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Financial assistance and payment plans for underinsured patients shopping for "shoppable" hospital services

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Abstract

Recent price transparency laws are designed to better inform patients as they compare hospital options and "shop" for health care services. In addition to prices, underinsured patients seeking care need information on financial assistance, discounts, payment plans, and upfront payment requirements to compare the affordability of care across hospitals. Little is known about the availability of this information and the experience of prospective patients seeking it. We contacted a random sample of 10% of general short-term hospitals across the United States in this "secret shopper" telephone study to assess financial options and navigation challenges faced by underinsured patients in need of a non-emergency procedure. The administrative friction was substantial. Most hospitals have 3 siloed offices for (1) financial assistance, (2) payment plans and discounts, and (3) upfront payment requirements. All relevant offices were unreachable in 3 attempted calls at 18.1% of hospitals. Among hospitals with available information, the majority have financial options for patients: 86.7% of hospitals offer financial assistance and 97.0% of hospitals offer payment plans to underinsured patients for non-emergency care. The length and terms of payments plans varied widely for hospital-administered and third-party financing arrangements. Upfront payments were sometimes required, potentially posing barriers for patients without cash or credit access.

Key words: underinsurance; affordability; hospital; shoppable services.

Introduction

Despite substantial coverage expansions in the wake of the Affordable Care Act, many patients continue to struggle with paying for medical care. Over 90% of Americans have health insurance, yet 2-in-5 adults have debt from medical or dental bills.[1,2] Collectively, Americans owe over $200 billion in debt for health care services, the majority of which is owed to hospitals.[3] Medical debt can pose a barrier to care as people report postponing or forgoing needed care due to their inability to pay out-of-pocket costs.[4] Some hospitals have refused patients care if they owe money on a past bill to the hospital.[5] Many families adjust housing, education, and daily necessities in order to pay their medical debt.[4,2]

One major contributor to medical debt is underinsurance, which is when an individual is enrolled in a health plan but still lacks affordable access to care. Twenty-three percent of working-age adults in the United States are underinsured.[6] The 2023 Kaiser Family Foundation's Employer Health Benefits Survey reports that 25% of employers with 50 or more employees believed that their employees had a "high" level of concern about the affordability of cost-sharing.[7] Understanding the experiences of the sizable population of underinsured Americans is critical to improving affordability and access to care. Additionally, growing underinsurance and patient out-of-pocket liability for care may raise concerns about the revenue stability of hospitals.

Two recently implemented federal policies include provisions intended to help patients better anticipate and understand the cost of their care. A hospital price transparency rule implemented in 2021 requires hospitals to post prices for 300 shoppable services.[8] Additionally, the No Surprises Act requires that health care providers offer uninsured or self-pay patients a good faith estimate, outlining the expected charges for items or services for planned health care, and in the future, insured patients are expected to be able to receive an advanced explanation of benefits as well.

While these policies represent important advances in price transparency and consumer protections, even more can be done. There are additional factors beyond price—such as eligibility for discounting, the timing of payment requirements, and availability of financing arrangements—that are important for patients trying to plan and pay for care. Consider a patient enrolled in a high-deductible health plan who needs a non-emergency, yet necessary, surgery but lacks the funds to cover the cost of their deductible. The patient can use new price transparency and estimate policies to find the hospital where the procedure would be most affordable. However, price alone does not truly indicate the financial burden on this patient. The totality of financial assistance, payment timing, and interest rates on financing plans affects whether patients accumulate debt and the consequent negative impact on their well-being.

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For example, when patients are shopping, they may find that 1 hospital has a lower price but requires partial upfront payment and full payment within 90 days, forcing the patient to use an interest-bearing loan or credit card. Another hospital may list a higher price but offer a 2-year, zero-interest payment plan or offer financial assistance to underinsured patients.[9] A higher priced hospital may be the more financially optimal option once payment timing and financial assistance are taken into account.

To provide insight into the ability of patients to ascertain information on these factors—in addition to their prevalence and variability across hospitals—we carried out a "secret shopper" study, telephoning hospitals posing as an underinsured prospective patient in need of knee endoscopy surgery. We chose a secret-shopper approach to gain an accurate understanding of the patient experience, and avoid any bias or change in the presentation of hospital policy and practices that may occur if representatives knew we were researchers.[10] This also allowed us to capture the administrative burden and real-world difficulties for patients in planning for the payment of their care, such as transfers between departments and frequent confusion from hospital representatives when asked financial planning questions.

Data and methods

The study comprised a 10% random sample of general short-term hospitals in the United States, as listed by the American Hospital Association. We excluded government-owned hospitals. We also excluded critical-access hospitals because, in initial exploratory calls, we found that knee endoscopy was often not a provided service, and it was more difficult to uphold anonymity when calling hospitals in smaller close-knit communities.

We called hospitals posing as an underinsured individual enrolled in a high-deductible commercial health plan. Following a uniform script, we told the hospital representatives that we needed a knee endoscopy, which is a "shoppable" service on the price transparency list, and asked what financial options were available to us (Online Supplement). This script included questions on financial assistance and the eligibility criteria and application process, hospital-administered and third-party payment plans and details on the length and structure of these plans, and deposits or upfront cost-sharing payments.

We asked hospitals whether we could be eligible for financial assistance and for information about the application and eligibility criteria, including whether we could be approved for financial assistance before the procedure or only after. We asked whether the hospital offered any payment plan options, whether these plans charged any interest or fees, if the plan was need-based or available to all patients, and the maximum time frame of the plan. We asked whether the hospital facilitated any third-party financing options, whether these options charged interest or fees, and the maximum time frame of these payment options. Finally, we asked whether we would be required to provide any out-of-pocket payment upfront before the procedure.

Phone calls were conducted between June and November 2023. We set a limit of 3 call attempts, each on a different day and at different times during the hospital's business hours, before designating that hospital as unreachable. We remained on hold for a maximum of 20 minutes, then disconnected. We also tracked the length of our calls and how many times we were transferred. Additional details on the protocol for telephone calls are provided in the Online Supplement.

Results

Sample of hospitals

There were 253 hospitals in our sample, but 4 of them reported that they did not offer knee endoscopies, resulting in an analytic sample of 249 hospitals. Of these 249 hospitals, 205 (82.3%) were affiliated with a system and 192 (77.1%) were nonprofit hospitals. The mean bed size was 225.6 beds (Table 1).

Representatives were unreachable at nearly 1 in 5 hospitals after 3 telephone call attempts

We reached someone to speak to at 204 hospitals (81.9%), but at the remaining 45 (18.1%) hospitals we called 3 times and never reached a person or got substantive information via voicemail or automated messages. The 45 hospitals that we could not reach were disproportionately for-profit, yet not statistically different in prevalence of system-affiliated or bed size from the 204 hospitals that were reachable.

Siloed offices handle financial assistance, billing, and upfront payment requirements at hospitals, and patients have to compile information across offices to get a full understanding of financial options

We called a total of 513 times across our sample of 249 hospitals. We were transferred a total of 613 times, a mean of 2.5 times per hospital. Our calls lasted a mean of 12.5 minutes and a median of 10 minutes (Table 1). The mean call time for hospitals that were unreachable was 8.4 minutes, and in most of these cases, our calls were forwarded to voicemail. We only reached the maximum hold time of 20 minutes on 8 calls.

The scope of information we were seeking was typically not available from a single hospital department. This resulted in inconsistent missing data when were able to reach some departments and not others within a given hospital. At a typical hospital, payment plan information was available from the billing department, and financial assistance information was available from the financial assistance department or a financial counselor. Questions about upfront payment requirements, such as a copayment or estimated coinsurance and deductible amount, at the time of service were often directed to a separate price estimate, scheduling, or other preadmissions office, which we generally could not reach without established patient information, specific health plan information, or a referring physician. Across the full analytic sample of 249 hospitals that provided knee endoscopies, we were able to collect information on our main outcomes of financial assistance at 203 (81.5%), hospital-administered payment plan information at 201 (80.7%), third-party payment plans at 190 (76.3%), and upfront payment requirements at 186 hospitals (74.7%).

Financial assistance is commonly available to insured patients, but roughly half of hospitals will not notify patients of their approval for assistance until after the service

Among the 204 hospitals where we obtained at least partial information for our main outcomes, 176 (86.3%) offered financial assistance to insured patients for non-emergency

Table 1. Hospital characteristics and communication summary.

	AHA sampling frame ($n = 2562$)		Study sample of hospitals ($n = 249$)		Study sample of hospitals ($n = 249$): Reachable hospitals with outcome data ($n = 204$)		Study sample of hospitals ($n = 249$): Unreachable hospitals ($n = 45$)		
	n	(%)	*n*	(%)	*n*	(%)	*n*	(%)	*P*
Hospital characteristics									
System-affiliated									
Yes	2000	(78.1)	205	(82.3)	168	(82.4)	37	(82.2)	.983[a]
No	562	(21.9)	44	(17.7)	36	(17.7)	8	(17.8)	
Ownership									
For-profit	443	(17.3)	57	(22.9)	41	(20.1)	16	(35.6)	.025[a]
Nonprofit	2119	(82.7)	192	(77.1)	163	(79.9)	29	(64.4)	
	Mean	**(SE)**	**Mean**	**(SE)**	**Mean**	**(SE)**	**Mean**	**(SE)**	
Hospital bed count	230.2	(227.7)	225.6	(186.5)	231.0	(188.3)	217.1	(185.7)	.656[b]
Communication summary									
Calls	—	—	2.1	(0.9)	1.8	(0.8)	3	(0.0)	
Transfers	—	—	2.5	(1.4)	2.3	(1.4)	N/A		
Minutes	—	—	12.5	(7.8)	13.4	(7.5)	8.4	(8.0)	
			n	(%)	*n*	(%)	*n*	(%)	
Data received									
Any information available	—	—	204	(81.9)	204	(100.0)	0	(0.0)	
No information available	—	—	45	(18.1)	0	(0.0)	45	(100.0)	

Source: Authors' analysis of data from calls to hospitals conducted between June and November 2023 and the American Hospital Association (AHA) annual survey. The AHA sampling frame includes all general short-term hospitals in the United States that are not government-owned or critical-access hospital. The study sample is a randomly selected 10% of the AHA sampling frame. There were 204 hospitals with at least partial information on our main outcomes: financial assistance, payment plans, and/or upfront payment requirements. The mean minutes includes time spent on hold. *P* values are between reachable and unreachable.
[a]Chi-square tests.
[b]Two-sample *t* test.

procedures, 27 (13.2%) did not offer financial assistance to patients in this circumstance, and financial assistance information was not obtained for 1 (0.5%) hospital (Figure 1). While not uniformly asked, 18 hospitals that did not offer financial assistance for our scenario mentioned they had financial assistance available to uninsured patients or patients who had received emergency care.

Of the 176 hospitals that offered financial assistance to insured patients for non-emergency services, a patient could qualify for financial assistance before the procedure at 79 (44.9%) of them. Eighty-one (46.0%) of these hospitals indicated that financial assistance could not be applied for or approved before the procedure, and this information was not provided by the remaining 16 (9.1%) hospitals (data not shown).

Although not systematically asked, some hospital representatives volunteered additional information about their financial assistance programs and application processes. Representatives of 10 hospitals explained that financial assistance approval was based on a percentage of the Federal Poverty Level (FPL), and 32 specifically mentioned that income documentation was required. For example, a hospital offered 100% off for individuals under 200% of the FPL and 50% off for individuals between 200% and 300% of the FPL. Two hospitals accepted documentation of Supplemental Nutrition Assistance Program eligibility as automatic entry into the program. Fifteen hospitals required a rejection from Medicaid as part of their financial assistance application. Three hospitals required patients to live within a certain geographic area, near the hospital, to qualify.

Payment plans are offered at the majority of hospitals with variation in structure, eligibility, time frames, fees, and other attributes

Among the 204 hospitals from which we obtained at least partial information on our main outcomes, 195 (95.5%) offered in-house, hospital-administered payment plans and 39 (19.1%) offered third-party payment options (Figure 1). We were unable to obtain payment plan information from 3 (1.5%) of these 204 hospitals.

Third-party payment options included medical credit cards and interest-bearing products, as well as interest-free financing options from revenue cycle management companies. All hospitals from which we obtained data offered an in-house payment plan or a third-party payment plan, or both. Six hospitals offered a third-party payment plan and no in-house payment plan option, and 33 hospitals offered both an in-house payment plan and a third-party payment option. Two hospitals offered 2 different third-party payment options (data not shown).

Eight (20.5%) of the 39 third-party payment plans accrued interest or charged fees (Table 2). We received information on the maximum length of the third-party payment plans for 24 (61.5%) of these plans, and maximum lengths ranged from 6 months to 72 months with a mean of 39.9 months.

Twelve (6.2%) of the 195 in-house payment plans accrued interest or charged fees (Table 2). Of the in-house payment plans, 172 (88.2%) gave us information about the maximum available time frame of the plan. The maximum length ranged from 3 months to 60 months, with a mean of 24.5 months.

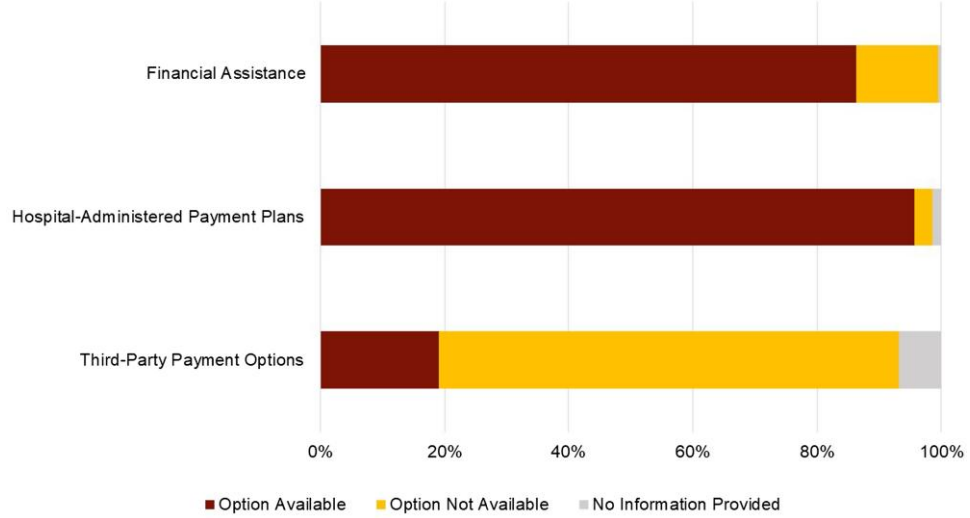

Figure 1. Financial assistance and payment plan offerings for insured patients undergoing elective procedures. Source: Authors' analysis of data from calls to hospitals conducted between June and November 2023. Percentages reported are based on the 204 hospitals with at least some information for our main outcomes.

Maximum repayment length often varied depending on the amount owed.

Of the 195 hospitals with in-house payment plans, 176 (90.3%) told us we could be approved for the plan before the procedure (data not shown). Some hospitals only offered in-house payment plans to certain patients; of the 195 hospitals with in-house payment plans, 172 (88.2%) were available for all patients, and 14 (7.2%) were means-tested (data not shown).

The application process for the third-party financing options varied. While not systematically asked, 27 hospitals told us that everyone was eligible for the third-party product while 2 hospitals had some form of qualification process. Two hospitals noted that there was a soft credit pull, and 4 explicitly gave reassurances that it would not affect credit. Some hospitals told us that an external extended payment plan option would become available after a few months enrolled in their in-house payment plan.

While payment plans were almost ubiquitous, systems for setting up payment plans and their operations varied widely. Some payment plans were standardized and available to all patients once they received a bill. Others required speaking with someone to set up an individualized plan; both the approval for a payment plan and the length of the plan would be determined on a case-by-case basis by a hospital representative. Sixteen hospitals required a down payment, often up to 50%, before allowing the rest of the bill to be paid in installments. Other hospitals had more generous policies: we were told by 12 hospitals that, as long as payments were made each month, the payment plan could go until the bill is paid.

As we inquired about payment plans, it was sometimes difficult to tell exactly where the lines between hospitals and outside companies were drawn. As hospital representatives described payment plans through third-party companies, it was often difficult to determine if the company was providing revenue cycle management for the hospital or offering a separate financial product. Some third-party companies seemed to be providing revenue cycle management services or technology services to facilitate online billing, while others may fully control patients' debt through loans and credit products.

Policies about upfront cost-sharing payments at the time of service differ across hospitals and circumstances

Cost-sharing was required to be paid upfront by an insured patient before an elective procedure at 41 (20.1%) of the 204 hospitals with information on some of our main outcomes (Figure 2). An additional 46 (22.5%) hospitals require patients to pay cost-sharing upfront under certain circumstances, while 39 (19.1%) hospitals told us that patients were not required to pay upfront. At 54 (26.5%) hospitals, representatives referred us to another department for information, such as preregistration, scheduling, or the price estimation line. We code these as "referred to another department" because it was generally challenging to gather information from these other departments without being an actual patient. At 24 (11.8%) hospitals, we were unable to obtain information about upfront payment requirements and were not referred.

Representatives framed requirements for upfront payments in various ways. Twenty hospitals explained that upfront payment was requested but could be billed later if the patient was unable to pay on the day of service. Requirements sometimes depended on the specific insurance plan, physicians, and procedure. Twenty-two hospitals reported that a cost-sharing amount was due before the procedure based on the price estimate, often 50% of estimated cost-sharing. Seven hospitals told us that upfront payment was not required for patients with insurance but may be required for uninsured patients.

Discussion

This secret-shopper study identified administrative burdens for patients seeking financial assistance and planning information from hospitals, including the 18.1% of hospitals in our sample where a hospital representative was unreachable after 3 attempts. The application and approval process for financial assistance varied significantly, and less than half the hospitals in this study that offered financial assistance indicated that a patient could be approved for financial assistance before the procedure. Overall, the hospitals we called were not set up to provide patients with all of the financial information they

Table 2. Hospital-administered and third-party payment plan characteristics.

Payment plan characteristics	Hospital administered payment plans ($n = 195$)		Third-party payment plans ($n = 39$)	
	n	**(%)**	***n***	**(%)**
Plan accrues interest or charges fees				
Yes	12	(6.2)	8	(20.5)
No	174	(89.2)	29	(74.4)
Unknown	9	(4.6)	2	(5.1)
	Mean	**(SE)**	**Mean**	**(SE)**
Maximum length of payment plan (months)	24.6	(14.7)	39.9	(19.0)
	Min	**Max**	**Min**	**Max**
	3	60	6	72

Abbreviations: Max, maximum; Min, minimum.
Source: Authors' analysis of data from calls to hospitals conducted between June and November 2023. Information on maximum length available for payment plan was available for 172 hospital-administered payment plans and 24 third-party payment plans. The minimum and maximum values describe the range of observations for each hospital's maximum length of payment plan reported in months.

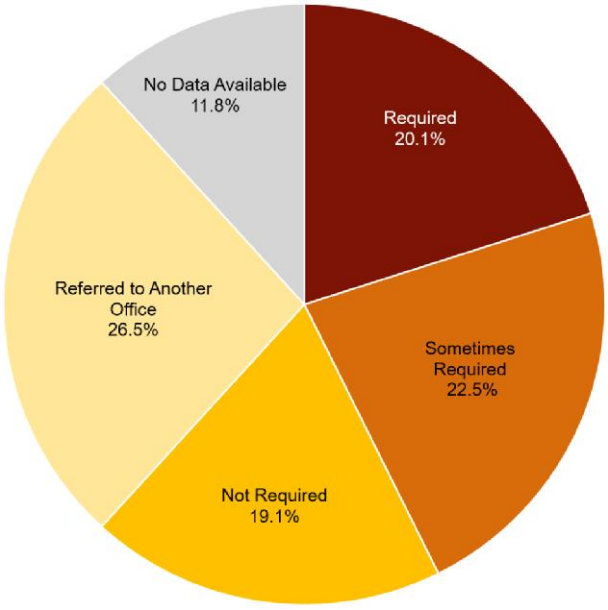

Figure 2. Hospital upfront cost-sharing payment requirements for insured patients undergoing elective procedures. Source: Authors' analysis of data from calls to hospitals conducted between June and November 2023. Percentages reported are based on the 204 hospitals with at least some information for our main outcomes.

need at 1 consumer-facing point of contact. Patients could benefit from a centralization of financial services and applications within hospitals.

Several recent reforms attempting to address the affordability of health care have targeted the price negotiated between hospitals and insurers, including price transparency policies. This study demonstrates that it is common for hospitals to offer payment assistance options to insured patients, indicating that these patients may not be required to pay their cost-sharing in full, or at least not promptly. This indicates that negotiated prices are an overestimate of hospitals' received revenue for a given service to insured patients. Policymakers and researchers should be aware of this divergence between negotiated prices and actual collected revenue when analyzing negotiated price data. The variation in payment plan timelines also suggests that some hospitals may be able to tolerate longer accounts-receivable timelines, while others may have a more constrained cash flow.

There are many established suggestions for reducing underinsurance. Researchers have shown that the immediate expansion of Medicaid in 2014 under the Affordable Care Act reduced medical debt in collections by an average of 44% over 7 years, and there are 10 states that have not yet adopted Medicaid expansion.[11] Additionally, 13 states mandate that hospitals screen patients for eligibility for a variety of programs, including Medicaid, other insurance, and the hospital's charity care and discount programs.[12] Fifteen states have policies regarding disclosure of charity care policies prior to collecting payment and when attempting to collect on a bill, which some states already require.[12] Colorado is the first state to require health care facilities to offer patients payment plans that do not exceed 4% of their monthly income.[13] In Oregon, beginning July 1, 2024, hospitals must refund patients who have already paid their bill if the patient applies for financial assistance after paying their bill but is found to have been eligible for assistance when the service was provided.[13] Furthermore, insurers could set rolling or monthly cost-sharing limits, rather than annual, to reduce patients' risk of owing a very large sum all at 1 time.[14,15]

Additionally, policymakers could expand price transparency regulations to include details about prompt pay discounts, financial assistance options, and payment plans. Patients currently have to make phone calls and typically speak with multiple hospital representatives to acquire this information. These burdensome encounters could exacerbate existing inequalities if patients who are less proficient in navigating administrative red tape cannot access important information about payment options. Increased transparency could enable patients to plan and manage their health care bills more effectively and promote equity. Notably, such transparency would not directly lower the cost of providing health care nor reduce the population of underinsured people.

Limitations

Our study is limited in 3 ways. First, our sample size is small as we balanced feasibility of data collection while striving for

generalizability. Second, we only interacted with hospital facilities, not surgeons, other professionals, or pre- and post-operative services. This understates the financial burden and administrative challenge for patients. Third, we could not contact pre-registration or scheduling departments, since we did not have a referring physician or more specific insurance information as secret shoppers, but we were referred to them on several occasions for questions regarding upfront payment requirements. We did not specify a health plan due to the difficulty identifying in-network, high-deductible health plans at each hospital.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

Notes

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