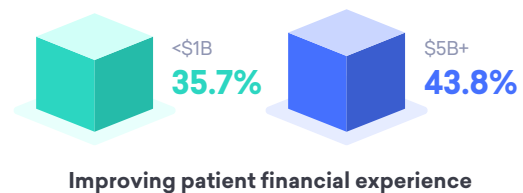
In 2025, 73% of systems identified patient balances as one of their top priorities. Today, that concern is nearly universal. The number of systems ranking patient balances as their single top priority has nearly doubled – from 11.4% in 2025 to 21.9% in 2026.

Commercial revenue remains the primary focus for 62.2% of health systems. But the data shows a system actively recalibrating, and patient balances are leading that shift.

The #1 Priority Shift



Top Priorities by Health System Size



The Importance of the Patient Financial Experience is Rising Fast

Increasing patient collections remains the top priority for 48.7% of health systems. However, the most significant year-over-year shift is the rising prioritization of the patient experience, which more than doubled from 18.5% in 2025 to 41.3% in 2026.

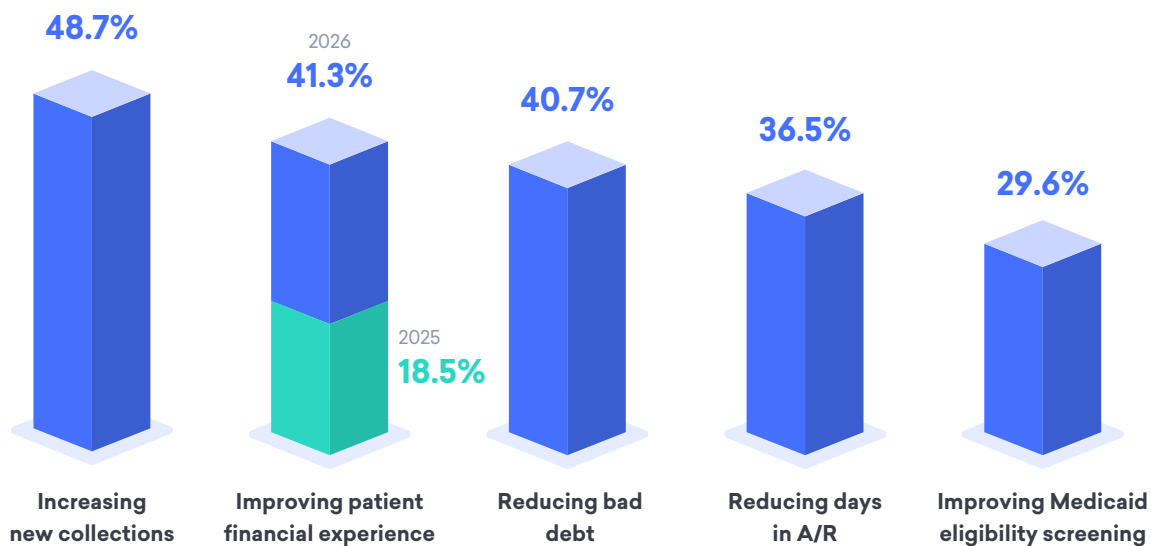
This shift reflects a broader change in the healthcare landscape. As patient responsibility continues to rise, affordability has become a defining factor in both access to care and financial performance.

Today, [more than 100 million Americans carry medical debt](#), and [38% have delayed or skipped care due to cost](#), underscoring the growing strain on patients and the need for more supportive financial experiences.

Consequently, health systems are aligning financial priorities with patient needs. Improving the patient experience (41.3%) and reducing bad debt (40.7%) are now nearly tied as second-place priorities for health systems.

Top Patient Balance Priorities for the Next 12 Months

📌 Interest in improving the patient financial experience more than doubled year over year



The bills are bigger. The terms are not.

6 in 10 hospitals cap in-house payment plans at 24 months or less

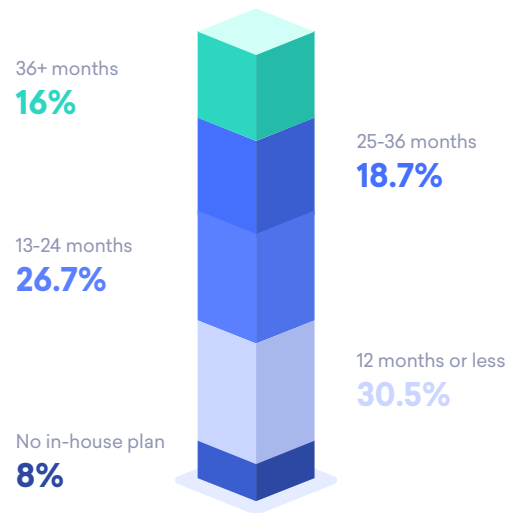
In-House Payment Plans Fall Short of Patient Needs

Most health systems rely on in-house, self-enrollment payment plans to help patients better afford large medical bills. While these plans are intended to support patient payments, their design often falls short of what patients can realistically afford. On average, patients can only afford [\\$82 per month toward medical bills](#). With that monthly payment, it would take over 5 years to pay off a \$5,000 medical bill. When balanced against the fact that fewer than 16% of systems offer terms greater than 36 months, this misalignment creates a structural ‘affordability gap’ that virtually guarantees higher default rates for patients with significant balances.

16.4%

of systems with less than \$1B NPR do not offer in-house payment plans

In-House Payment Plan Term Length Distribution



Nearly 6 in 10 hospitals cap in-house payment plans at 24 months or less

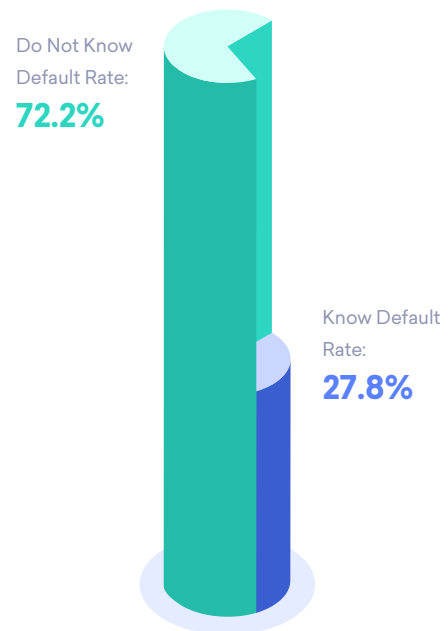
FLYING BLIND:

Health Systems Don't Know In-House Defaults

Beyond restrictive terms, health systems face a significant visibility hurdle with in-house plans. A staggering 72.2% of organizations report they do not know their average default rate for in-house payment plans longer than 12 months.

For the small subset that provided a self-reported figure, the average default rate was 13.3%. However, when PayZen conducts a direct evaluation of in-house program performance, the average default rate rises to 20% for 12-month+ payment plans. This contrast suggests that organizations may be **underestimating their internal risk by more than 50%**, emphasizing the need for more accurate performance tracking and specialized financing partnerships.

Visibility into In-House Payment Plan Performance



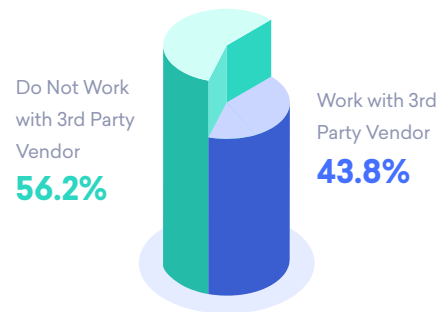
72% of health systems don't know their default rate.

Fewer Than Half of Health Systems Have Adopted Third-Party Financing

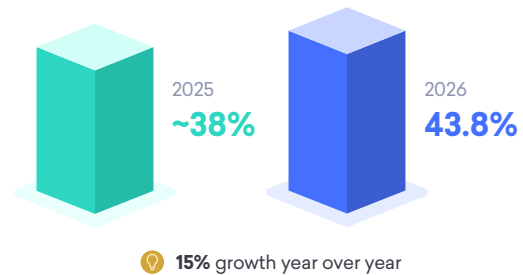
Most health systems continue to shoulder the risk and administrative weight of patient balances on their own. With **56.2% of organizations yet to adopt third-party patient financing**, the industry remains heavily reliant on in-house models that often struggle to balance patient affordability with system cash flow.

Adoption of third-party patient financing rose to 43.8% in 2026, a **15% year-over-year increase**, signaling a meaningful market pivot. Among these adopters, the primary driver is clear: **35.8% rank cash acceleration as their top priority**. By partnering with external vendors, these systems can offer flexible, long-term options essential to supporting patient affordability in a high-cost environment.

2026 Adoption Breakdown



Third-Party Adoption Growth



02

PATIENT AS THE PAYER REQUIRES A NEW BLUEPRINT

Engage Earlier or Collect Less. The Data Is Clear.

POLICIES WITHOUT PERFORMANCE:

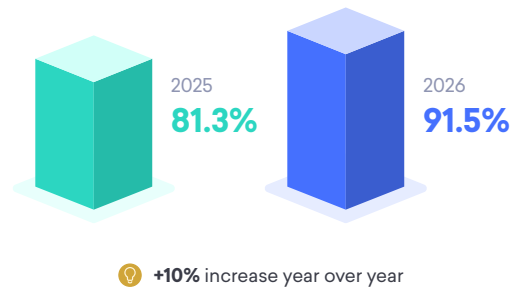
The Pre-Service Collections Problem

Pre-service collections are now standard practice across health systems. In 2026, 91.5% of organizations report either encouraging payment, requiring payment, or collecting a payment method on file during the estimate process, up from 81.3% the prior year.

Despite this increase in adoption, pre-service collection performance hasn't meaningfully increased. In 2026, the **average pre-service collection rate reached 20.69%** of total collections, modest gains over 2025 at 16%.

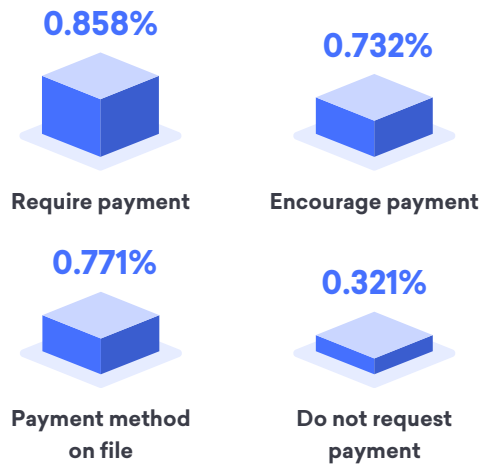
This plateau is driven by a fundamental tension between financial enforcement and the clinical mission. Systems are increasingly sensitive to the risk of care avoidance—where strict upfront payment requirements inadvertently discourage patients from seeking necessary treatment. Currently, **among the 17.1% of organizations that officially “require” payment, 68% ultimately proceed with care even if the requirement is not met.** A rigid approach without sufficient options and solutions, such as affordable payment options, not only risks patient health but also fails to improve financial performance, as systems reach the natural limit of what manual encouragement can achieve.

Adoption of Pre-Service Payment Policies



Pre-Service Collection Rates by Policy Type

(% are based on total NPR)



2x

Pre-service policies drive 2x higher pre-service collections.

Large Systems Lead the Shift Toward Active Pre-Service Collections

Large health systems (\$1B+) are aggressively closing the gap between patient estimates and payments prior to service. Today, only 3.2% of large systems remain “passive” during the estimate process.

However, systems under \$1B in NPR are **over four times more likely to provide estimates without requesting a payment**, often missing the critical window of highest patient engagement. By failing to tie estimates to affordable payment options, these smaller organizations see significantly lower upfront performance, reporting less than half the pre-service collections as larger systems.

The Size Divide in Pre-Service Collections

SMALL SYSTEMS (<\$1B)

14.0%

No Pre-Service Payment Policy

0.402%

Pre-Service Collection Rate (% of NPR)

LARGE SYSTEMS (\$5B+)

3.2%

No Pre-Service Payment Policy

0.987%

Pre-Service Collection Rate (% of NPR)

SIMPLE IN THEORY. SIGNIFICANT IN PRACTICE.

Pre-Service Payment Policies Drive Higher Pre-Service Collections

Pre-service payment policies are strongly associated with higher patient collection performance. On average, **health systems with any pre-service payment policy collect 5.08% of total patient billings before care is delivered, compared to just 2.42% for systems with no policy.** That's more than twice as much.

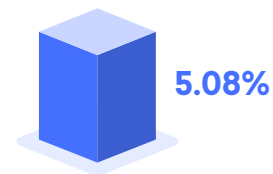
What's striking is that the type of policy matters less than having one. Systems that simply encourage payment collect 5.05%, nearly identical to those that formally require it at 4.30%. The data suggests that how health systems engage patients financially may be just as important as the policy itself. A softer, more supportive approach can be just as effective as a rigid one and carries far less risk of discouraging patients from seeking care.

20%

of patient collections now occur pre-service

Pre-Service Collections by Pre-Service Policy

(% of total patient billings)



Early Engagement Strategies

(Require or encourage payment or collect payment method)



No Pre-Service Policy

(Do not request payment)

2x higher pre-service collection with early financial engagement strategies

61% want to screen
at scheduling.

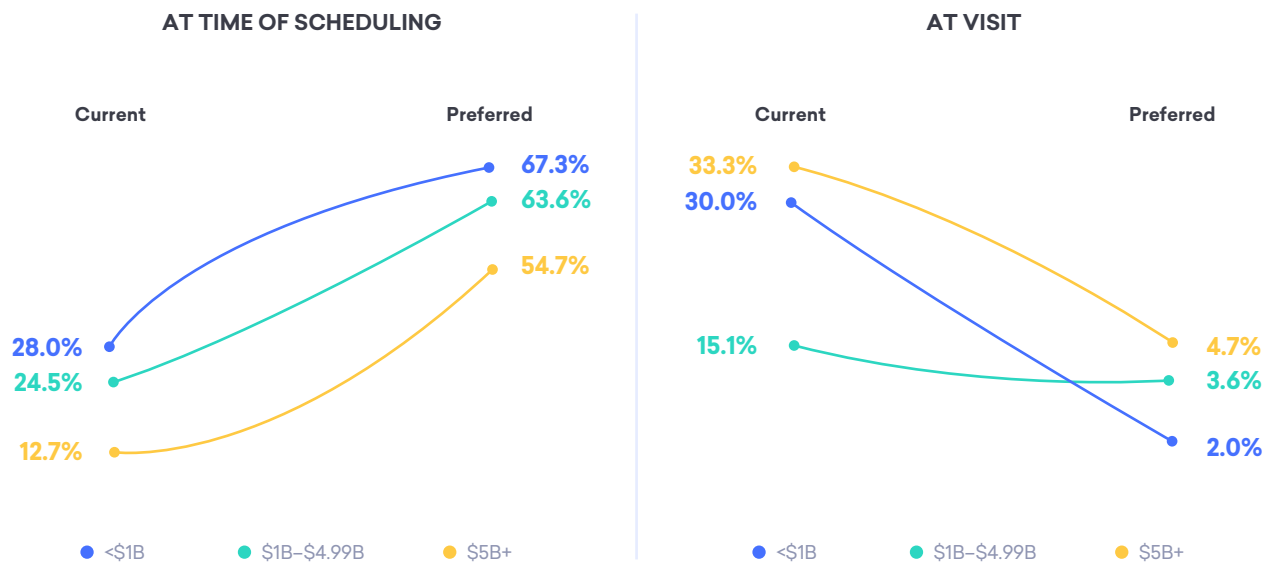
Only **21%** do.

The Future of Financial Clearance: Eliminating the ‘At-Visit’ Scramble

Health systems are signaling a clear strategic pivot toward the “point of entry.” This involves engaging access teams as a critical piece of the financial engagement strategy to eliminate the friction typically found at the point of care. While most organizations currently screen for Medicaid or financial assistance after scheduling but before the visit, there is a massive industry-wide desire to push this interaction to the very start of the patient journey.

The data reveals a dramatic shift in preference: **61.3% of leaders believe screening should occur at the time of scheduling, yet only 21.1% do so today.** Conversely, while **26.5% of organizations currently screen “at the visit,” a mere 3.6% believe this should be the standard** in the future. This migration toward the point of entry is designed to reduce at-visit friction and ensure affordability is addressed before care is delivered. But shifting financial engagement earlier – across every patient, every visit, every system – requires more than policy changes. It requires technology that can make earlier engagement scalable, consistent, and personalized.

Current vs Preferred Screening Timing by System Size



03

PATIENT AS THE PAYER REQUIRES A NEW BLUEPRINT

AI Started with Denials. The Patient Is Next.

Curiosity Is Universal. Adoption Isn't. Yet.

Nearly every revenue cycle leader has AI on their radar. The question is no longer whether to adopt it – it's when and where to start.

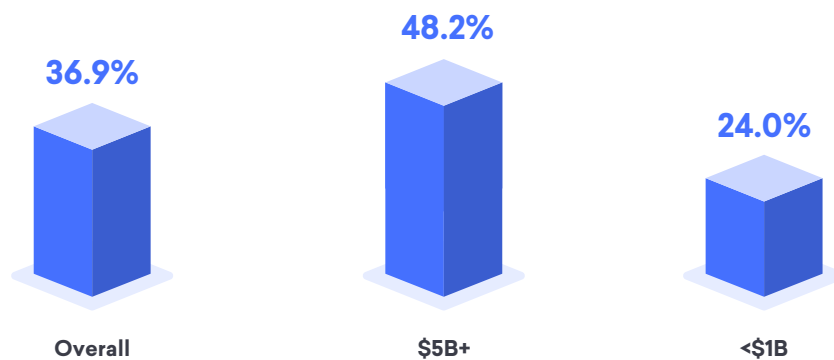
More Than 1 in 3

health systems are already using generative AI

Today, **36.9% of health systems are already using generative AI within the revenue cycle.** Among those not yet using it, **84.7% say they are interested or very interested in adoption.** The curiosity is nearly universal. But implementation remains uneven, with larger health systems moving faster while smaller organizations are still finding their entry point.

Generative AI Adoption in the Revenue Cycle

% of health systems



💡 Large systems are **2x more likely** to be using AI than smaller organizations

From Denials to the Patient. AI Experiments Are Underway.

Across the industry, denial management and appeals stand out as the most common applications of generative AI within the patient revenue cycle. Overall, **45.0% of health systems report using AI for denials-related workflows**, making it the clear leading use case. This trend holds across organizations of all sizes, though the level of adoption varies significantly.

Among smaller health systems (<\$1B), usage is highly concentrated, with **70.0% reporting AI use for denial management and appeals**, compared to **50.0% of mid-sized systems** and **30.0% of large systems (\$5B+)**. This suggests smaller organizations are prioritizing AI to address one of the most immediate and resource-intensive challenges in the revenue cycle.

Beyond denials, use cases begin to diverge by system size. Smaller systems remain focused on core revenue cycle workflows, including **coding**

support and CDI (60.0%) and **analytics and predictive modeling (30.0%)**, using AI to improve efficiency and reduce administrative burden.

Systems \$5B+ show a more distributed set of use cases. While denials remain the top application, adoption is spread across functions such as **prior authorization (20.0%)**, **patient access and scheduling (20.0%)**, and **financial assistance and eligibility workflows (20.0%)**, reflecting a broader strategy to enhance patient engagement and streamline front-end processes.

SMALLER SYSTEMS (<\$1B)

2x

More likely to prioritize **operational AI** use cases like denials management and coding support

LARGER SYSTEMS (\$5B+)

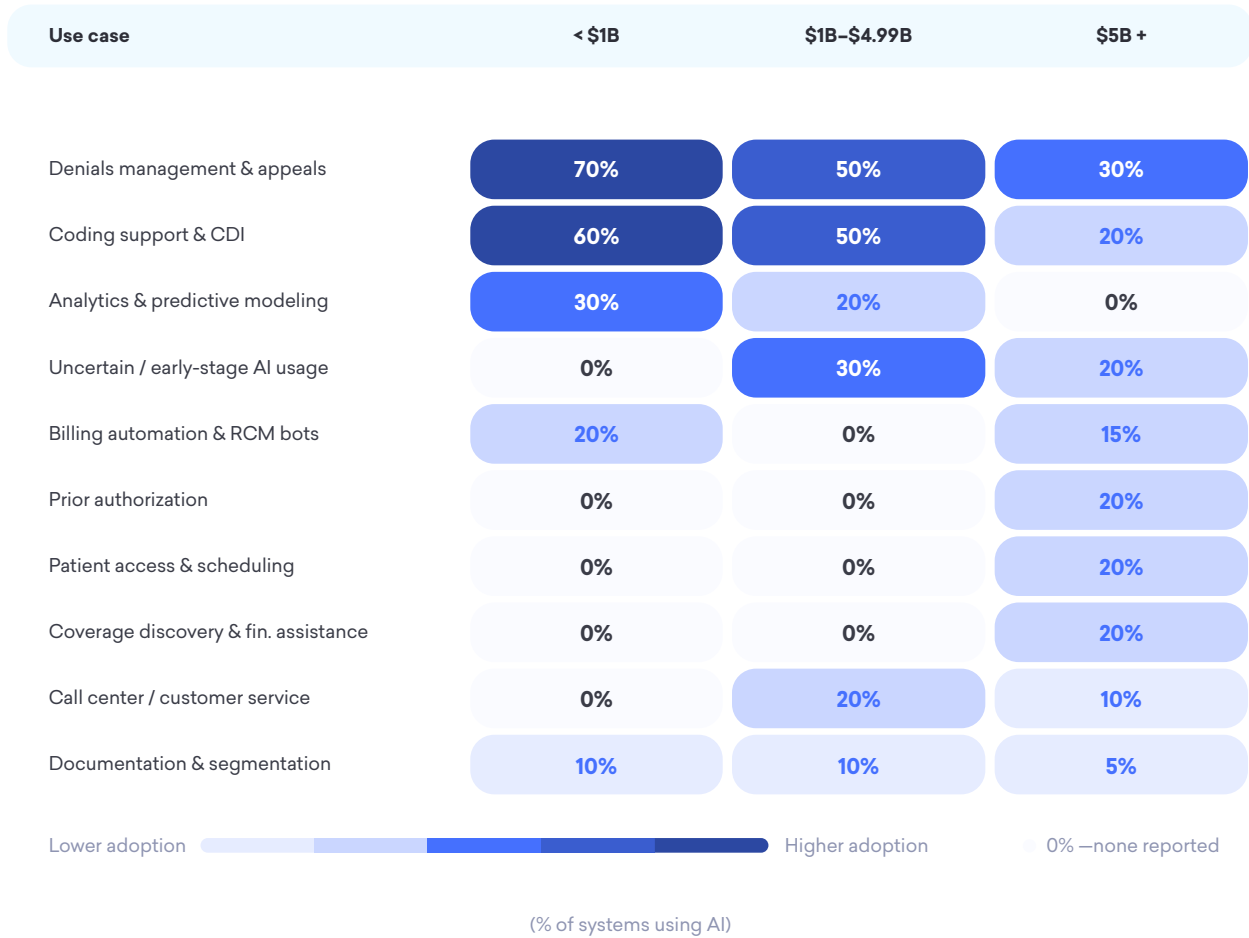


More likely to extend AI into **patient-facing** applications like scheduling, eligibility, and call center automation

48% of large health systems are already using generative AI.

The AI Adoption Map

Generative AI use cases by health system size



Financial Benchmarks

Patient collections remain a meaningful, but highly constrained, component of health system revenue. On average, **systems collect just 31% of total patient billings**, a level of performance that would be untenable in most industries. This reflects the growing strain on both providers and patients, as rising out-of-pocket costs and fragmented payment experiences make it increasingly difficult to convert responsibility into revenue.

At the same time, patient financial responsibility continues to represent a substantial and increasing portion of overall revenue. On average, **patient billings account for 12% of total net patient revenue (NPR)**, reinforcing the growing importance of effective patient payment strategies.

Despite these gains, a significant portion of patient revenue remains unresolved. Approximately **23% of patient collections are tied up in open payment plans**, limiting cash flow and extending time to resolution. This reliance on extended repayment continues to introduce both operational complexity and financial risk.

Encouragingly, earlier engagement is showing progress. **Pre-service collections now account for 20.69% of self-pay collections**, up from prior year benchmarks, signaling that more organizations are successfully capturing revenue before care is delivered.

Taken together, these benchmarks highlight a clear reality: while patient collections are increasingly important, much of that revenue remains delayed or at risk, reinforcing the need for more proactive, flexible, and scalable approaches to patient financial engagement.

2026

31%

Patient Collections
(as % of Patient Billings)

0.95%

Outstanding Balances
(% of NPR)

20.69%

Pre-Service Collections
(% of self-pay collections occurring in pre-service)

12%

Patient Billings
(as % of NPR)

23%

of patient payments are made via a payment plan

A New Model for Patient Financial Engagement Is Emerging

The current healthcare financial infrastructure was not built for a world where patients shoulder a greater share of the cost of care. As out-of-pocket costs and HDHP plans continue to rise, health systems are being forced to rapidly adjust legacy strategies designed for a different era. The data in this report highlights a clear shift: **successful organizations are adjusting their strategies to better support affordability while improving financial performance.**

Across priorities, processes, and workflows, a consistent theme emerges: the **most effective approaches focus on engaging patients earlier and simplifying the financial experience.** From affordable, pre-service payment options to upfront financial assistance, earlier engagement helps patients understand and manage costs before care is delivered, moving beyond a model of billing and reacting to one that thoughtfully guides patients.

At the same time, health systems are increasingly turning to technology and generative AI to scale these efforts. From patient communication and

financial counseling to workflow automation, these tools are enabling more proactive, personalized engagement across the revenue cycle. While adoption is still evolving, the direction is clear: technology will play a central role in delivering more efficient operations and better patient experiences at scale.

Organizations that successfully make this transition will be better positioned to increase collections, reduce bad debt, minimize care avoidance, and improve scheduling efficiency, while ensuring patients can access and afford the care they need.

**Transform the Patient Experience.
Strengthen Collections.
Scale with AI.**

PayZen helps health systems enhance the patient financial experience and improve collections through an AI-powered platform embedded in existing systems and workflows.

From pre-service engagement to personalized payment options and financial navigation, PayZen enables earlier, more proactive interactions that support patients and drive better financial outcomes.

Connect with [PayZen](#) to explore how you can improve affordability, elevate the patient experience, and optimize collections.

