

The Patient Payment Crisis:

Collections Challenges Facing
U.S. Hospitals & ASCs



Rising Patient Financial Responsibility and High-Deductible Plans

Over the past decade, patients’ out-of-pocket financial responsibility for healthcare has climbed sharply, driven largely by the rise of high-deductible health plans (HDHPs) and higher co-pays. This cost-shifting means a greater portion of provider revenue now hinges on patient payments. In fact, one analysis found **self-pay after insurance accounted for nearly 58% of hospital bad debt in 2021, up from only 11% in 2018**– a fivefold jump coinciding with the proliferation of HDHPs . Patients are being billed larger amounts: the share of patient billing statements with balances over \$7,500 **more than tripled from 5% in 2018 to about 18% by 2021** . These higher balances often stem from unmet deductibles and co-insurance, and they are far more difficult for patients to pay, leading to greater collection challenges for providers.

Bad Debt Surge	
Self-Pay After Insurance as Share of Hospital Bad Debt :	
Year	Percentage
2018	11%
2021	58%

Higher Balances	
Patient Billing Statements Over \$7,500 :	
Year	Percentage
2018	5%
2021	18%

Not surprisingly, many Americans struggle to meet these rising obligations. **Four in ten U.S. adults with employer coverage reported difficulty affording a medical or insurance bill in the past year**, according to a 2019 survey . More broadly, about **40% of Americans could not cover an unexpected \$400 expense** – a telling statistic for healthcare affordability.

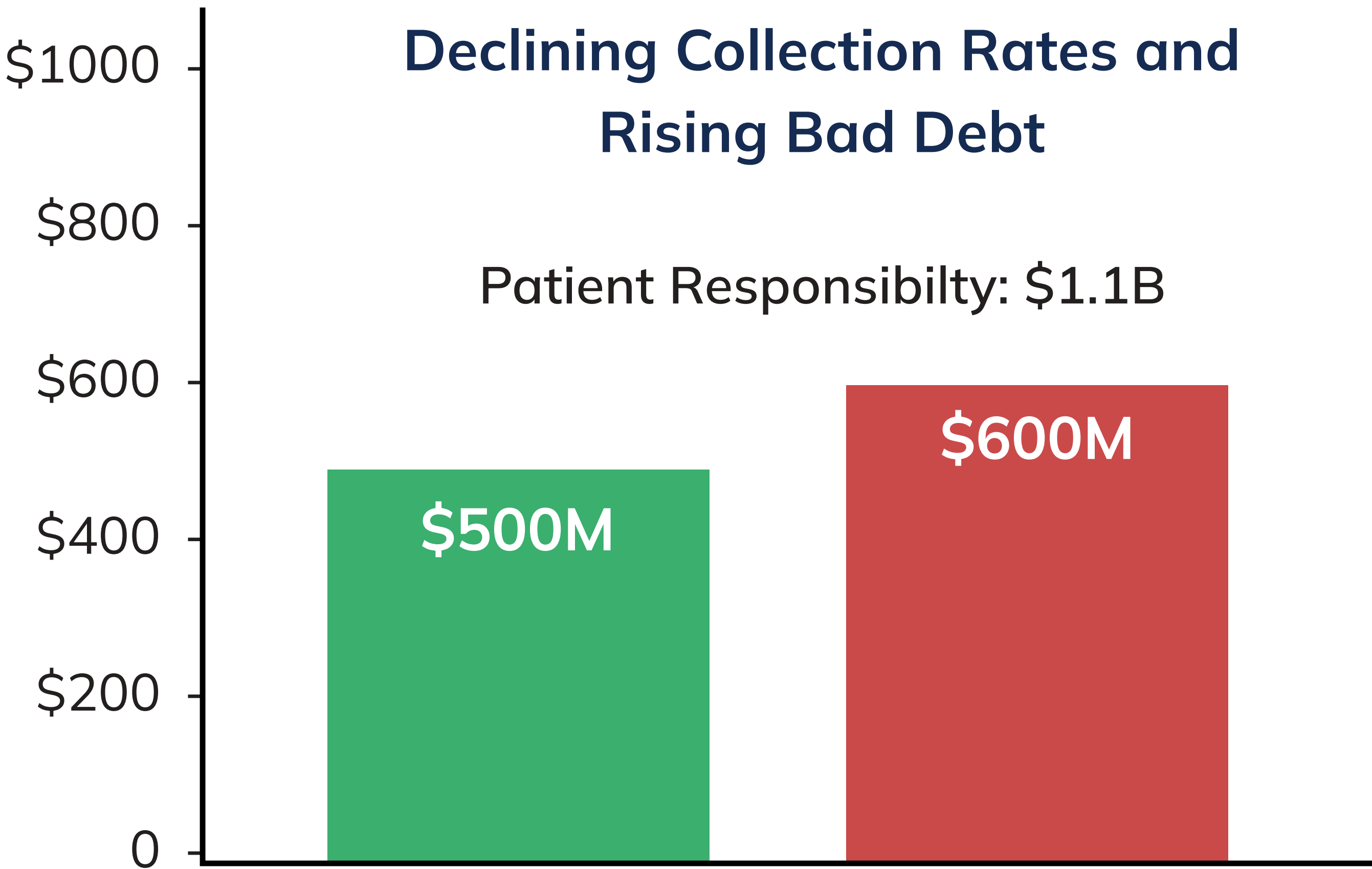
Affordability Challenges

- ✓ **40%** had employer coverage, but struggled to afford a medical/insurance bill.
- ✓ **40%** of Americans can’t cover a **\$400** emergency expense.
- ✓ **Most hospital bad debt** now comes from insured patients, not the uninsured.

The result is that patients increasingly delay or forgo care and, when they do receive care, providers often face unpaid bills. Even insured middle-class patients are slipping into debt: most hospital bad debt is now associated with patients who have insurance, rather than the uninsured . In short, rising deductibles and cost-sharing have created a systemic affordability gap that undercuts patient collections.

Declining Collection Rates and Rising Bad Debt

Healthcare providers’ success in collecting patient balances has deteriorated during 2018–2025, contributing to mounting bad debt. Recent data show that **the average patient collection rate fell from 54.8% in 2021 to just 47.8% in 2022–2023**. In other words, providers are now collecting less than half of what patients owe. An analysis of \$5 billion in provider payments found about **\$1.1 billion was the patient’s responsibility, but only ~\$500 million was actually collected** – less than 50% .



This means hundreds of millions in patient fees went unrecouped. Notably, patients appear willing to pay small medical bills (under about \$500) but often avoid paying larger bills over \$500, causing higher-balance accounts to languish unpaid. As average claim balances have grown, this behavioral cutoff has dragged down overall collection rates.

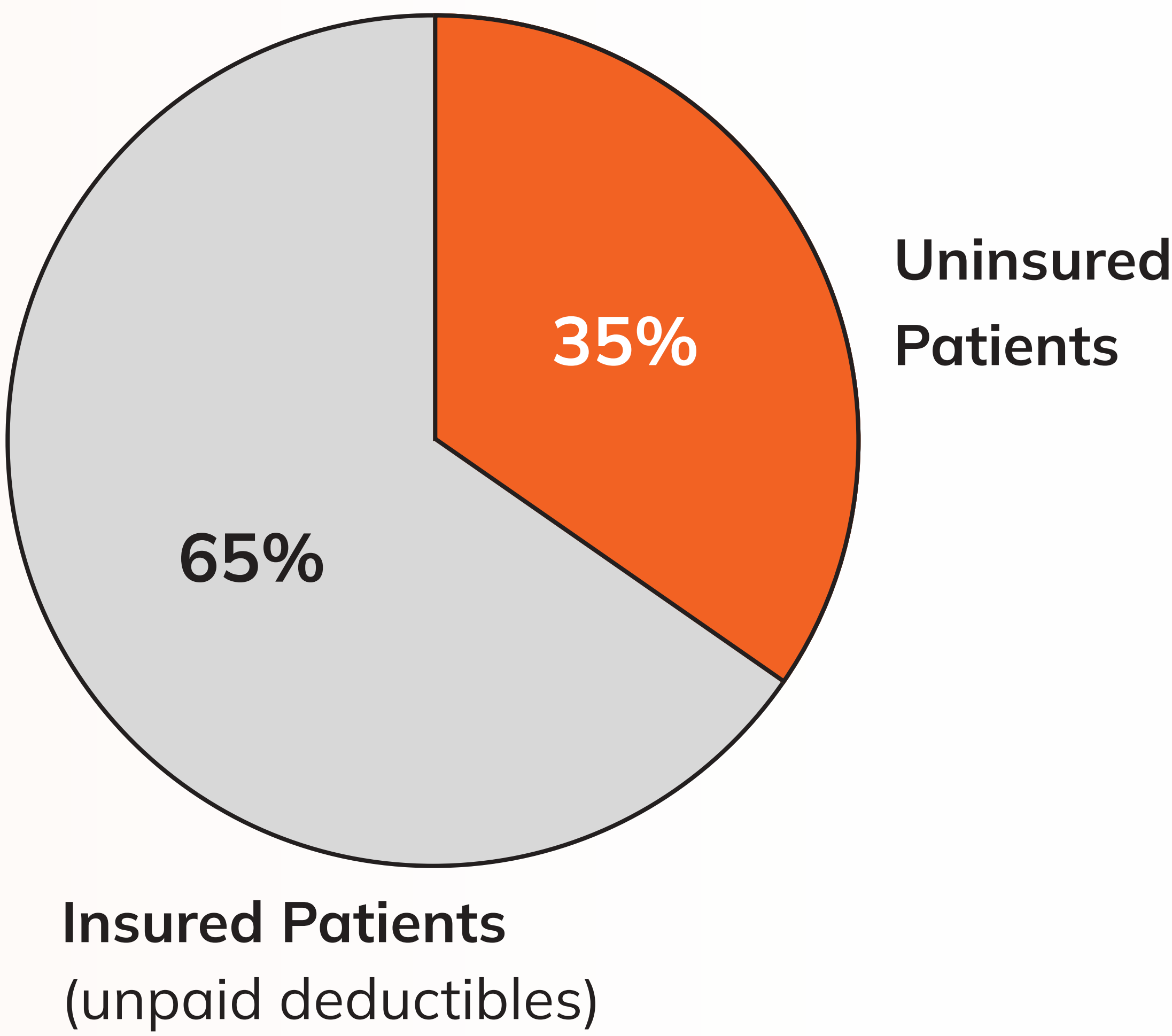
The direct consequence of lower collections is a spike in provider bad debt (money owed that is deemed uncollectible). Hospitals and health systems have seen bad debt levels **surge into the tens of billions**. By 2023, hospital bad debt nationwide exceeded **\$50 billion** according to industry reports . Over **17% growth in bad debt was observed from 2023 to early 2025** alone, per one analysis . Providers’ charity care write-offs have also risen double-digits, partly due to patients’ inability to pay . One review of Q1 2025 performance noted uncompensated care (bad debt + charity) per day was **14% higher than the prior year and about 20% higher than in 2021** – illustrating a rapid rise in uncollected receivables.

“By 2023, hospital bad debt nationwide exceeded **\$50 billion** according to industry reports.”

Put simply, **providers are now leaving a growing share of billed revenue on the table**. Kodiak Solutions found that in 2022–23, lower patient collections translated to **over \$17.4 billion in bad debts for providers in that period** . Importantly, a majority of that bad debt (about 53% in 2023) came from patients who had some form of insurance (commercial, managed care, Medicare, etc.) . Self-pay (uninsured) patients still account for a disproportionate amount of write-offs as well , but the fact that insured patients contribute more than half of bad debt underscores how under-collection is now a mainstream issue, not one confined to the uninsured. This trend threatens providers’ financial stability: for many hospitals, **patient out-of-pocket payments can represent 10–30% of total revenue**, so poor collection performance directly erodes margins. Indeed, **collecting even a portion of what patients owe can make the difference between a procedure being profitable or a net loss**, especially in low-margin settings like surgery centers . The industry is thus grappling with how to improve these collection rates in the face of structural headwinds.

Challenges for Hospitals in Patient Collections

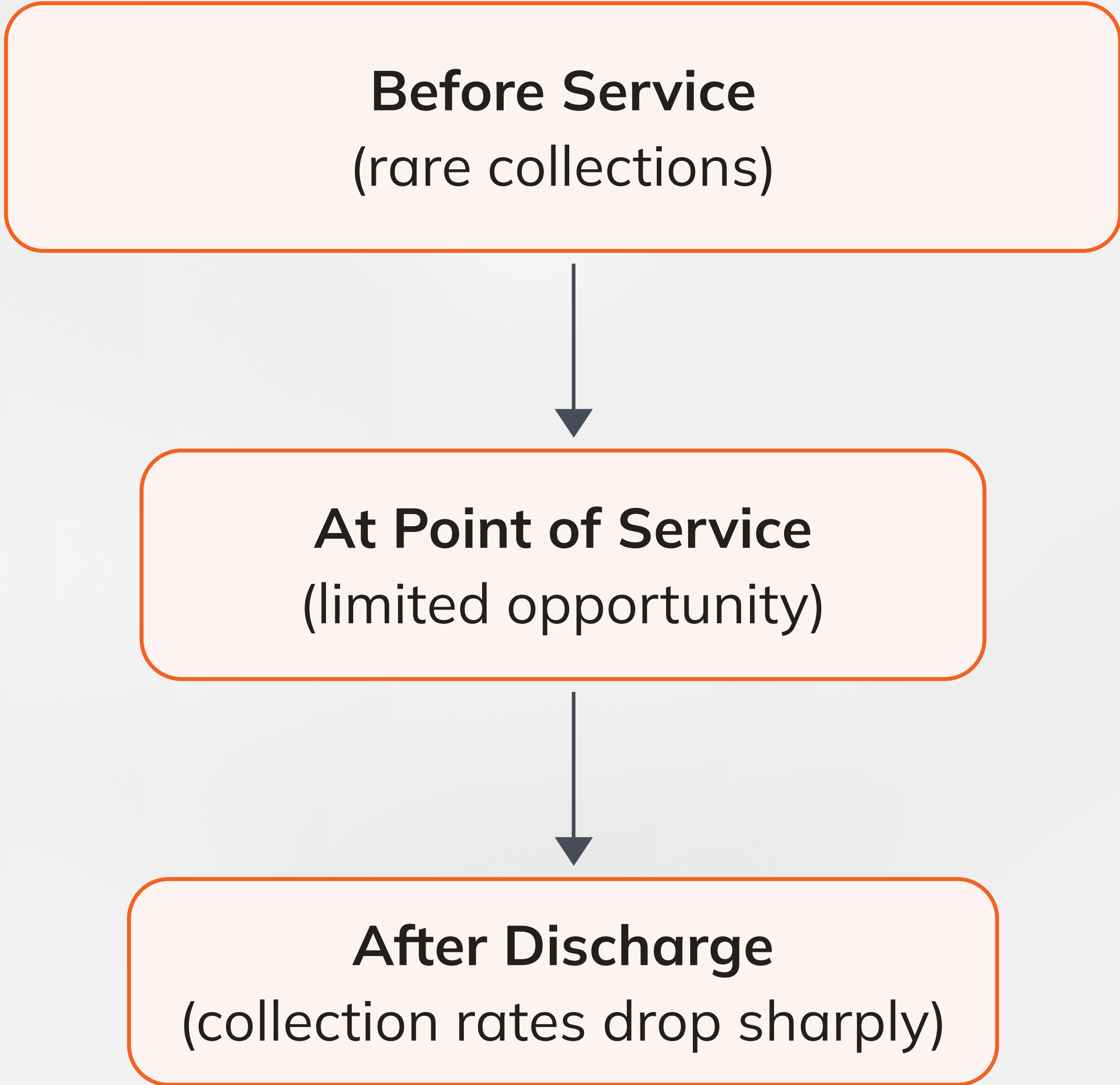
Hospitals face particularly acute challenges with **patient collections**, given their role as safety-net providers and the frequency of emergent care (where up-front payment is not feasible). Hospitals must treat all comers – including the uninsured and those who cannot pay – which inevitably leads to higher uncompensated care. The expansion of HDHPs has only exacerbated this.



Sources of Hospital Bad Debt

Many hospitals now report annual bad debt totals in the tens of millions; nearly one in three hospitals had over \$10 million in bad debt on their books according to a 2022 analysis . Large health systems cumulatively carry enormous patient debt loads (for example, HCA Healthcare alone reported >\$2.5 billion in bad debt) . These figures have been climbing despite hospitals’ efforts, due to both patient-side and payer-side factors.

One challenge is that hospitals often have **little opportunity to collect from patients until after care is delivered**. Emergency departments and urgent admissions can’t practically demand payment upfront. Yet once a patient “walks out the door,” the likelihood of collecting in full drops significantly . Hospitals then must pursue collections post-service, which is labor-intensive and often unsuccessful, especially for large balances. On top of that, hospitals are seeing more insured patients unable to pay their deductibles.



Patient Payment Funnel

Crowe LLP found that by 2021 the majority of hospital bad debt came from insured patients who **failed to pay their portion**. High medical bills even for insured middle-class families have become routine– a systemic issue leading to calls for more hospital financial assistance and transparency.

Hospitals also face **public and regulatory scrutiny in how they handle patient debt**. Investigations have revealed some nonprofit hospitals suing thousands of patients or using aggressive collections tactics, sparking backlash . In response, states like New York have considered policies to curb hospital medical-debt lawsuits (e.g. barring lawsuits against low-income patients) . This puts hospitals in a difficult position: they need to improve collections to sustain finances, but heavy-handed collection efforts can harm community trust and draw political ire. Hospitals are increasingly expected to expand charity care or offer lenient payment plans, even as they struggle with their own slim operating margins.

Hospitals’ Balancing Act: Financial Health vs. Community Trust

Need to Collect	Risks of Aggressive Collection
• Revenue sustainability • Slim operating margins	• Community backlash • Lawsuits & political pressure

It’s worth noting that **the COVID-19 pandemic’s aftermath has added new challenges**. During the pandemic, many patients delayed care (reducing collectible revenue), and coming out of it, **insurance coverage disruptions (e.g. Medicaid re-determinations) have driven up both charity care and bad debt** for hospitals . At the same time, **health insurers have become more aggressive in denying claims and delaying payments to hospitals**, which indirectly affects patient billing too (discussed more below) . All these pressures mean hospitals must invest more in revenue cycle processes just to maintain baseline collections. Many are turning to technology and outsourcing for help, yet the **scale of the problem – tens of billions in unpaid patient debt – indicates a systemic issue beyond any one hospital’s policies**.

Challenges for Ambulatory Surgery Centers (ASCs) in Collections

Ambulatory surgery centers face their own set of patient collection challenges, often distinct from hospitals'. **ASCs operate on lean margins with tighter reimbursement, so every dollar of patient responsibility is crucial** – the patient's share of a surgery's cost can determine whether the case is profitable or not . In recent years, more surgeries have shifted to ASCs because of cost advantages for payers and patients. But this means ASCs are treating more patients who have high deductibles and cost sensitivities. **Patients' out-of-pocket obligations tend to be concentrated at the beginning of the year ("high-deductible season"), which can cause ASC accounts receivable to balloon in those months** . One financing firm noted that ASC A/R **"can grow exponentially" due to high deductibles**, requiring centers to extend payment plans or financing options for patients during that period . Essentially, when many patients haven't met their deductible, the ASC is initially on the hook to collect the full allowed charge from the patient, delaying revenue collection.

"Every dollar of patient responsibility can determine whether an ASC breaks even or takes a loss."

Collecting payment upfront is a best practice for ASCs, yet it's easier said than done. Many ASCs perform elective or scheduled procedures, which is an advantage – patients can be informed of costs in advance and asked to pay on or before the day of surgery. In fact, experts strongly recommend **estimating patient costs beforehand and collecting as much as possible pre-surgery** (once services are rendered, the odds of payment drop sharply) . ASCs that are proactive about this tend to fare better: one industry consultant observed that **"complacent" ASCs might collect only ~20 cents on the dollar before sending an account to collections, whereas more "proactive" centers can collect ~40 cents on the dollar before resorting to collections agencies** . This highlights how internal policies impact outcomes.

However, not all ASCs have robust pre-payment processes; some historically just billed patients afterward, leading to money left on the table.

High-Deductible Season = Cash Flow Crunch

- A/R spikes early in the year
- Payment plans often required
- Revenue delays strain margins

Another issue is patient education and communication. Even in an ASC setting, patients are frequently **surprised by how high their bills are, despite years of rising deductibles**. ASC staff report that many patients mistakenly believe that paying high insurance premiums means their surgery will be mostly covered, thus they are shocked to owe thousands out-of-pocket. This can lead to last-minute cancellations (if a patient panics upon learning the cost) or non-payment after the fact. **Providing price estimates well in advance is critical** – patients should know a week or more ahead if they’ll owe a large sum, not the day before surgery. Many ASCs now emphasize financial counseling as part of pre-registration, to walk patients through their insurance coverage, deductible status, and payment options. Without clear communication, ASCs risk both lost revenue & poor patient satisfaction scores related to billing.

Proactive ASC	Complacent ASC
• Estimates cost upfront	• Bills afterward
• Collects before surgery	• Relies on collections
• Recovers ~40¢ per \$1 before collections	• Recovers ~20¢ per \$1

Administrative constraints also affect ASCs. **The typical days in accounts receivable (A/R) for ASCs is around 32 days** (about a month) under good conditions . This metric can worsen if there are inefficiencies in insurance verification, billing, or patient follow-up. ASCs, often smaller than hospitals, may have limited billing staff and less sophisticated RCM systems, making them vulnerable to spikes in A/R. In recent years, **factors like surgical case cancellations and documentation delays have increased A/R days for some ASCs**. Every extra day means delayed cash flow. To mitigate this, some ASCs use third-party patient financing: certain lenders will pay the ASC shortly after the procedure and then service a 12–24-month loan with the patient, improving near-term cash flow and affordability. **However, approval friction remains—traditional medical lenders often approve only a minority of applicants (frequently <40%),** leaving a large share of balances uncollected. Fintech models like **Credee** close this gap by approving every patient **without a credit check and guaranteeing the ASC’s monthly payments**, effectively **converting “dead” receivables into predictable monthly recurring revenue** while reducing days in A/R, write-offs, and collection costs.

Efficient ASC: ~32 days in A/R (healthy cash flow)
Strained ASC: 40+ days in A/R (delayed revenue, higher write-offs)

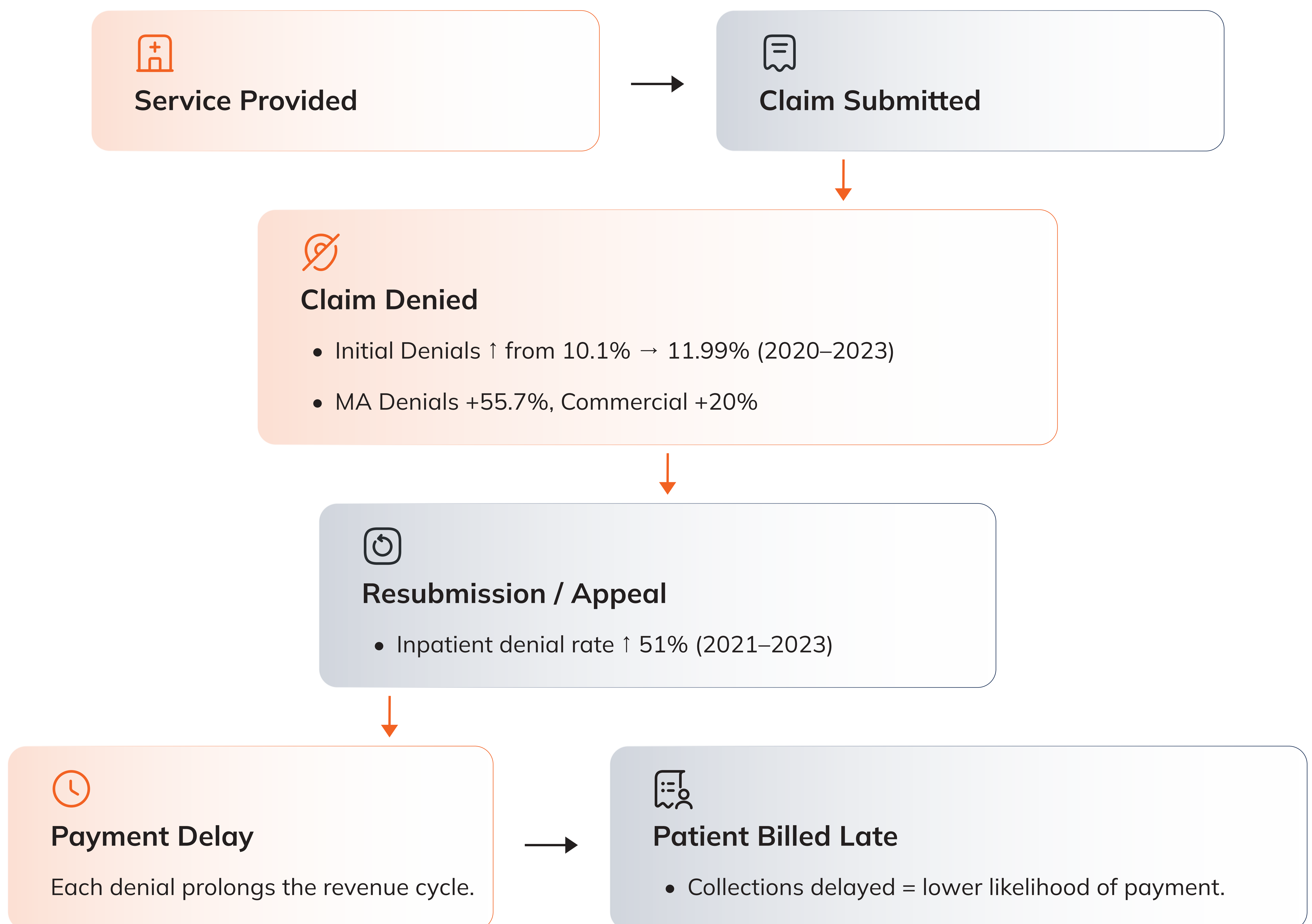
In summary, ASCs must juggle **front-end patient engagement (pre-surgery estimates, payment plans) and back-end efficiency** to keep collections strong in the face of high patient cost-sharing.

Insurance Reimbursement Delays and Their Impact

Another major challenge – affecting both hospitals and ASCs – is the delay in payments from insurers, especially due to claim denials and administrative hurdles. When insurers slow down or deny payment, it indirectly hampers patient collections too (as patients may not be billed their portion until the insurer pays, or confusion arises about what the patient owes). Over 2018–2025, providers have seen a marked rise in payer-driven delays:

Claim denials have reached record levels.

Between 2020 and 2023, the average initial denial rate on healthcare claims rose from 10.1% to 11.99% . The American Hospital Association reported that Medicare Advantage denials jumped 55.7% in that period, and commercial plan denials climbed about 20% . Inpatient hospital stays are particularly affected: the final denial rate on inpatient claims increased **51% from 2021 to 2023** . Each denied or delayed claim prolongs the revenue cycle.



Significant payment lags:

On average, providers experience a **20–30 day delay in receiving revenue for denied claims** while appeals are undertaken . Even clean claims can face slow processing. Every extra day an insurer takes to pay is a day longer that the patient’s bill remains unresolved as well. **Providers often cannot bill the patient for their share until the insurer adjudicates the claim**, so insurance delays directly translate to later (and lower probability) patient collections . A revenue cycle survey by HFMA found these delays so concerning that **90% of health systems now cite claims denials as the #1 challenge for their RCM teams** .

Payer Type	Denial Rate Growth	Impact on Revenue Cycle
Medicare Advantage	+55.7% 🚫 (severe)	High (slow payment cycle)🚫
Commercial Plans	+20% 🟡 (moderate)	Medium 🟡
Inpatient Stays	+51% 🚫 (severe)	Very High 🚫

Denials are rising sharply across payer types, with Medicare Advantage and inpatient claims showing the most severe impact on revenue cycle performance.

Administrative burden and cost:

Managing denials and pre-authorization has become enormously costly for providers. Hospitals must invest time and staff to chase down payments. The AMA estimates each appealed denial costs \$25–\$50 in administrative expense . Nationally, hospitals spent nearly \$20 billion in 2022 just on resolving denied claims (reworking and resubmitting them) . They spend an additional \$10 billion per year on dealing with insurers’ prior authorization requirements .

Though around 50–60% of denied claims are ultimately recovered , the effort and delay involved mean net revenue loss and cash-flow strain. In effect, payers’ slow or partial reimbursement is pushing more cost and risk onto providers, which trickles down to patients in the form of more aggressive collections to make up the gap.



+55.7%
Jump in denials (2020–2023)



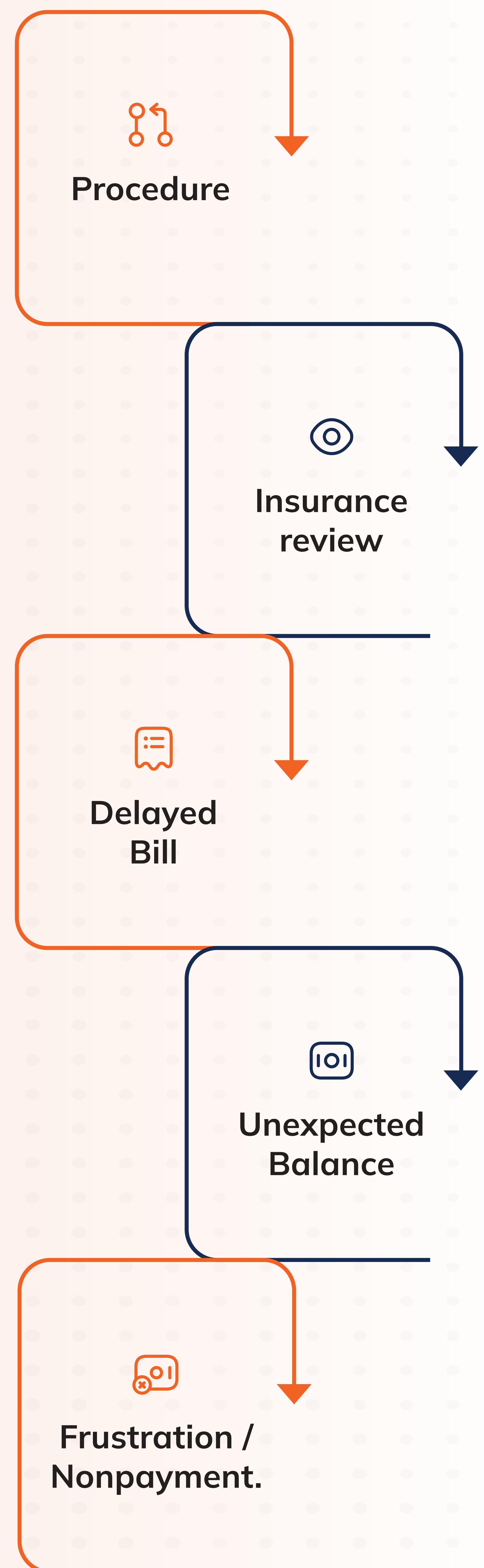
+51%
Final denial rate increase (2021–2023)



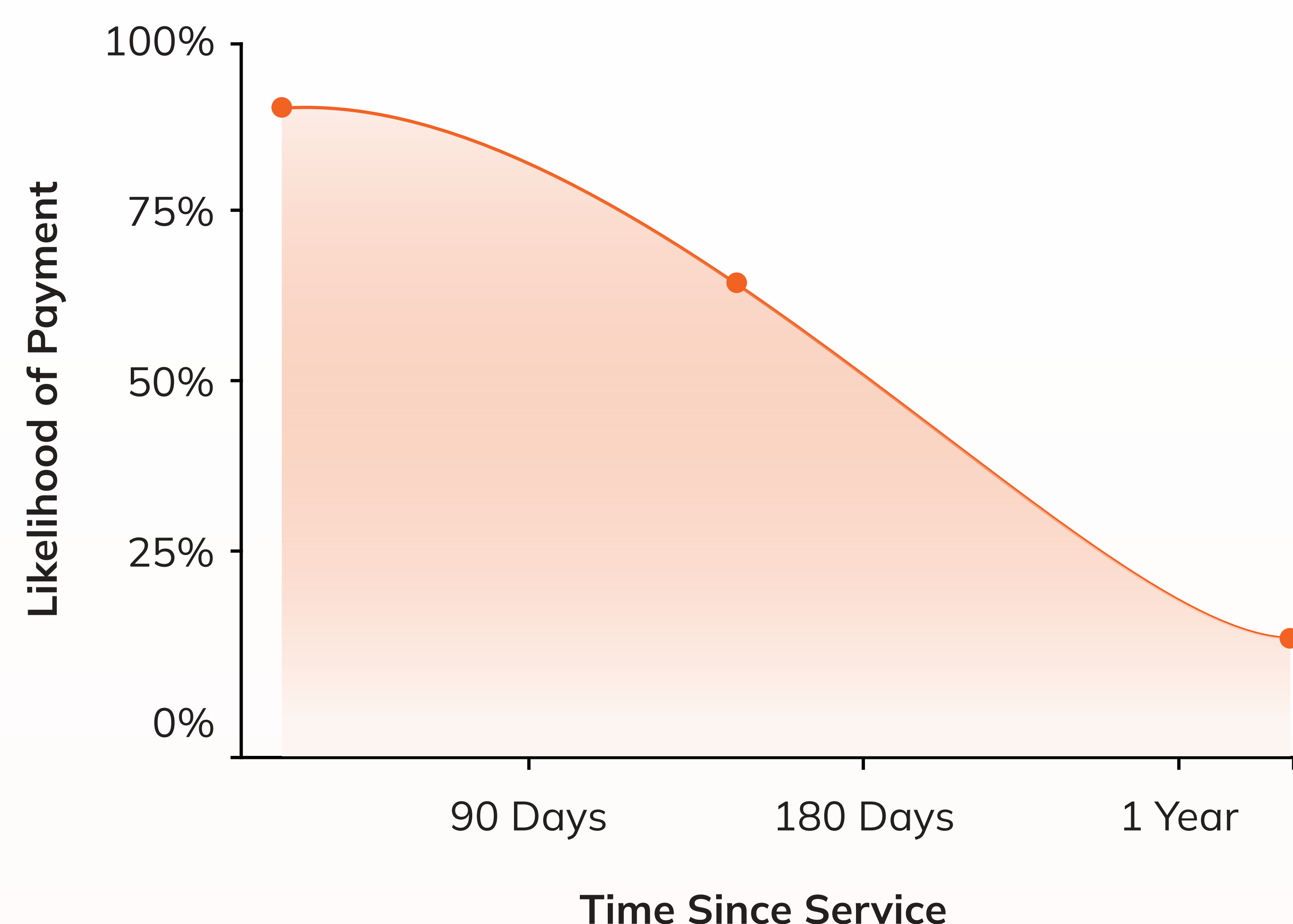
+20%
Denials climb across commercial payers

Communication Gaps and Administrative Barriers

Underlying many of these issues are **communication failures and administrative shortcomings** that hinder effective collections. On the patient side, a lack of transparent communication about costs and payment expectations is a major barrier. Patients often report confusion about their bills – for example, even after the federal No Surprises Act took effect, **20% of adults said they received an unexpected medical bill they thought was not covered**. This points to ongoing issues with patients understanding what their insurance covers and what they owe. In many cases, patients simply do not receive clear estimates or timely bills. A common scenario: a patient has a procedure and months later receives a large bill for the balance, by which time they may have assumed insurance covered it or may have difficulty paying. Every additional touchpoint and delay increases the chance of nonpayment. It's notable that **only 45% of Americans are confident they know what an ER visit will cost them** (versus ~70% who feel they know the cost of a routine primary care visit). That uncertainty often translates to surprise and frustration when the hospital bill arrives, which can reduce willingness to pay.



From the provider side, **administrative inefficiencies and lack of patient-friendly billing processes are significant obstacles.** Many providers historically relied on mailing paper statements and passive billing – tactics that are increasingly ineffective. Revenue cycle experts observe that simply “**sending a statement and assuming it will be paid is not enough**”, yet some organizations still have lenient or inconsistent follow-up processes .



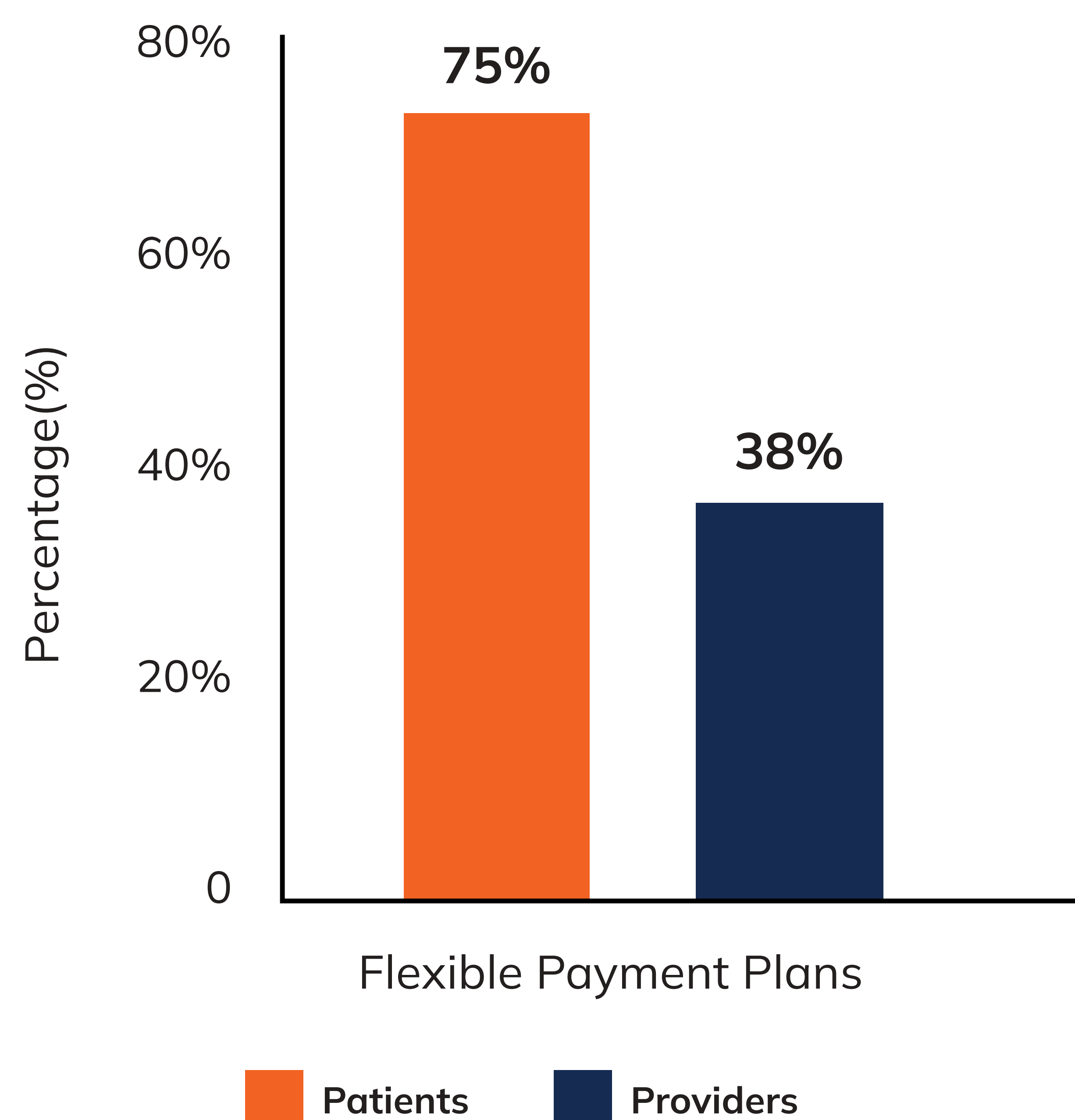
If staff do not rigorously adhere to collection protocols (e.g. multiple follow-up contacts, timely assignment to collections agencies), money gets left on the table and aged accounts grow . Data shows that the likelihood of collecting a bill drops dramatically as time passes – it is “nearly impossible” to collect from a patient a year or more after service . That puts a premium on efficient, prompt billing operations.

However, many provider organizations struggle with outdated systems and high workload. **Each step of the billing process, from coding to claim submission to patient invoicing, can be a failure point if not executed properly.** For instance, if documentation or coding is lacking, a claim may be denied, delaying the whole cycle by weeks or months (and thus delaying patient billing) . A former hospital CFO noted that when claims sit unworked or get backlogged due to inadequate staffing/systems, they eventually get written off or sent to collections – meaning the provider recovers only a fraction of what was owed .

In essence, **inefficient revenue cycle operations directly increase bad debt** . This is an internal, fixable barrier: many hospitals are now investing in automation, analytics, and staff training to improve in this area. In fact, health system CFOs see promise in new tech – there’s a “tremendous opportunity” for advanced tools (like AI-driven claim denial management and price estimation software) to streamline collections and reduce manual burdens . Nearly two-thirds of organizations plan to boost spending on RCM technology in the next few years, in part to address these pain points.



What patients want (75%) → minus what providers offer (38%) → **gap (37%)**.



Another administrative hurdle is **the lack of alignment between billing policies and patients' ability to pay**. Many providers historically offered only short-term payment plans (e.g. 3–6 months), which may not be feasible for large balances. According to a 2024 patient survey, **75% of patients said having the option to pay medical bills over an extended period would make them more likely to pay in full**. Yet a companion survey of healthcare finance leaders found **62% of health systems do not partner with any third-party to offer extended payment plans (12+ months)**.

This mismatch leads to more accounts going to bad debt collections that perhaps could have been resolved with a longer, interest-free payment plan. Forward-looking providers are starting to address this by offering more flexible financing, as mentioned earlier (e.g. 12-, 24-, or even 36-month installment options, sometimes via fintech partners). The goal is to bridge the affordability gap – because patient non-payment is rarely due to unwillingness, but rather lack of viable payment options that fit their budget.

Finally, communication and administrative diligence must come together to improve the overall patient financial experience. Best practices emerging in the late 2010s and early 2020s include: **informing patients of costs early, educating them on their insurance benefits, training staff to discuss finances with empathy and clarity, and leveraging online payment portals/tools** for convenience. Providers who implemented these saw not only better collection rates but sometimes improved patient satisfaction scores (patients appreciate transparency and support with financial matters, which are part of the care experience). Conversely, poor communication can lead to backlash – for example, if a patient feels blindsided by a bill or mistreated in the collections process, it can damage the provider's reputation and even result in regulatory complaints. Thus, addressing the “softer” side of collections – through patient engagement, clear communication, and compassionate billing practices – is now recognized as key to success.

Trends and Systemic Issues

Stepping back, the period 2018–2025 has highlighted several systemic issues in patient collections for U.S. healthcare:

Cost shift to patients:



Higher deductibles and co-pays have made patients effectively the “payer” for a larger portion of healthcare revenue. This trend is likely to continue, forcing both hospitals and ASCs to treat patient collections as a top priority rather than an afterthought. Providers must adapt to what is now a consumer-centric payment dynamic.

Under-performance in collections:



Despite more focus, collection rates on patient balances remain disappointingly low (under 50% for many providers). The industry has seen **net patient revenue leakage** in the form of growing bad debt year over year. This represents a structural financial challenge for healthcare, squeezing already thin margins.

Bad debt becoming an insured problem:



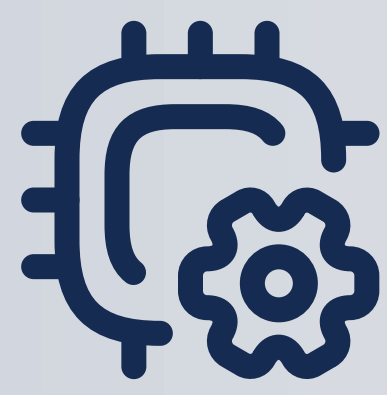
Unlike a decade ago, insured patients with jobs are a major source of bad debt today, not just the uninsured or indigent. This points to broader economic and insurance design issues (e.g. affordability of care even for the insured). It also means traditional charity care policies (which focused on uninsured patients) may need revision to help under-insured patients.

Payer-related friction:



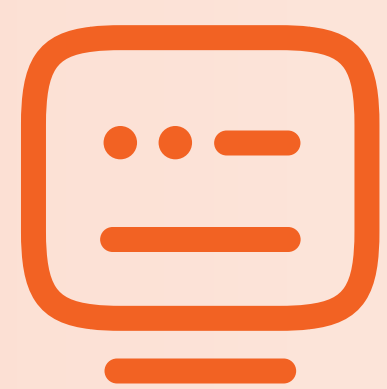
Insurance reimbursement delays and denials are a significant drag on the revenue cycle, in effect financing costs that providers must bear. The need to contend with increasingly complex payer rules has elevated providers’ cost-to-collect. In many ways, **the revenue cycle is becoming more inefficient due to external bureaucracy**, and providers are lobbying for reforms (for instance, to curb excessive denials or streamline prior auth processes) as well as deploying tech solutions to cope.

Need for technology and process improvement:



The sheer scale of revenue at risk has pushed healthcare organizations to modernize their collection efforts. This includes adopting predictive analytics to identify patients' propensity to pay, using automated reminders and online billing, and integrating price transparency tools. Some providers are benchmarking performance and **setting targets like collecting 3–5% of net patient revenue at point-of-service** (time of care) as recommended by HFMA, to boost upfront cash and reduce downstream billing. The coming years will likely see heavier use of AI and automation in revenue cycle management to tackle denials and engage patients through self-service platforms.

Regulatory and ethical considerations:



There is growing attention on **healthcare affordability and billing fairness** from regulators, media, and the public. Legislation like the No Surprises Act addresses one piece of the puzzle (surprise out-of-network bills), and proposals in some states aim to limit aggressive collections. Hospitals and ASCs are being encouraged to offer more charity care or financial assistance, especially for low-income patients, to avoid pushing individuals into bankruptcy over medical bills. This is part of the larger conversation about the **systemic burden of medical debt in the U.S.**, which studies have shown affects over half of adults at some point. Providers are caught between trying to collect what is owed and fulfilling a mission to care for the community – a balance that is still being navigated.

In summary, patient collections have become a central concern for the healthcare revenue cycle from 2018 through 2025, with clear trends of patient balances growing, collection effectiveness eroding, and bad debt mounting for both hospitals and ASCs. Contributing factors include high-deductible insurance designs, gaps in patient communication, rising payer denials, and internal process limitations. Addressing this will require a multifaceted approach: better upfront engagement with patients about costs, more flexible payment solutions, streamlined billing operations, and collaboration with insurers and policymakers to reduce unreasonable payment delays. The data and experiences of recent years highlight that without changes, both providers and patients will continue to face financial distress – providers from lost revenue, and patients from unaffordable medical bills. The healthcare industry is thus actively seeking strategies to bridge this payment divide, with the twin goals of improving financial performance and maintaining patient trust.



About the Author

Ankur Chadha Vice President of Growth, Credee

Ankur has worked with ambulatory surgery center administrators and executives across the United States to better understand the financial and operational pressures created by rising patient out-of-pocket costs. His industry engagement and research inform this analysis of how patient financing models affect ASC revenue stability, care accessibility, and long-term sustainability.



ankur@credee.com

Linked 

References:

- Becker's Hospital Review – **Finance** (Feb. 2024). "Patient collections fall to 48%."
- Becker's ASC Review (2019). "What the rise in high-deductible health plans means for ASCs – Q&A."
- Definitive Healthcare (Oct. 2023). "5 hospital bad debt statistics you need to know."
- HealthLeaders Media (Feb. 2025). "Increasing Bad Debt, Charity Care Slowing Down Hospital Finances."
- Becker's Hospital Review – **Finance** (May 2025). "Health system bad debt piles up: 5 things to know."
- Montecito Medical (Sept. 2024). "Behind every CFO's challenge lies a hidden opportunity."
- Becker's ASC Review (2018). "7 dos and don'ts of patient collections."
- Physicians Practice (Oct. 2022). "Challenges with documentation in ASC billing."
- WhiteSpace Health (2023). "Payers' rising claim denials and delays devastate provider revenue cycles."
- HFMA/Eliciting Insights (2024). Health System CFO Survey Press Release.