Patient Financing for High-Deductible Health Plans: Protecting Revenue as Out-of-Pocket Costs Rise

Author: Gary Johnson, Chief Growth Officer, Curae
Reading Time: Approximately 10 minutes

Quick Answer

High-deductible health plans now cover more than half of all American workers with employer-sponsored insurance, and the IRS raised the HDHP out-of-pocket maximum to $17,000 for family coverage in 2026, up from prior year limits. For health systems, this means a growing share of commercially insured patients present for care with financial obligations they cannot absorb at the point of service, creating patient responsibility balances that traditional collection models can't recover. Health systems that offer structured patient financing at or before the point of service convert these balances into funded receivables before they age into bad debt, protecting revenue that the HDHP environment is actively eroding. CURAEPay, the patient financing solution managed by Curae, offers qualifying patients a revolving line of credit of up to $10,000 at 0% APR, with more than 90% of applicants approved, full upfront funding to the health system within 48 hours, and all credit risk transferred to Curae on a fully non-recourse basis.

2026 Changes and What they Mean for Your Revenue Cycle

The financial pressure that high-deductible health plans place on health system revenue is not new. HDHPs have been growing as a share of employer-sponsored coverage for more than a decade, driven by employers seeking to reduce premium costs by shifting financial responsibility onto employees. What changed in 2026 is the size of that responsibility.

The IRS raised the HDHP out-of-pocket maximum to $17,000 for family coverage and $8,500 for self-only coverage in 2026, the highest levels in the history of the HDHP framework. This means a commercially insured family experiencing a significant medical event, like surgery, a hospitalization, or a cancer diagnosis can now face up to $17,000 in patient financial responsibility *before* their insurance begins covering the full cost of care. For self-only coverage, the cost is $8,500 *before* insurance.

This is happening in real time. According to the Kaiser Family Foundation's 2024 Employer Health Benefits Survey, more than half of all covered workers are now enrolled in high-deductible health plans. This means most of the commercially insured patients a health system serves are enrolled in plans that expose them to thousands of dollars in out-of-pocket costs before their coverage provides meaningful financial protection, and even once insurance does activate, out of pocket costs can still compound for some patients with ongoing treatment plans.

Patient responsibility balances are growing in both size and volume. The balances are generated from commercially insured patients, meaning they pass through eligibility verification without triggering a charity care screening and appear on the health system's books as insured accounts. However, their actual financial capacity to pay their portion of the balance is often no greater than a self-pay patient, because their deductible has not been met, their out-of-pocket maximum is far from reached, and their household budget does not have $5,000 or $10,000+ available for an unexpected medical expense.
The result is a structural mismatch between how these patients appear in revenue cycle workflows and what you can realistically collect from them. Addressing that mismatch is crucial and requires a financing solution, not a collection strategy.

The HDHP Collection Problem by the Numbers

According to the Healthcare Financial Management Association, health systems collect only 30% to 50% of what patients owe on average, and patient responsibility now represents more than 30% of total net patient revenue. These figures were established before the 2026 HDHP out-of-pocket maximum increase took effect. As deductibles and out-of-pocket maximums grow, the average patient responsibility balance per account grows with them, but the collection rate on those larger balances declines.

The Kaiser Family Foundation reports that 41% of American adults carry healthcare debt. A meaningful share of that debt is held by commercially insured patients who were enrolled in high-deductible plans when they received care and could not pay the patient responsibility portion of their balance. These are not uninsured patients. They are insured patients whose coverage structure left them with a financial obligation they could not meet. For health systems, the practical consequence is that growing HDHP enrollment is creating a growing population of commercially insured patients with self-pay-like collection dynamics. These patients generate claims that are processed and adjudicated normally. The payer pays its share and patient

responsibility balance lands on the account. The collection rate on that balance then reflects the patient's financial reality, not their insurance status. Kaufman Hall's annual hospital performance data consistently shows that U.S. hospitals operate on 1% to 3% margins. In this environment, the difference between collecting 35% and 50% of patient responsibility is not a marginal performance improvement. It is the difference between operating in the black and absorbing structural losses that compound over time.

Why Traditional Collection Approaches Fail HDHP Patients

The traditional medical billing collection sequence was designed for a patient population with modest, predictable out-of-pocket obligations. A patient with a $200 copay who did not pay within 30 days could reasonably be assumed to have the capacity to pay if contacted effectively. Send a statement. Send a reminder. Call the patient.

An HDHP patient with a $4,500 deductible balance does not respond to this sequence for a different reason: not lack of awareness, but lack of financial capacity. The patient knows they owe the balance. They received the statement. They are not paying because $4,500 is not available in their household budget on any timeline that traditional collections are designed to accommodate.

The three structural failures of traditional collection approaches in the HDHP environment are well documented.

Statements and reminders do not resolve the inability to pay. A patient facing a $4,500 deductible balance who receives three billing statements over 90 days is not more likely to pay at statement three than at statement one. Statements don't create awareness of an obligation the patient didn't know about; they create friction and anxiety around an obligation the patient knows they cannot meet. The result is disengagement, care avoidance, and eventual account aging.

In-house payment plans do not accelerate cash or transfer risk. A patient who agrees to pay $200 per month on a $4,500 balance will take nearly two years to pay it off, generating no upfront cash for the health system and retaining 100% of the default risk. When the patient defaults, which happens frequently on balances of this size, the health system absorbs the full remaining balance as bad debt.

Third-party collections recover pennies on the dollar. Third-party collection agencies typically charge 25% to 40% of recovered balances as their fee, and

their recovery rates on high-balance HDHP accounts with low propensity to pay are materially lower than their recovery rates on smaller, older accounts. After fees and low recovery rates are applied, the net recovery on a $4,500 HDHP balance sent to collections is often less than $500. The health system has absorbed more than $4,000 in bad debt and damaged the patient relationship in the process.

None of these failures are addressable through better execution of the same approach. They are failures of a model applied to a patient population it was not designed to serve.

The Financing-First Response to HDHP Patient Responsibility

The operational response to the HDHP collection problem is not a better collection strategy. It is a financing strategy that converts patient responsibility balances into funded receivables at or before the point of service, before they enter the collection cycle.

The logic is straightforward. A patient who cannot pay a $4,500 deductible balance in full at the point of service can, in many cases, pay $150 to $200 per month over 24 months. The obstacle to payment is not willingness. It is the requirement to pay a large sum at once. Patient financing removes that obstacle by spreading the payment over time at no additional cost to the patient, while delivering full upfront funding to the health system immediately. Under CURAEPay's model, the operational sequence works as follows.

Before or at the point of service, the patient is offered a revolving line of credit of up to $10,000 through a short digital application that takes minutes to complete. A light credit review, which does not affect the patient's credit score, determines eligibility. Ninety percent or more on average are approved, including patients with limited or challenged credit histories that standard medical credit card underwriting would decline.

Upon approval, the patient receives a provider-branded revolving line of credit to pay the current balance and any future balances at the same health system, without reapplying for each episode of care. For an HDHP patient who will accumulate multiple balances throughout the year as they work toward their out-of-pocket maximum, this single-application structure removes the friction of repeated financing applications at each encounter.

Within 48 hours of account financing, the health system receives full upfront funding for the patient's balance. The account is removed from the AR aging

cycle. The health system's cash position improves immediately, without waiting for the patient's repayment timeline.

After funding, Curae manages all patient repayment, customer service, and account servicing. All credit risk transfers to Curae permanently on a non-recourse basis. If the patient does not repay, Curae absorbs the loss. The health system's revenue is protected regardless of the patient's subsequent repayment behavior.

The 2027 Outlook: Why This Problem Is Getting Worse

The 2026 HDHP out-of-pocket maximum increase is not the end of the trend. It is a data point in an accelerating, multi-year trajectory.

PwC projects a 9% group medical cost trend for 2027, the highest in nearly two decades. As employer healthcare costs rise, the pressure on employers to shift more cost-sharing onto employees intensifies. Mercer projects employer cost per employee could top $20,000 in 2027, and 48% of large employers are planning plan design changes for 2027 that raise employee deductibles and copays. Each plan design change increases the patient responsibility a commercially insured patient generates when they seek care, and each one widens the gap between what the patient owes and what they can pay without a financing solution.

Health systems that implement a patient financing infrastructure now will be positioned to absorb the 2027 cost environment without absorbing the bad debt it would otherwise produce. Health systems that continue to rely on traditional collection approaches will find that the bad debt growth produced by the 2027 HDHP environment compounds on top of the losses already being generated by the 2026 out-of-pocket maximum increase.

What HDHP Patient Financing Looks Like for the Patient

The patient experience dimension of HDHP financing is as important as the financial one, and health system revenue cycle strategy often underweights it.

An HDHP patient who receives a $4,500 statement 30 days after discharge and has no financing option faces a binary choice: pay a sum they do not have or ignore the bill and absorb the credit and relationship consequences. Most choose the latter. The health system loses current revenue and the patient relationship, which can cost future revenue, at the same time.

The same patient, who is offered 0% APR financing at or before the point of service, faces a different choice: pay $150 per month over 24 months at no additional cost, or pay nothing and risk their relationship with a health system that just demonstrated it understood their financial situation and tried to help. Most choose the former.

Curae tracks NPS on its patient financing program, and health systems implementing CURAEPay consistently report a 30-point improvement in NPS scores on the financing experience itself. The financing offer is not just a revenue recovery tool. It is a patient retention tool and a loyalty driver that operates through the same mechanism as any other positive patient experience: the health system treated the patient with respect and provided a practical solution at a moment of need.

Key Takeaways

- The IRS raised the HDHP out-of-pocket maximum to $17,000 for family coverage and $8,500 for self-only coverage in 2026, the highest levels in the history of the HDHP framework, meaning commercially insured patients can now face tens of thousands of dollars in patient financial responsibility before their coverage provides full protection.
- More than half of all covered workers are enrolled in high-deductible health plans, making HDHP patient responsibility the dominant patient financial challenge in health system revenue cycles.
- Traditional collection approaches, including statements, in-house payment plans, and third-party collections, fail HDHP patients not because of poor execution but because they are structurally misaligned with a patient population whose obstacle to payment is financial capacity, not awareness.
- CURAEPay's financing-first model converts HDHP patient responsibility balances into funded receivables at or before the point of service, delivering full upfront funding to the health system within 48 hours and transferring all credit risk to Curae permanently on a non-recourse basis.
- A single revolving line of credit of up to $10,000 covers all balances at the same health system without reapplication, eliminating the financing friction that compounds across multiple HDHP encounters throughout the year.
- The 2027 cost environment, including a projected 9% medical cost trend and employer plan design changes raising employee cost-sharing will deepen the HDHP patient responsibility challenge. Health systems with a patient financing infrastructure in place now will absorb the 2027

environment without absorbing the bad debt it would otherwise produce.

Frequently Asked Questions

What is the HDHP out-of-pocket maximum for 2026? The IRS set the HDHP out-of-pocket maximum at $17,000 for family coverage and $8,500 for self-only coverage in 2026, the highest levels in the history of the high-deductible health plan framework. These limits represent the maximum amount a patient enrolled in an HDHP can be required to pay in covered out-of-pocket costs in a plan year, not including premiums. For health systems, the increase means commercially insured patients can now face patient responsibility balances of up to $17,000 per family per year before their insurance begins covering the full cost of care.

Why do high-deductible health plans create a revenue cycle problem for hospitals? High-deductible health plans create a revenue cycle problem because they shift significant financial responsibility onto patients who may not have the financial capacity to meet that responsibility at the point of service or within standard billing cycles. A commercially insured patient enrolled in an HDHP appears as an insured account in eligibility verification workflows, but their actual collectability may be no greater than a self-pay patient because their deductible has not been met and their household budget does not have thousands of dollars available for an unexpected medical expense. Health systems collect only 30% to 50% of what patients owe on average, and HDHP balances are among the hardest to collect using traditional approaches.

How does patient financing help health systems collect HDHP balances? Patient financing converts HDHP patient responsibility balances into funded receivables at or before the point of service, before they enter the collection cycle. Rather than sending a statement for a $4,500 deductible balance and waiting for the patient to respond, a health system that offers 0% APR financing at scheduling or registration converts that balance into immediate cash. The patient pays $150 to $200 per month at no additional cost. The health system receives full upfront funding within 48 hours. The financing company assumes all credit risk. The balance is removed from the AR aging cycle entirely.

What percentage of workers are enrolled in high-deductible health plans? According to the Kaiser Family Foundation's 2024 Employer Health Benefits Survey, more than half of all covered workers with employer-sponsored health insurance are enrolled in high-deductible health plans. This makes HDHP

enrollment the majority experience for commercially insured patients, not an edge case. For health systems, this means most commercially insured patients they serve are enrolled in plans that expose them to high out-of-pocket costs before coverage provides full protection, making patient financing infrastructure a mainstream revenue cycle requirement rather than a supplemental tool.

What is 0% APR patient financing and how does it work for HDHP patients? Zero percent APR patient financing offers qualifying patients a line of credit to pay healthcare balances over time with no interest charges. The patient repays exactly what was borrowed, with no additional cost regardless of the repayment timeline. For an HDHP patient facing a $4,500 deductible balance, 0% APR financing converts an unmanageable lump sum into a manageable monthly payment, typically $150 to $200 per month over 24 months, at no additional cost to the patient. The health system receives full upfront funding immediately. The patient avoids the credit and relationship damage of an unpaid balance.

How does CURAEPay handle multiple HDHP balances throughout the year? CURAEPay issues a revolving line of credit of up to $10,000 that covers all patient balances at the same health system without requiring a new application for each episode of care. For an HDHP patient who accumulates multiple balances throughout the year as they work toward their out-of-pocket maximum, this single-application structure means the financing relationship established at the first encounter automatically supports all subsequent encounters within the credit limit. The patient does not face a new application process at each visit, and the health system does not face a new financing decision on each account.

What is the 2027 outlook for HDHP patient responsibility and health system collections? PwC projects a 9% group medical cost trend for 2027, the highest in nearly two decades, driven by rising pharmacy spend, AI-enabled provider revenue optimization tools, and behavioral health utilization growth. In response, 48% of large employers are planning plan design changes for 2027 that raise employee deductibles and copays, directly increasing the patient responsibility balance that commercially insured patients generate when they seek care. Mercer projects employer cost per employee could top $20,000 in 2027. Each of these changes deepens the gap between what HDHP patients owe and what they can pay without a financing solution, making patient financing infrastructure more critical to health system revenue performance in 2027 than it is today.

How quickly does CURAEPay fund a health system after a patient account is financed? Health systems receive full upfront funding within 48 hours of account financing through CURAEPay. The financing is provided on a fully non-recourse basis, meaning all credit risk transfers permanently to Curae at the time of funding. The health system retains the revenue it received and has no further financial obligation related to that account, regardless of whether the patient repays. This converts HDHP patient responsibility balances that would otherwise sit in AR aging buckets for 90, 180, or 360 days into immediate cash without balance-sheet exposure or reserve requirements.

References and Sources

1. Internal Revenue Service. *Revenue Procedure 2025-19: HSA and HDHP Inflation Adjustments for 2026.* IRS, 2025. https://www.irs.gov/pub/irs-drop/rp-25-19.pdf
2. Kaiser Family Foundation. "2024 Employer Health Benefits Survey." KFF, October 2024. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/
3. Healthcare Financial Management Association. "Patients as Payers: Five Ways to Improve the Patient Experience." HFMA, February 10, 2023. https://www.hfma.org/revenue-cycle/patients-as-payers-five-ways-to-improve-the-patient-experience/
4. Kaiser Family Foundation. "Health Care Debt in the United States." KFF Health Care Debt Survey, June 2022. https://www.kff.org/health-costs/report/kff-health-care-debt-survey/
5. Kaufman Hall. *National Hospital Flash Report.* Kaufman Hall Annual Hospital Performance Data, 2024. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report
6. PwC Health Research Institute. "Medical Cost Trend: Behind the Numbers 2027." PwC, June 2026. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html
7. Mercer. "Large U.S. Employers Expect Health Benefit Costs to Jump in 2027." Mercer National Survey of Employer-Sponsored Health Plans, June 2026. https://www.mercer.com/en-us/insights/us-health-news/large-us-employers-expect-health-benefit-costs-to-jump-in-2027/
8. American Hospital Association. *Uncompensated Hospital Care Cost Fact Sheet.* AHA Annual Survey Data. https://www.aha.org/fact-sheets/2021-01-07-uncompensated-hospital-care-cost-fact-sheet
9. Curae. *CURAEPay Patient Payment Financing Platform: Outcomes Data.* Internal program performance data. Curae Finance, LLC, 2025.

Curae® is a registered trademark of Curae Finance, LLC. CURAEPay is the patient financing solution managed by Curae within its Patient Financial

Access Platform, which also includes CURAEAdvocate (ACA coverage access). Curae makes available approved credit lines issued by a federally regulated bank to patients, operating under Regulation B and Regulation Z. To learn how CURAEPay can protect your health system's revenue in the HDHP era, visit curae.com.