THE PRICE OF CARE

A HEALTHCARE LEADER'S GUIDE TO BUILDING TRUST THROUGH HEALTH INSURANCE AND FINANCIAL LITERACY

BRANDON EDWARDS
WITH KEVIN THILBORGER

THE PRICE OF CARE

A HEALTHCARE LEADER'S GUIDE TO BUILDING TRUST THROUGH HEALTH INSURANCE AND FINANCIAL LITERACY

BRANDON EDWARDS
WITH KEVIN THILBORGER

E-book ISBN: 979-8-234-00686-8
Paperback ISBN: 979-8-234-00685-1

DEDICATION

This book is dedicated to the men and women who lead payor relations and managed care strategy for hospitals, health systems, physician groups, and other healthcare provider organizations in the U.S. These professionals toil in one of the most challenging business environments in the nation, battling incredibly powerful payors for fair contract rates and language that keeps their doors open and their organizations sustainable. This often-thankless work requires incredible analytical ability, deep expertise, and negotiating acumen.

We feel lucky that we have worked with some of the best in the industry. A few of those many colleagues include Clint Hailey, John Brownlow, Michael McMillan, Michael Parkerson, Mark Carley, Debi Hueter, Stuart Kilpinen, Harpreet Cheema, Paula Claytore, Barbara Corey, Jeff Bross, Michael Troska, Paul Butler, Shannon Glover, Brad Sher, Sheri Haun, Judy Apland, Judy Mitzlaff, Diane Kazmierski, Philip Boyce, Jim Horrar, Douglas Sturnick, Gayla Harvey, and many others. Of course, they can only be effective with the help of top managed care attorneys and consultants, many of whom have been trusted partners and referral sources over the years.

CONTENTS

INTRODUCTION

THE CONVERSATION WE AVOID

Money conversations have always felt taboo in healthcare.

Today, hospitals are expected to publish prices, comply with price-transparency laws, and help patients understand their out-of-pocket financial responsibility. Yet any talk about cost or pricing still makes many leaders uncomfortable.

Many times we struggle with the fundamental question of whether to call something a cost or a price. The whole subject feels messy and complicated. For mission-driven organizations, it feels awkward—almost inappropriate—to talk openly about money when your purpose is caring for people.

The reality, though, is that patients are already having the money conversations. Or worse, they are afraid and avoid care because of cost. KFF estimates that the cost of copayments and deductibles for a family was $3,564 in 2025.[1] The only question is whether we will join those conversations or start them when they aren't happening.

People are talking about it in living rooms, in break rooms at work, in whispered exchanges in hospital hallways, and on social media threads full of fear, frustration, and misinformation.

For millions of Americans, financial uncertainty (instead of real clinical health needs) determines whether they seek care at all. This reality has created the single biggest access crisis of our time. It's an access problem created by the financial complexity and uncertainty that permeates the healthcare system.

Financial issues are access issues.

Across the country, patients are delaying MRIs, abandoning physical therapy, declining procedures, and ignoring preventive screenings. It's not because they don't think they need them, but because they don't know whether they can afford them. They're confused by insurance, terrified of surprise billing, and not sure whom they can trust. Many believe (often correctly) that they won't get a clear answer even if they decide to ask.

Meanwhile, hospitals and health systems—organizations built on compassion, service, and mission—usually avoid these conversations entirely. We hide behind complexity, which is a real problem. Yet the need to simplify the complexity and communicate clearly doesn't go away. Healthcare executives do this, not because they don't care, but because they don't feel confident or empowered to speak into the financial side of care without sounding overly transactional or less than mission-driven. Or maybe because they are just afraid of getting it wrong.

The result is a widening gap between what healthcare brands say (we care and we're here for you) and what patients experience (confusion, uncertainty, and financial strain). This gap is what we call the *financial blind spot*, and it's eroding trust faster than any clinical mistake or missed diagnosis ever could.

In our previous book, *Authentic Healthcare Marketing*, we argued that effective healthcare marketing in the post-truth era requires authenticity and a willingness to change messengers, messages, and channels to connect with 100% of the people we can possibly reach as part of our mission. We define Authenticity as honesty, empathy, and clarity rooted in an organization's mission and values. We also introduced a framework to help healthcare leaders reach today's skeptical audiences by speaking human truths, delivering meaningful messages, earning belief, and building trust.

The Price of Care is the natural extension of that work. If *Authentic Healthcare Marketing* was about what authenticity requires, this book is about the place where authenticity is most urgently needed—and most often missing: *financial education and communication*. This is a real gap that can be filled now, and the organizations that fill that gap will cement a leadership position in their markets and in the industry.

WHEN PRICE BECOMES THE BARRIER TO CARE

In this book, the core problem we're addressing is that *financial issues are access issues*.

In today's system, reputation cannot be separated from financial clarity. You may have the most advanced clinical capabilities and the most empathetic nurses in your region. However, none of that matters if people are too afraid of the bill to walk through your doors. The giant sign on the front of your building and your website says "Stop: Financial Danger."

Over the last fifteen years, insurance companies shifted massive financial responsibility onto consumers under the guise of "consumer-directed health care" (CDHC) without giving them the tools, education, or support to manage it. We asked people to shop for care without educating them about the products or explaining how prices

work. Our perspective is that healthcare is not a commodity. Price is not the only differentiating factor between similar health services delivered by different providers.

While we have developed transparency tools for price, the healthcare "shopper" does not have access to compare data regarding the percentage of accuracy of a provider's diagnoses or appropriateness of a provider's treatment. Health insurance cards full of acronyms that few people understand started to become the map people used to navigate a highly complicated system—with all of the risk but very little guidance.

The result is a system where financial fear trumps clinical advice. Too many people believe that any engagement with the healthcare system threatens their financial stability, and in many cases, they are right.

Hospitals and health systems did not create this dysfunctional environment, and they cannot fix the national system alone. Yet they *can* fix something that is squarely within their control: the way they communicate about money.

This is not just a financial issue—it's a *brand* issue, a *mission* issue, and ultimately an *access* issue. That makes it too important to ignore any longer.

WHY WE WROTE THIS BOOK

We wrote this book for the same reasons we wrote the last one: because we've seen the consequences of getting this wrong. We are missing an opportunity, and people may not have the access they need as a result.

For more than thirty years, we've worked at the intersection of healthcare marketing, strategy, finance, and access. We've seen the system from every angle—brand strategy, crisis communication, operational leadership, and patient experience. And we know how much people who work in healthcare really, really care about the people they serve.

Time and again, we have watched people delay or avoid essential care because no one helped them understand the costs or navigate insurance. We've seen patients choose less-capable providers because they perceived them as more affordable. We have also watched great organizations lose trust because they didn't know how to talk about price.

We don't like to admit it, but the truth is pretty simple: *we cannot serve patients well if we ignore the part of care they talk about least*. We cannot count on payors to solve this problem because they have a financial incentive to leave things murky and scary.

Patients don't just need clinical guidance—they need *financial* guidance. They need leaders who are willing to speak honestly, clearly, and empathetically about the real costs of care, the available options, and the steps they can take to protect themselves. They need to understand why we invest in what we do, why things cost what they cost, and what we do every day to address those high costs.

And perhaps most of all, they need organizations willing to bring transparency to a system that has grown increasingly opaque over the last few decades.

HOW THIS BOOK CAN HELP YOU

We've written this book for healthcare leaders (CEOs, CFOs, CMOs, board members, and marketing executives) who understand that trust is the foundation of every health system's mission. Specifically, we want to help you:

- Recognize affordability as a strategic and mission-critical challenge.
- Integrate authentic financial education and communication into your brand strategy.
- Equip your teams to have honest, empathetic conversations about cost and coverage with significant training and education.

- Build trust, loyalty, and access by removing the fear and confusion that surround healthcare pricing.
- Establish context for future payor negotiations, especially those difficult negotiations that occasionally become visible PR issues.

Unlike most healthcare marketing books, this one tackles the most avoided topic in medicine: *money*. It blends empathy with economics, marketing with finance, and authenticity with leadership. The good news is that you don't need a perfect system to do this well. You only need a willingness to lead.

In Part One, we'll explore the financial access crisis and why healthcare organizations have avoided this conversation for so long. In Part Two, we'll present a framework for authentic financial communication—practical, actionable, and grounded in human behavior. Then in Part Three we'll look at the leadership imperative: how financial transparency strengthens mission, brand, and community trust.

If we keep avoiding this topic, the trust deficit will only grow. Yet if we confront it with authenticity, we can reshape the way people experience and access care.

We'll begin in Chapter One by understanding just how deep the financial crisis really runs.

ENDNOTE

1 Health System Tracker, "How Much Do People with Employer Plans Spend Out of Pocket on Cost Sharing?", accessed via https://www.healthsystemtracker.org/chart-collection/how-much-do-people-with-employer-plans-spend-out-of-pocket-on-cost-sharing/.

PART 1

THE PROBLEM— FINANCIAL FEAR AND THE TRUST DEFICIT

CHAPTER ONE

THE FINANCIAL ACCESS CRISIS

For many years, when people talked about "financial issues" in healthcare, they typically meant one of two things.

First, it could mean a problem between the health insurance company and the provider: *What does my contract say? Am I being paid accurately? Is this patient covered by their insurance? Am I making margin on this business?*

Or second, it could mean a problem between the provider and the patient after the fact: *You've been here, you've received services, I've now sent you a bill. And if I don't collect against that bill, I'm going to have to charge the patient the full amount or write it off as bad debt.*

Both of those things are still true. However, in the last several years, a widespread problem has emerged. The uncertainty around what care will cost, what insurance will cover, and how big the bill might be is keeping people from seeking care in the first place.[1]

For example, the Kaiser Family Foundation reports that "The cost of health care can lead some to put off needed care. About one-third (36%) of adults say that in the past 12 months they have skipped or postponed getting health care they needed because of the cost. Notably three in four (75%) uninsured adults under age 65 say they went without needed care because of the cost... Notable shares of adults say they are worried about affording medical costs such as the cost of health care services (including out-of-pocket costs not covered by insurance, such as copays and deductibles) or unexpected bills. About six in ten adults say they are either 'very' or 'somewhat worried' about being able to afford the cost of health care services (62%) or unexpected medical bills (61%) for themselves and their families."

These fears create a ripple effect.

Financial issues are not just back-end problems in the revenue cycle. They are an impediment, a roadblock, to people seeking the care they need.

People are self-diagnosing the severity of their illness or injury and quietly asking themselves, "Is this really worth me taking the financial risk of seeking care?" This problem has only intensified in the last five to ten years as the so-called consumer-directed health plans have increased deductibles and copayment. As far as we can tell, almost no one in the broader healthcare system is doing anything to solve it.

That's why in this chapter, we want to define the problem as clearly as possible: what the access crisis caused by financial issues looks like, how it shows up in real people's lives, and how it erodes trust in healthcare organizations even when those organizations believe they are doing everything right.

RESPONSIBILITY WITHOUT TOOLS

If we step back and look at the U.S. healthcare system, here's what we see. We have shifted an enormous amount of financial responsibility

onto patients/consumers, but we did not give them the tools, education, or support they needed to handle that responsibility. We assumed incorrectly that employers and health plans would own the accountability for educating *patients o*n the changes and what to expect.

After all, these parties created the benefits and the plans that employers then bought to "save money and have their employees have some skin in the game." The CDHC revolution of two decades ago has morphed in a way that has not helped consumers, their families, or healthcare providers. Rather, due to avoidance of needed care, including physicals and routine diagnostics, there were short- term gains by insurance companies and employers but long-term losses.

Once upon a time, the model was basically that consumers received the care they needed, and then they figured out what they were going to owe out of pocket. There were flaws in that model, but at least the financial piece was not the primary gatekeeper. In fact, the rise of deductible/coinsurance-style plans changed all that. In employer-sponsored insurance, 46% of employees are covered under a high-deductible health plan, according to Kaiser Family Foundation.[2] And on the exchanges, 7.27 million people chose a bronze plan, which is a type of high-deductible health plan.[3]

People buy what they can afford without knowing the long-term consequences then cower at the prospect of their out-of-pocket financial responsibility.

Today, the cost has skyrocketed and there is a huge amount of uncertainty about whether something is going to be covered or how much it's going to impact out-of-pocket financial responsibility. As a result, people are increasingly looking at healthcare through a financial lens more than a clinical or quality lens.

You've likely heard people talk about CDHC or had conversations about it yourself. This refers to raising consumer cost-share with the

goal of encouraging them to compare prices when making healthcare decisions. The idea was to give people tools to make good choices and more control over their spending, which hopefully leads to better use of the system. This was all the rage in the early 2000s, before the big payors bought every company focused on CDHC.[4]

Of course, the research now shows that a primary—and realized—goal was to actually reduce healthcare spending. "Families enrolling in HDHPs or CDHPs for the first time spent 14% less than similar families enrolled in conventional plans. Families in firms offering an HDHP or a CDHP spent less than those in other firms. Significant savings for enrollees were realized only for plans with deductibles of at least $1,000, and savings decreased with generous employer contributions to healthcare accounts. Enrollment in HDHPs or CDHPs was also associated with moderate reductions in the use of preventive care." That last sentence seems particularly important.

As it turns out, we have given people significantly more responsibility and financial risk, and almost none of the information they need to effectively compare the cost. The irony is that many of the payors shifted their own risk onto patients, while also shifting quality outcomes to healthcare providers.[5] These shifts overestimate the general public's health literacy.

The amount of risk has far surpassed inflation as well. As the average American household median income in 2024 was $84,000, the post-tax income was about $73,000. If the average HDHP deductible for two or more people was $10,000 and the out-of-pocket max was $12,000-$15,000, then we are asking people to self-insure with approximately 15-20% of their total pre-tax income? How would a hospital or physician ever expect to collect such a balance in any given year? Moreover, it becomes abundantly clear that employers and insurers created these products to have people think at least once if not twice about whether they needed care or wanted it from a financial perspective.

A reasonable person would look at the above and say, "Well, it feels like either the government or health insurance companies should do something for people." But the reality is that neither really does.

So where does that leave people? It leaves them with an insurance card—assuming their carrier still issues printed cards—covered with phone numbers and acronyms that most of us don't really understand. That card is supposed to be the tool patients use to know what coverage they have. In practice, the system's complexity truly cannot be contained on a wallet-sized piece of plastic.

Right now, take a moment to pull out your own insurance card. Before you do so, do you actually know the name of your insurance company and what product you are on? When we make this point to others over dinner or drinks, almost all family members, friends, and peers fail to know the insurance product and only half remember who their insurance company is. Many often do not have the card on them or do not remember the password on the app to pull it up on their phones. Once you actually do look at the card and all the information contained therein, ask yourself, "Do I actually know what to do with all of this? Does my spouse or college-age dependent?"

When people are frustrated and confused, they weigh clinical possibility against financial reality. They look at their symptoms and don't ask how serious it is, but rather, is it serious enough to risk the cost of an ER visit or trip to the doctor. If they don't have good information, they often err on the side of not seeking care—including critically important preventative care. After all, they have checked WebMD and maybe Mayo Clinic or TikTok and decided they do not have something worth worrying about at this time. This will only be exacerbated with the onset of AI.

Most recently, at a Becker's CEO conference, we were speaking to a group of orthopedic leaders who noticed over the last two years that

their urgent cares had seen a 2% drop per year in urgent care visits. They asked if we thought it was a change in benefit plan design specific to urgent care. We shared it was more likely patients self-diagnosing and avoiding care for sprains or rolled ankles due to the ever-increasing costs.

When their front-line leader looked at the benefit plan designs, there wasn't a noticeable change in overall coverage. Thus, our insight was most likely correct. Patients were evaluating the injury and self-caring first before potentially seeking care immediately even with the onslaught of pickle-ball injuries. Meanwhile, there are no prices for care on the health insurance websites even though the health insurance companies have all the information.

Why? Because AHIP, Arnold Ventures, and other lobbying groups did an amazing job of convincing Congress and state legislatures that it was the duty of the healthcare provider or hospital and not the insurance company to explain the benefit and cost of care.

That is the first layer of the financial access crisis: we have asked people to act like informed consumers without giving them basic healthcare finance education and the tools to be informed.

PRIOR AUTHORIZATION, DENIALS, AND THE CULTURE OF DELAY

Even when people decide to enter the healthcare system, the financial access crisis follows them through every step.

One of the most obvious examples is prior authorization. Prior authorization was supposed to be about making sure that care is appropriate and necessary. In reality, it has become a major barrier to people being allowed to follow through on what their doctors recommend.

Here's a personal example. A close family relative went to the doctor because her shoulder had been hurting for some time. The doctor

examined her and said, "I think you have a torn labrum. We need to do an MRI." So the MRI was ordered and scheduled for two days later.

About four hours later, we got a call: Cigna had denied prior authorization for the MRI.

If she wanted to have the MRI without authorization, we were looking at about $650 out of pocket, versus a $200 copay if it were approved. So what did we do? We waited, and we waited, and waited some more. The doctor's office had to sort it out with the insurance company or the radiology benefit management (RBM) company that handles high-cost diagnostics. After three weeks or multiple interactions, the MRI was finally scheduled.

This is a relatively minor issue in the grand scheme of healthcare. Yet think about how absurd that situation is. She saw a doctor for pain she'd had for a long period of time. There was a preliminary diagnosis and imaging was ordered to confirm that diagnosis. But the insurance company simply said no. They made no suggestion for a different test that might be cheaper, the authorization was simply denied. Furthermore, it had to cost them a significant amount of money to have multiple interactions only to approve what had been requested originally.

What possible basis does an insurance company have to overrule what a physician has recommended for a patient they examined in person? Many of the insurance company contracts with physicians specifically say that nothing in the contract should be construed that the insurance company is practicing medicine and yet...

We know from the data that 94% of physicians say prior authorizations are causing their patients to delay, defer, or cancel recommended or needed care.[6] And almost 30% of physicians surveyed said that the delay in authorization resulted in significant harm to at least one of their patients. We also know that prior authorizations themselves have increased dramatically.

Strangely, it started not long after the pandemic. Most recently, the lobbying groups have convinced CMS that it is a good idea to ask for authorizations on certain services for traditional Medicare as well. Today, the average physician spends thirteen hours a week dealing with prior authorizations.[7]

That's over a day and a half each week they are spending to essentially ask permission to practice medicine. Many of our clients have also stated that most authorizations requested are ultimately approved. So what is the point in asking for the authorizations if most are approved? And now, with an aging population and increasing authorizations required, how will any practice manage to keep up?

Then there are denials, which have gone up dramatically over the last few years. Medicare Advantage denials, for example, increased 50% from 2022 to 2023, and commercial denials increased 22% in the same period.[8] Again, these started increasing dramatically after the pandemic. Many of our clients saw their denials go up from single to double digit percentages for the initial denials. Others watched as the Blues plans all decided that they needed medical records for every claim over $35,000. According to our research, denials are the highest in Medicaid, which means the socioeconomically disadvantaged people who rely on government assistance are more likely to have payment for their care denied than people with commercial insurance, Medicare, or Medicare Advantage.

Regardless of the insurance type, when a claim is denied, the patient is suddenly in the middle of a financial mess. They've already received the care and the provider has incurred the expense, or they are in need of treatment but their insurance company will not cover it. Now the insurance company has taken the position, "We're not responsible and we are not paying."

From the patient's perspective, every encounter with the system starts to feel like financial roulette. The provider then has three choices: write

it off as bad debt after numerous and laborious appeal processes, pursue the patient for payment, or withhold needed care from the patient.

Patients with denied claims that result in billing issues with their providers are less likely to seek care in the future. In addition, the patient's friends, family, and coworkers who hear the story may be more reluctant to seek care. There is that ripple effect again.

Prior authorizations and denials don't just frustrate patients and providers. They actively deter future needed care and make the financial access crisis that much worse. In addition to limiting access, these administrative barriers add stress to the entire cadre of people involved and the overall population cared for is actually less healthy than when the process started. The loss of trust also occurs when the service being requested has been pre-authorized and is then denied.

It is substantially more expensive for the employer when the payor is wrong in the denial as well.[9] Entire departments within the health system or physician office have been built just to collect the money that has been contractually agreed to. The waste is heartbreaking.

A recent example from Duke Health in North Carolina is revealing. Duke's CEO said, "At Duke, we employ 236 people full time to appeal all denials from payors, which is frankly outrageous and is not in the spirit of both parties partnering to provide value to beneficiaries, patients, communities. Finally, United Healthcare has been 57% slower to pay claims than our other payors and takes over 60 days to respond to claims they deny. Thus, Duke Health spends substantial time and money to collect payment that should have been made and made promptly." This kind of dysfunction, and all the costs and impacts that go with it, are not uncommon. In fact, they are commonplace.

The denial rate for authorization ranges from about 10% to 30% depending on the health plan. It is critical that purchasers of health

insurance obtain this data prior to selecting a plan. A "cheaper" plan that has a high denial rate will provide less coverage than a more expensive plan with a more reasonable denial rate. In the long run having less denials can result in a healthier workforce and will be less costly in the long run.

THE CONFUSING PRICE OF THE PATIENT JOURNEY

The financial barriers don't just show up at the point of prior authorization or denial. These barriers are present at every stage of the patient journey, which is increasingly financial as much as clinical.

At the very front end, before someone has even decided to see a doctor, they're trying to understand basic things like: *Which doctor or health system do I want to go to and is this physician or hospital in my network? What's my deductible? What is my annual out-of-pocket maximum? Will this be covered by my insurance?* Those terms are not well understood by most people, and yet we expect them to use that information to decide whether to seek care.

When people move from possibly needing care to picking a provider, the research is very clear: the single most important factor is, "Does this doctor take my insurance? Are they in the network of providers contracted by my insurance company?"

Patients are often not focused on more important questions such as: "Are they a good doctor?" or "Do they have great reviews?"[10] The number one question is, "Are they in-network with my insurance?" And the second is, "Can I get an appointment in a reasonable period of time?" People read reviews, and reputations matter, but only after the all-important pre-qualification of insurance network participation.

What constitutes a reasonable period of time is different depending on the cohorts of patients and the diagnosis the patients received or

think they may have. We often use the example of endocrinology when talking through this example. Even as an established patient with an endocrinology cancer diagnosis, a coworker had to wait nine months for an appointment for annual follow-up and even longer for the screening tests. When he received the original diagnosis and followed up on the mental health referral, he was told by the psych department that there was a five-year waitlist—yes, that's years, not months.

Then there is the question of what happens once a course of treatment is recommended. How much is that course of treatment going to cost? How long will it take? Does it cross over from one benefit plan year to another?

As you can imagine, an oncology diagnosis is stressful enough for the patient and their family members. Then, the course of treatment might be radiation or chemotherapy, and we have all heard the stories of how difficult such treatment can be.

Let's use chemotherapy as an example. Very few people start a six-month chemotherapy regimen saying, "Tell me exactly how much this is going to cost, and what happens after that." Even if a hospital can give some estimates for the services it provides, there may be three different doctors in three different settings, all billing differently. No one has a tool to say, "Here is what this is going to cost you, from beginning to end."

Price estimators help, but so does overall education and context setting. First, the employees of the health system would need to be schooled. And patients must understand there are impacts from the insurance company's payment systems, as well as the plan and product. Also, consider that no patient would likely opt for a cheaper but less effective care plan when they have cancer. Then, all of this language would need to be explained in layperson's terms. Unfortunately, there is very little data profiling outcomes by physician or by hospital.

Then we have the bill. If you've ever received healthcare services and then a bill from a hospital, you know exactly how confusing it can be. There's a long list of original charges, disallowed charges, amounts paid by the insurance, and amounts due from the patient. HFMA—the Healthcare Financial Management Association—has been working on bill simplification for many years, and yet we still don't have standardized bills that the average person can understand.

Savvy patients may compare bills from providers to Explanations of Benefits from their insurer, but most patients are not equipped to sort through the mountain of paperwork much less advocate for themselves should the bill be wrong. They don't know if their bill is accurate, and they certainly don't know what the codes mean, even with google or AI resources. They don't know what portion is their responsibility versus the insurer's responsibility. So they grab onto the only things they recognize—such as the $5 Advil tablet or the expensive box of tissues—because those are at least familiar. It's a pejorative example, of course, but you get the idea.

Price transparency regulations were supposed to fix some of this, but truly shoppable services represent only about five percent of total healthcare spend. What does a lower price mean? A better contract for a very few patients who are using any of the insurance company benefits ... or lower quality outcomes? How would the average person know? In reality, most of the tools out there are relatively unhelpful. You might feel comfortable shopping for diagnostic imaging and lab services, or a few very specific elective procedures. When it comes to drugs, only upon sticker shock do patients then shop among the pharmacies. In some cases, half the drugs are cheaper at one store and the other half at another chain. That's it.

The idea of shopping is problematic from the outset. People who need specialty services, imaging, and the like mostly take referrals from their

primary doctors. What we're talking about is creating education and awareness of what people are going to owe for their care. People shouldn't have to be actuaries to understand it. They also shouldn't be afraid of getting the healthcare services they need because of financial concerns.

Another recent example is an academic medical center (AMC) which employs physicians and refuses to use Quest or LabCorp for lab services. Thus, what could have cost $230 for routine panels costs $770 for a captive audience if they wish to seek those specialists for care. The AMC now has a perception issue that will be difficult to overcome when in-network labs are available. There might be strong quality or timing reasons for why this AMC refuses to allow use of Quest or LabCorp, but silence from the team there allows the patients to create the narrative of a wealthy population of physicians and executives only getting more so.

WHY THIS IS ULTIMATELY A MISSION PROBLEM

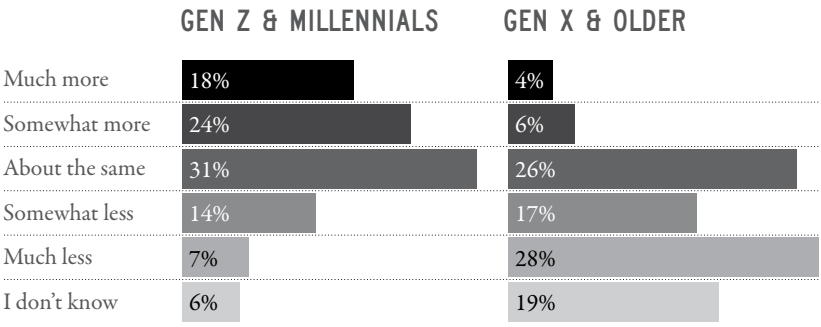
All of this leads to a simple but uncomfortable conclusion: if people are avoiding or delaying care because of financial fear and confusion, then the financial side of healthcare is no longer just a finance problem. It is a mission problem.

In *Authentic Healthcare Marketing*, we argued that if your mission is to serve your whole community, then you have to be willing to communicate with everyone, including the people you are not reaching today with your marketing. You need new messages, messengers, and channels to reach all audiences and fulfill your mission.

Data shows that roughly half of Gen Z trust their favorite influencers as much as they trust traditional sources of information. When your organization was founded many years ago, would your founders ever have thought that you would be fighting social media influencers for credibility or be responsible for explaining parts of the healthcare system out of your control? And yet, that is where we stand today.

The same logic applies here for those not seeking care in the immediate moment. There is a meaningful cohort of people who are not seeking care, or who are delaying care, because they do not understand what their out-of-pocket (OOP) financial responsibilities are going to be, and they don't want to get avoidable care that could bankrupt them. We have all seen the stories of balance billing for denied services that included putting liens on patients' homes or assets.

SURVEY: Compared to traditional advertising, how much do you trust product recommendations from creators and influencers Source: *The New Consumer*, November 2025



If your mission is to serve everyone, then you have to do a better job explaining financial issues to remove that barrier.

We want to be very clear: We are not saying healthcare organizations need to act now to make healthcare cheaper. That is a different problem that requires different solutions, and frankly, a different book. What we are saying is that regardless of what the price is, we have to do a better job removing the barrier that is created by uncertainty and fear.

Patients need more than just clinical guidance. They need education for the process and financial guidance. They need someone to say, "Here is how this works. Here is what you can expect. Here are the questions you should be asking. Here is the insurance you should choose should you wish to seek services here. Here is who you should ask."

When provider organizations fail to communicate about pricing and financial responsibility, they don't just risk bad debt or write-offs. They risk losing trust and patients and eroding their brand equity. They also create a perception in the marketplace that engaging with them is financially dangerous. This is particularly true when there is a perception that there are dollars spent on extravagant finishes, naming stadiums, and branding professional teams, all while the organization is listed as non-profit.

And that cuts directly against why most healthcare organizations exist in the first place.

So if the problem is so pervasive, why don't we talk about it more directly? Why does money still feel off-limits in healthcare conversations, even when we know that financial fear is keeping people away?

In the next chapter, we'll explore why we don't talk about money in healthcare and why continuing to avoid that conversation is no longer compatible with the mission that healthcare organizations claim to uphold.

ENDNOTES

1 Kaiser Family Foundation, "Americans' Challenges with Health Care Costs," https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.

2 Kaiser Family Foundation, "2025 Employer Health Benefits Survey," https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.

3 White House, "Expansion of HSA Eligibility under the OBBB Act to Improve Marketplace Coverage, Affordability, and Access," https://www.whitehouse.gov/research/2025/09/expansion-of-hsa-eligibility-under-obbb-act-to-improve-marketplace-coverage-affordability-and-access/.

4 See this article from 2011, which shows the intention was for CDHCs to spend less: Melinda B. Buntin et al., "The Benefits of Health Information Technology: A Review of the Recent Literature," *American Journal of Managed Care* 17, no. 3 (2011): 222–230, https://www.ajmc.com/view/ajmc_11mar_buntin_222to230.

5 Unlock Health, "Want to Fix Healthcare? Start with Health Literacy," https://unlockhealth.com/resources/blogs/want-to-fix-healthcare-start-with-health-literacy/.

6 American Medical Association, "AMA Survey Indicates Prior Authorization Wreaks Havoc on Patient Care," https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-indicates-prior-authorization-wreaks-havoc-patient-care.

7 American Medical Association, "Fixing Prior Authorization: Nearly 40 Prior Authorizations per Physician per Week," https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-nearly-40-prior-authorizations-week-way.

8 American Hospital Association, *Skyrocketing Hospital Administrative Costs: Burdensome Commercial Insurer Policies Are Impacting Patient Care* (2024), https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-Are-Impacting-Patient-Care.pdf.

9 Duke University Health System, "Duke University Health System Addresses UnitedHealthcare Negotiations," https://corporate.dukehealth.org/news/duke-university-health-system-addresses-uhc-negotiations; Becker's Hospital Review, "Duke Health CEO's Significant Concerns About UnitedHealthcare Contract," https://www.beckershospitalreview.com/finance/duke-health-ceos-significant-concerns-about-unitedhealthcare-contract/.

10 Whether they're in the network is the first consideration, but data show that people do read reviews when hunting for doctors. Repugen, "Statistics on Patient Reviews for Healthcare Professionals," https://www.repugen.com/blog/statistics-on-patient-reviews-for-healthcare-professionals.

CHAPTER TWO

WHY WE DON'T TALK ABOUT MONEY IN HEALTHCARE

Conversations about healthcare typically focus on issues such as quality, access, staffing, technology, community needs, and cost trends in general. Yet specific conversations about money are ones we typically avoid with our critical audiences.

Why? It's not because it's unimportant, but because it feels uncomfortable and complicated. In many cases, talking about financial topics seems contradictory to the mission-driven identity so many organizations in healthcare hold.

There is a cultural reluctance in healthcare organizations, especially nonprofits, to talk openly about cost, insurance, or financial responsibility. There's a sense that talking about money is somehow not "patient-first," or that it cheapens the noble motivations that bring people into the healthcare field.

That is an outdated notion, especially considering how the overall system has evolved. Families on high-deductible health plans are now responsible for 100% of the first $3,400-$17,000 of care.[1] Since it's their money, healthcare organizations must be willing to talk and educate patients on what may need to be paid. This discussion needs to happen with more compassion and empathy.

Many leaders and clinicians entered healthcare because they wanted to help people and still prefer to leave talk about deductibles or copays to the billing team. And yet, the cost of care is now top of mind for patients and their families at almost every step. It is not an afterthought or a side issue.

In many cases, it is *the* issue.

The result is a paradox. When providers avoid conversations about money, they believe they are being compassionate, coming from a place where they are trying to protect the patient. Yet in the end, that silence is exactly what fuels patient frustration, mistrust, and confusion.

If we want to fix the financial access crisis, we have to start by understanding why the conversation about cost and price feels so impossible in the first place.

THE CULTURAL AND MISSION-DRIVEN TABOO

One of the biggest reasons healthcare organizations don't talk about money is that we don't have a culture that supports those conversations.

Healthcare (especially nonprofit healthcare) has long been framed as a *calling*. People work in healthcare because they care about people, because they want to make lives better and solve meaningful problems. And in that mindset, money feels out of place. It feels crass and disconnected from the mission.

The same dynamic appears in the academic world. Professors talk about teaching, scholarship, ideas, and intellectual concepts. Yet college has become enormously expensive, and many professors remain insulated from any conversation about the cost. They're not the ones explaining tuition increases or financial aid. They're allowed to stay inside the "pure" world of ideas and hypotheses.

Yet healthcare is different. Patients cannot be insulated from the financial realities of care, both because the financial realities are everywhere and also because the consequences of the decisions—whether clinical or financial—are theirs. The cost of care is very high for a lot of reasons; it's the product of thousands of choices we have made about the U.S. healthcare system. It's confusing, hidden in layers of billing codes, insurance rules, benefit designs, and opaque processes. Patients feel the impact of those costs every moment they engage with the system.

The biggest irony is that many people in healthcare genuinely believe that avoiding conversations about cost is an act of compassion. They think: "We're here to care for people, not to talk about money. Talking about money might scare or discourage them."

The opposite is usually true. Avoidance creates confusion, which leads to fear. And fear drives people away from most things. Perversely, the very step we take to "protect" people causes them to avoid care and put themselves at risk.

Another cultural contributor is the nonprofit mindset. About half of U.S. hospitals are nonprofit, and with that comes a deep sense of mission. Leaders and staff talk about service, community good, and care for the vulnerable. Yet when financial issues become tangled and opaque, people inside the system feel unprepared. They don't know how to talk about something they don't fully understand, so they avoid talking about it at all.

Now imagine that a health system reports to a board of regents in a university setting. Based on the above, the academics in the university will often instruct the health system to avoid any such statements or positions when it comes to payor conversations, much less patient conversations. Thus, a much-needed campaign to notify the public about a tough negotiation may not occur, even if the result is the health system cutting services or being unable to attract needed physicians to meet the care needs of the community.

People in healthcare don't talk about money because, when copays were predictable—before the onset of so-called consumerism—they didn't need to. As more of the cost burden has shifted to consumers healthcare organizations lack the tools, language, or confidence to guide them through it.

COMPLEXITY, CONFUSION, AND THE MISSING MUSCLE

Another reason money is so hard to talk about is because the system is enormously complicated. The number of intermediaries involved, the layers of billing, the mix of payors, the contract variations, the benefit designs, the coding requirements, the prior authorization rules—none of those elements are designed for a consumer-facing conversation.

The system was developed as a business to business (B2B) interaction, not business to consumer (B2C). Consumers simply weren't part of the design. But now that consumers carry far more financial responsibility, the lack of B2C orientation and thinking has become a major liability.

The number one factor that drives selection of a health plan is the premium, which is arguably the least important financial factor. Many people don't know how their deductible works, and even more don't know how their annual out-of-pocket maximum works. They don't know why their cost for the same service is different at two different places. They don't know why their insurance card has eight phone numbers on it or what any of the acronyms mean.

Remember the insurance card exercise from earlier in the book. If you thought it was confusing, you're not alone. Because whatever the insurer might say, these cards aren't designed for the consumer. They're designed to tell providers what to collect from you at the time of service. If they were designed for you, the font would be readable, and they wouldn't have abbreviations nobody can decipher.

Aside from the arcana of the insurance card, we have an education problem. We do not teach financial literacy at any meaningful level in this country. We don't teach people how to balance a checkbook, how to save for retirement, how to understand their insurance, or how to navigate basic financial decisions. These issues have an enormous effect on people's lives and families, but no institution has taken responsibility for teaching them.

Interestingly enough, there is also the discussion of desire and accountability. Most consumers take more time to decide what cell phone to buy than they do which insurance plan to select. Before cell phones, we used to use the example of which CD player, but you get the point. Many are so confused or turned off by insurance and healthcare overall that they shut down or choose not to investigate.

Rather they trust a broker or HR department or friend to guide them on their insurance approach. Keep in mind, however, what might be good for the friend or relative may not be good for the person selecting a new insurance plan.

Healthcare organizations haven't taken that responsibility, either. They do screenings, set up health fairs, and talk about wellness and prevention. But no one stands up and says, "We're going to teach you how to understand your health insurance plan so you can make better, informed decisions."

There's also a talent gap. Very few people inside healthcare organizations have the expertise (or the job description) to teach financial literacy,

even if the organization wanted to do it. The people who know financial nuances are usually in the revenue cycle, billing, or contracting departments, and they're often not trained how to communicate with patients beyond the transactional requirements. Most also do not have the time to communicate with patients.

And let's be brutally honest: some stakeholders benefit from consumer confusion, especially health plans. It certainly makes it easier for brokers who are incentivized for specific plans based on the volume of sales. Thus, they may lead people to what may be good for some, but not all, of their clients' specific needs. Brokers and consultants are held out as subject matter experts, thus the clients seeking a simpler buying process may not ask the right questions.

If an insurance company can collect premiums and care is delayed, the claims are also delayed. Such delays allow companies to make money on the lack of expense. Whether intentional or not, financial opacity reduces utilization, which increases insurer margins. So the overall system drifts toward complexity because complexity benefits lots of people within the system at least in the short-term.

THE CONSEQUENCES OF SILENCE

All of these actions or inactions leave healthcare provider leaders with a problem. They don't talk about money because the system is so complicated that most don't feel equipped to explain it or, quite frankly, they are not allowed to due to other responsibilities. And when people feel under- or unprepared, or under- or uninformed, they stay silent.

Silence has consequences—not just for the patient journey, but for health outcomes, organizational trust, and long-term financial health.

One of the worst consequences is necessary care that is deferred or avoided. This avoidance is the financial equivalent of what happened during the COVID-19 pandemic. People avoided hospitals and clinics

because they were afraid of catching the virus. In places like New York, deaths in ambulances and hospital emergency departments from non-COVID causes (heart attacks, strokes, other acute conditions) rose almost fivefold, according to some data sources. People were dying because they delayed lifesaving care that oftentimes they were informed that they needed.

The same pattern is emerging now, but the fear is financial rather than clinical. People put off seeing the doctor, afraid of what it's going to cost, until the symptoms are unavoidable.

Minor conditions often become major ones when left untreated. So, when people delay care because of money, they often face more expensive treatments and worse health outcomes.

Financial avoidance also affects elective care. People live with pain, mobility limitations, or lower quality of life because they're afraid to pursue the care that could resolve it. There is no clear financial metric for the value of a pain-free life, or a restored lifestyle, but the impact is real.

On the organizational side, silence about costs and prices erodes trust. When patients don't understand why something costs what it costs, or how much they will have to pay for it personally, they start to question the motives of the healthcare provider. Especially when the media is full of payor narratives around providers driving up healthcare costs. Patients begin to wonder if the recommendations are clinical or financially driven. Patients then ask whether the system is working for them or against them.

Meanwhile, whether politically or financially motivated, other individuals are creating a brand, influence, and power by speaking their "truth" where there is a void. These individuals have a found a gap in the communication strategy where they too can make money or be seen as

influential. Most of these individuals are not clinically trained. They are building their brand and influence at the expense of the health systems and physicians.

Thus, the health care provider's patients share stories about opaque billing practices, unpredictable pricing, or confusing financial processes. It does immeasurable harm to the organization's brand. Most recently, the same co-worker who sought care for endocrinology cancer received their bill for a 15-minute office visit for annual follow-up care. This was billed as a 99214 office visit (over 30 minutes, treating one or more chronic conditions, and other complexities) which was not the case. Thus, as this story is told, your perception of this AMC physician practice might change.

Avoiding early conversations about cost—who will be billing the patient and for how much—also increases the level of bad debt an organization carries. When people can't understand or anticipate what they owe, they're more likely to default. And when the patients finally call or review their MyChart account, they're met with less information than expected. If the bill is questioned and the revenue cycle team takes ownership but doesn't respond for weeks, then payment is delayed or completely forgotten.

The result is that we have a two-tiered healthcare system. There's healthcare if you have insurance *and* money, and healthcare for everybody else.

AVOIDING THE CONVERSATION FEELS COMPASSIONATE BUT CAUSES HARM

The final barrier to talking about money is emotional and ideological. Many people in healthcare genuinely believe that introducing financial conversations will make care feel less personal and more transactional. They fear it will undermine empathy or dilute the non-profit mission.

Executives, physicians, and board members worry that talking about money first doesn't align with patient-first values.

This creates a paradox of silence: in an attempt to avoid conversations that feel unkind, patients are ultimately harmed.

Avoiding the money conversation may also feel easier, more compassionate, and more aligned with mission. Yet that only benefits those who have to deliver the message and the people they report to. The lack of communication leaves patients without guidance in a topic they are often not well-versed in. It forces them to make decisions based on fear and misinformation from aforementioned influencers, not information.

This situation leads to the obvious question you're probably wondering: *How do I talk about something that I don't understand, that's enormously complex, and that feels disconnected from our mission—even though it's embedded in the mission?*

There are many reason people in healthcare avoid talking about money:

- They're uncomfortable with the topic
- They don't feel qualified
- They don't want to scare patients
- They don't want to appear profit-driven
- They don't want to contradict the organization's mission

Even so, patient-first care requires patient-first communication. This communication must include financial clarity, because financial fear is now one of the primary barriers to access.

We cannot claim to be mission-driven if we ignore the number-one factor determining whether people seek care. We did not create the current complexities, and we certainly did not create benefit plan designs that have been sold as money saving options to employers.

If cultural taboos, complexity, fear, and mission misalignment keep healthcare organizations from talking about money, the obvious question becomes: What happens when they do talk about it? What changes when transparency becomes part of the patient experience, rather than an afterthought?

We'll tackle that in Part Two, but, before we get there, let's take one more chapter to explore the problem a little more deeply. In Chapter Three, we'll take a closer look at how the complexity of the healthcare "system"—which is not really a system at all—contributes to the overall problem of financial fear.

ENDNOTE

1 Keenan & Associates, "IRS Announces 2026 HSA and HDHP Limits," https://www.keenan.com/knowledge-center/news-and-insights/blogs/irs-announces-2026-hsa-and-hdhp-limits/.

CHAPTER THREE

A SYSTEM THAT ISN'T A SYSTEM

If there's one word that people use to describe how healthcare is organized in the United States, it's *system*. Politicians, journalists, authors, providers, and patients talk about the *healthcare system*. We've even used these words many times already in this book.

Yet if you peel back even one layer, it becomes extraordinarily clear that we don't actually have a coherent system at all. What we have is a series of overlapping arrangements, mismatched incentives, conflicting rules, public and private funding streams, and benefit designs that vary by state, employer, insurer, and even individual health benefit plan.

It's not really a system. Instead, it's a set of arrangements that we call a system because it's easier—and perhaps more comforting—to think of it that way.

Yet because we don't have a real system, every financial conversation, pricing question, and attempt at transparency becomes harder. The chaos of the structure itself is a barrier to clarity.

In this chapter, we're not going to try to rewrite the entire healthcare system or critique every piece of how it works. Instead, my goal is to give you a quick primer on how the U.S. healthcare financing structure actually works, why it feels so incoherent, and why hospitals bear the brunt of confusion while still having the most influence on local trust.

We may not be able to fix the *system*, but we can fix communication inside the system we have inherited.

A SYSTEM IN NAME ONLY

When people talk casually about "the healthcare system," they usually assume a level of design, planning, and cohesion that simply does not exist. The reality is that American healthcare is a hybrid model that includes:

- Federal government programs (Medicare, Medicare Advantage, military and veteran's health)
- State government programs (Medicaid, CHIP)
- Self-insured employer health plans (thousands of unique benefit designs offered by dozens of major payors and many smaller ones)
- Individual market plans (especially the ACA exchanges)
- Private insurance companies (each with its own policies and rules)
- Hospitals and physician groups (public, private, nonprofit, for-profit)
- Specialty carve-outs (pharmacy benefit managers, behavioral carve-out plans, radiology benefit managers, reproductive benefit managers, TPAs, you name it)

This is not a true "system" because there is no single organizing principle or plan. There is no central authority and no consistent set of rules applied across all these entities. What we actually have is a B2B environment built for insurers, brokers, and providers, operating inside a world where consumers now carry far more financial responsibility. Let me say that again—the company that purposely took on all the risk

in the insurance model is off-loading a majority of the risk, especially in a high-deductible health plan, to the individual patient.

And for patients, everything feels disjointed because everything *is* disjointed.

That disjointed framework is the core mismatch. The entire financing structure evolved during a time when patients were not expected to understand pricing, cost-sharing, benefit design, or insurance rules. The system evolved for hospitals and insurers to negotiate with each other, not for consumers to navigate.

Yet today, consumers are on the hook for rising deductibles and most of the initial costs of healthcare with the exception in some cases of the annual wellness visit. Deductibles and out-of-pocket costs are higher than ever before. Yet the structure around them—the rules, processes, and flow of communication—has not adapted to be more consumer-friendly. The resources to support consumerism are almost nonexistent.

The system has stayed B2B while the financial burden shifted to B2C. And because the structure remains oriented around business-to-business interactions, it creates friction everywhere for patients.

This is why people say things like: *Why can't I just know what this costs? Why does my insurance company have to approve what my doctor already ordered? Why did I get five different bills for the same surgery?*

These questions feel irrational to patients because the system is indeed irrational ... for almost everyone except for one set of entities.

WHO THE SYSTEM IS BUILT FOR

Most people believe the healthcare system was set up for doctors, but we've come to realize is that it's really set up for insurance companies. It has certainly evolved the same way as one tracks the profits.

If you want to understand why the rules work the way they do, the golden rule applies: *he who has the gold makes the rules*.

In healthcare, the entity with the most leverage is the payor—health insurance companies, which are some of the largest companies in the world.[1] They control all sorts of elements:

- Which services require prior authorization
- Which claims are paid, denied, or delayed
- What claims require a medical record
- What benefits are covered and what the member cost share is
- The contracted rates that providers rely on to keep their doors open
- How provider networks are designed and which clinicians are included
- Policies that influence access, affordability, and utilization

Hospitals and physicians often feel like they're fighting uphill battles. They're trying to provide care in a landscape where someone else controls the finances that keep their doors open. Patients are caught in the middle, trying to understand rules that were never designed for human comprehension.

We're not villainizing insurers for the sake of argument, but rather describing how it actually works. *Insurance companies design the financial scaffolding of healthcare. Providers must operate within that scaffolding. Patients must live with it.*

In a truly free-market system, consumers would be able to shop, compare, and choose based on price, quality, and service. In a truly government-run system, rules would be standardized and consistent. Instead, we have a hybrid model where:

- Medicare is federal but is administered and paid differently in different states and regions

- Medicaid is state-specific but may have side deals with safety net hospitals and academic medical centers
- Commercial insurance follows its own rules with state-level oversight
- Employer plans are subject to ERISA or not, and each adds their own twists
- Pharmacy benefits are carved out to separate entities
- Each insurer has unique billing, coding, and authorization requirements
- Each employer negotiates different benefits and coverage levels
- Each patient's plan has entirely different rules, even within the same insurance company

If you tried to design a system to be as confusing as possible, you'd be hard-pressed to do better than what we currently have.

THE COST-SHIFT THAT DISTORTS EVERYTHING

One of the least understood dynamics in healthcare, yet one of the most important, is cost-shifting. About 20% of the U.S. population is covered by Medicare, with roughly half of those beneficiaries in a Medicare Advantage plan. Medicaid plans cover another 20% of people, and 4% are covered by military health plans (TRICARE, VA, or CHAMPVA).[2]

To put it plainly, hospitals lose money on every Medicare, Medicare Advantage, and Medicaid patient they treat. They also lose money on every uninsured patient they treat—around 8% of the population.[3] Thus, hospitals and providers don't receive adequate compensation for costs related to the majority of all patients who walk in the door. We then "cost shift" onto commercially insured patients to compensate for all the accumulated losses created by everyone else. Would you run any other business that way?

We know it sounds crazy, but that is not an exaggeration. It's the economic reality of payment for healthcare services. Medicare and

Medicaid set their rates, and those rates are well below the actual cost of providing care. That means hospitals rely entirely on patients with commercial insurance to make up the difference and stay financially sustainable.

This creates a fragile balancing act. A hospital's financial viability depends on many factors, including the proportion of patients with government insurance, the proportion with commercial insurance, the reimbursement rates paid by each, the mix of services being provided, and the case complexity in each population.

If the payor mix shifts—for example, more Medicare patients, or more Medicaid-covered patients, or fewer commercially insured patients—the entire financial equation is disrupted. The health system must keep a very keen eye on the balance of commercial patients versus all others as the commercial patients offset the losses from everyone else.

That balancing act creates two distortions.

The first distortion is that *payment becomes inflated and inconsistent*.

Hospitals must expect higher payments for commercially insured services to compensate for government underpayments. That means the "list price"—the hospital's chargemaster—is much, much higher than the actual cost of those items. It also means different insurers negotiate dramatically different reimbursement discounts from the chargemaster for the same procedure at the same hospital.

The chargemaster becomes a figment, an artificial construct that drives many of the prices charged to consumers. And the chargemaster serves as the basis for every bill issued to an uninsured patient, even if the total amount is eventually discounted heavily.

Patients look at those prices and think, "How can the same procedure cost $15,000, $30,000, or $50,000 depending on who pays?" The answer is that it's not really the cost, it's the cost-shift.

The second distortion is that *affordability concerns get worse.*

When prices appear inflated and unpredictable, patients lose trust in the hospital or provider of care. They worry they're being overcharged or that someone is taking advantage of them, especially if that organization has substantial resources. They also assume that the system is designed to extract money from them rather than help them with the care they need.

And because Medicare itself is projected to become insolvent by 2033, the problem is only going to intensify.[4] If taxes don't increase and benefits aren't adjusted, hospitals will face even greater payment pressure as more people age in from commercial insurance to Medicare. This age-in process will only increase reliance on commercially insured patients. One organization in the Midwest had the first of their "silver tsunamis" already—it cost them 2% of overall profit which made them move from profitable to unprofitable, all within 18 months.

This is why the financial access crisis cannot be solved at the system level. The structural incentives themselves are misaligned.

WHY HOSPITALS BEAR THE BRUNT BUT STILL CONTROL THE NARRATIVE LOCALLY

Even though hospitals don't control most of the financial rules (insurers do, as we mentioned earlier), they are the primary target of patient blame. When a bill is confusing, it has the hospital's name on it. When a prior authorization is denied, the patient calls the doctor or hospital in frustration. When an insurer changes coverage or shifts cost-sharing, the patient assumes the provider is involved. When an explanation of benefits (EOB) from the insurance company doesn't match a bill, the patient asks the provider to explain.

Hospitals are the face of a system they did not design and do not fully control. Yet at the same time, this perception is a great opportunity for hospitals.

While there are many factors that hospitals don't control, they *do* control several things, including:

- The way they communicate with their community
- How clearly they explain financial responsibilities
- How transparent they are with pricing and billing
- The tone and empathy they use with patients
- Whether their financial communication builds trust or erodes it

Even within a wildly confusing system, hospitals have the ability to create clarity, reduce fear, and communicate in ways that align financial guidance with their mission.

Hospitals are local, but most insurers are not. Therefore, the communication from hospitals can carry an impressive amount of influence. Patients trust the hospitals in their communities far more than the insurance companies whose policies govern them and their choices. Hospitals and their employees are the ones with the relationships. They are the ones who can educate and close the gap between what the system demands and what patients understand.

Thus, the heart of my message: *You can't fix the system, but you can fix how you communicate within it.*

Hospitals cannot redesign Medicare policy, but we would argue they can influence it—a discussion for a later date or another book. They cannot rewrite insurance formularies or create a national framework for financial literacy.

But they *can* translate the complexity of the system into plain language. They *can* teach people how to navigate their plans and prepare patients for what to expect financially. They can also remove uncertainty, which is one of the biggest barriers to care.

And most importantly, hospitals can stay aligned with their mission by removing the fear that keeps people away. This removal of fear and

increase in education is the real work ahead of us.

So if the U.S. healthcare structure is not actually a system, how do we move forward? How do healthcare organizations communicate in a landscape defined by inconsistency, cost-shifting, and structural complexity?

In the next chapter, we shift the focus from diagnosis to strategy. We'll look at how hospitals and health systems can begin to build clarity, transparency, and trust—not by fixing the national system, but by improving the financial conversations that shape the patient experience every day.

ENDNOTES

1 The Fortune 500 list from January 1, 2026 puts UnitedHealth at #3 behind Wal-Mart and Amazon, with CVS Health coming in at #5. 50Pros, "Fortune 500 Companies," https://www.50pros.com/fortune500.

2 Association of Health Care Journalists, "New Report Reveals Major Gaps in Medicare Access, Quality, and Affordability," https://healthjournalism.org/blog/2025/10/new-report-reveals-major-gaps-in-medicare-access-quality-and-affordability/; Kaiser Family Foundation, "Medicare Advantage Enrollment Update and Key Trends," https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/; Kaiser Family Foundation, "Medicaid Enrollment and Spending Growth, FY 2025–2026," https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2025-2026/; Statista, "Percentage of U.S. Americans Covered by Medicaid," https://www.statista.com/statistics/241966/percentage-of-us-americans-covered-by-medicaid/.

3 Kaiser Family Foundation, "Health Policy 101: The Uninsured Population and Health Coverage," https://www.kff.org/uninsured/health-policy-101-the-uninsured-population-and-health-coverage/.

4 Centers for Medicare & Medicaid Services, *2025 Actuarial Report on the Financial Outlook for Medicare*, https://www.cms.gov/oact/tr/2025.

PART TWO

THE SOLUTION— AUTHENTIC FINANCIAL COMMUNICATION

CHAPTER FOUR

FINANCIAL ISSUES = ACCESS ISSUES

In the last chapter, we looked at how the so-called healthcare system isn't really a system at all. It's a patchwork of public and private arrangements, designed primarily as a financing mechanism rather than an access mechanism. In that environment, it's easy to talk about insurance, payment, or pricing as abstract policy issues.

Yet they're not abstract to the people you serve. For patients, financial issues show up in one very concrete, very personal way. *They often determine whether someone seeks care at all.*

That's why we say financial issues are access issues. We can't treat the cost of care and access to care as separate categories anymore as we consider the best course of actions for patients. When people are choosing, or avoiding, care entirely based on what they fear it might cost them, then finances are no longer a back-end problem. The financial concerns are the front door.

In this chapter, we want to unpack that idea in a practical way. We'll dive into how people are really making decisions now, why uncertainty is often more dangerous than the actual price, and how transparency and empathy can turn financial literacy into better access.

We're not going to solve the insurance market or redesign benefit structures, even though we would really like to do so. But we *are* going to talk about how you, as a provider organization, can remove financial fear as a barrier to care.

THE NEW PATIENT REALITY: OUT-OF-POCKET EXPOSURE DRIVES CHOICE

When we talk about the cost of healthcare, employers, payors, and policymakers usually mean the *total* cost of care. What does a procedure cost in the aggregate? What is the trend line in medical inflation? What are we spending per member, per month?

Consumers don't think that way. Most of the research shows that people don't actually care what healthcare costs are in total. Patients care what their personal out-of-pocket exposure is. That's a very important distinction given the intent of high-deductible health plans and other similar products over the last couple of decades.

If you are a self-insured employer, you care deeply about the total cost because you're bearing risk for the total cost. But if you're a consumer, your focus is much narrower. You're thinking about your deductible, your copay, and your annual out-of-pocket maximum—if you even know what and how much that is.

Our human tendency is to fixate on the elements we think we understand and then over-index on them while ignoring that which we don't understand.

Here's a simple example: you go to the doctor, and your copay is $20. No deductible applies. During your visit, your doctor draws $100

worth of labs. That $100 goes toward your deductible. Let's say your deductible is $1,500. You might reasonably think, "Once I hit $1,500, I'm done paying."

But you're not. What actually happens is this:

1. You pay first-dollar costs until you meet your deductible.
2. Then you usually pay a percentage (often 20%) of additional costs until you hit your annual out-of-pocket maximum, which is a much larger number than your deductible.
3. Only after that does your plan cover 100% of costs for covered services.

That's a level of nuance most people don't know, because no one has ever explained it to them. Yet we ask people to make major decisions about care based on this incomplete understanding. Not to overcomplicate this, but that same person may be offered a new option the following year where there's an entirely separate deductible for prescription drugs.

When you ask people in national surveys, "How do you select a physician to care for you?" the top two factors are:

1. Does this doctor take my insurance?
2. Can I get an appointment?

Notice what's missing. Those questions are not quality measures or even quality oriented. These criteria are not based on outcomes data or clinical expertise. The first is a financial question. The second is an availability question. Both are basically access issues.

What's really interesting is the patient asking those questions might end up at the least preferred, least quality-oriented doctor because he is available and covered by insurance. This decision could then become even more costly in the long run.

Quality, in the measurable sense—outcomes, readmission rates, complication rates—barely makes the list. Instead, we judge hospitals by the near-same standards as we evaluate hotel services. Is it clean, is the food decent, does my TV have premium channels, did the nurse come quickly when I pushed the button? And let's not forget that private room.

We understand those hospitality criteria intuitively. We do not understand quality metrics or pricing structures intuitively.

So when we say financial issues are access issues, we mean it literally. The result is that individuals realize the following:

- *If my insurance doesn't cover a provider, that provider isn't really in my consideration set.*
- *If I can't understand what I might owe, I become hesitant to seek care at all.*
- *If I'm unsure whether my plan will authorize what my doctor recommends, I may delay or avoid it.*

The access problem isn't just about appointment availability or clinic locations anymore. It's about what a person believes they can afford, and whether they trust the system enough to risk finding out.

UNCERTAINTY, DENIALS, AND THE HIGH-STAKES GAMBLE

If you buy a pack of gum and end up not liking the flavor, it doesn't matter all that much. My maximum financial exposure is a dollar or two. But if you make a poorly informed decision seeking healthcare, the consequences can be catastrophic.

It might be the difference between staying solvent and going bankrupt, treating a disease or illness early or late, or even between living and dying.

What makes this so problematic is the imbalance of information. The provider is the most well-positioned entity in this equation to know

what is clinically appropriate to treat the issue at hand. The insurance company knows what services are covered and how those services will be paid. The patient knows almost nothing about either.

And unfortunately, the tools we give patients are minimal. Think of the aforementioned disaster of an insurance card, a benefits booklet no one reads (though they should), a website not built for everyday consumers, and a customer service line staffed by non-clinical people sticking to preset scripts—which aren't even based in the U.S.

On top of that, the environment is getting harder, not easier. The reading level has dropped over the last few years from eighth grade to sixth grade. When math is included, the literacy rate in the U.S. drops even further.

From 2022 to 2023, the denial rate in commercial insurance increased by 20.2%.[1] In the same year, the denial rate in Medicare Advantage increased by 55.7% in a single year.[2] If it feels like it's gotten harder to collect the money owed, it's because it has become harder, and therefore more expensive.

Denials and prior authorizations create a powerful deterrent effect. Imagine this sequence from a patient's perspective:

- You select a doctor in network.
- The doctor recommends imaging, a surgery, or a course of treatment.
- The insurer approves your prior authorization.
- The insurer later determines the provider is out of network and then reprices the claim accordingly, leaving you with a much larger bill.
- The claim pays at the out-of-network level and you're suddenly facing a large bill you didn't expect.

The provider now faces a choice: pursue the agreed upon amount through multiple administrative processes established by the payor, write it off or pursue payment from you. Meanwhile, you're stuck in

the middle, trying to understand how you could have done "everything right" and still be financially exposed.

From a systems perspective, it's not hard to see how payors benefit from this. When people pay premiums for coverage they're afraid to use, utilization stays low. The lower the utilization, the better the payor's margins. Whether or not that's anyone's explicit intent, the outcome is the same and is reflected in the quarterly statements to Wall Street.

It's incredibly easy to be unhealthy in the U.S. As a society, we're more sedentary than we've ever been, and cheaply made, highly processed foods abound. In this context, financial hesitancy when it comes to healthcare isn't just a budgeting problem. It's a public health problem. When people arrive later and sicker, their situation is more complicated and more expensive to treat. They often have worse outcomes than would have been experienced if they sought care earlier.

Uncertainty is the real enemy here. People can live with cost if they know what it is and can plan for it. But what they cannot live with is feeling like they're risking financial disaster every time they need health care services.

CHOOSING COMMUNICATION THAT OPENS THE DOOR

So how do we improve financial literacy to create better access? The answer isn't another mandate or spreadsheet. It's a set of communication choices that make financial clarity a routine part of the patient journey, instead of a surprise at the end.

Here are a few practical approaches we've seen work.

1. "KNOW BEFORE YOU GO" AS A MINDSET, NOT JUST A CAMPAIGN.

The principle behind these campaigns is simple: do everything you reasonably can to make sure your patients understand the likely financial impact of care *before* they receive it.

That can include:

- Providing simple, plain-language cost ranges for common services
- Offering pre-visit financial education and counseling, especially for higher-cost procedures
- Training front-desk and scheduling staff with scripts that normalize financial questions ("Do you have any questions about your insurance or costs before you come in?")

When patients hear, "Based on your insurance and what we know today, here's the approximate range you can expect," it changes the emotional experience. They feel respected. They feel informed. They feel like someone is on their side.

2. INTEGRATING FINANCIAL EDUCATION INTO EARLY TOUCHPOINTS.

Another opportunity is to integrate financial education into existing touchpoints, rather than creating new ones.

For example:

- When a new patient registers, you can provide a one-page, visual explanation of deductible, copay, and out-of-pocket maximum, using examples instead of jargon.
- When someone schedules a surgery or procedure, you can proactively ask, "Would you like to talk to someone on our team about what to expect financially?"
- When you send appointment reminders, you can include a gentle prompt, "If you have questions about your insurance or potential costs, call this number before your visit."

These are small changes, but they send a big message: we know money matters, and we're not afraid to talk about it with you.

3. FRAMING FINANCIAL CONVERSATIONS WITH EMPATHY, NOT DEFENSIVENESS.

How we talk about money matters as much as what we say. Too often, financial conversations are framed as transactional or adversarial. We say things like: "This is what you owe." "Insurance didn't cover that." "You'll need to call your insurance company."

From the patient's perspective, that sounds like: "This is your problem. Good luck." However, an empathetic approach acknowledges the complexity of the situation and validates the patient's experience. A few ideas for how to communicate this:

- "I know this is confusing. You're not alone, and in fact most people feel overwhelmed by this."
- "Here's what your insurance told us. Let me walk you through what that means in plain language."
- "If this amount is a hardship, let's talk about options. We may be able to work with you."

You can't fix every financial problem. But you can avoid making the patient feel blamed, shamed, or abandoned. And we can avoid the ripple effect when that happens—when people tell their friends, family, and co-workers what happened and they get scared too.

4. POSITIONING FINANCIAL GUIDANCE AS PART OF YOUR MISSION.

Finally, it's important to connect these efforts back to your mission. If your mission statement includes words like "community," "access," "compassion," or "serving all," then financial clarity is not optional. It's part of how you live that mission.

You are not responsible for solving the national healthcare financing puzzle. But you *are* responsible for making sure people in your

community are not avoiding care simply because they don't understand how the system works and how you as a healthcare provider are navigating said system.

In that sense, financial guidance is not separate from care. It *is* care.

When you frame financial guidance as part of the care internally, it changes how your teams approach the work. Instead of thinking, "We're just talking about bills," they approach it a different way by saying, "We're helping someone feel safe enough to get the care they need."

The bottom line is that financial issues are no longer a downstream concern reserved for the billing office or the revenue cycle team. They shape who walks through your doors, when they do it, and whether they come back. In a dynamic where it's easier to be unhealthy than healthy, demystifying the financial aspect of care is one of the most powerful access tools you have.

In the next chapter, we'll start to translate these ideas into a more structured approach by looking at how to build an authentic financial communication strategy that aligns with your brand and gives patients the confidence to use the care you work so hard to provide.

ENDNOTES

1 American Hospital Association, *The Costs of Caring: 2024*, https://www.aha.org/guidesreports/2025-04-28-2024-costs-caring.

2 American Hospital Association, *The Costs of Caring: 2024*, https://www.aha.org/guidesreports/2025-04-28-2024-costs-caring.

CHAPTER FIVE

BRINGING AUTHENTICITY TO MONEY CONVERSATIONS

In *Authentic Healthcare Marketing*, I (Brandon) argued that authenticity in healthcare isn't a buzzword. Rather, it's a discipline. It's the hard work of aligning what you say with what you actually do—and what your audiences actually experience.

But it is increasingly difficult to do in the post-truth era when people refuse to hear messages delivered by messengers that don't match their world view.

We framed that work around the Authenticity Index, made up of four elements:

- Human Truth
- Meaning
- Believability
- Trust

In that book, the index was mostly to brand positioning, advertising, and experience design. Now we're going to bring those same ideas into one of the hardest and most avoided areas of healthcare communication: *money*.

Most organizations don't struggle with *wanting* to be authentic around financial issues. Many have not educated their teams on the finances of healthcare as they deemed it too expensive, too time consuming, or lower on the priority scale. Their teams therefore struggle with being authentic and effective at the same time. They care about their patients and don't want to scare them. The framework is incredibly complex so they're afraid of saying the wrong thing. Therefore, they lean away from the conversation entirely.

This avoidance results in a serious problem: *avoiding money conversations creates far more stress for people than talking about the money.*

In this chapter, we want to apply the Authenticity Index directly to the money conversation and then look at what that means for everyday interactions with patients—at the front desk, on the phone, in the portal, and in those moments when the system gets messy.

THE AUTHENTICITY INDEX MEETS THE MONEY CONVERSATION

Authenticity is not just about sounding honest. It's about communicating in a way that reflects your values and your respect for the people you serve. It's about showing up in different channels with different messages and messengers to meet people where they are. That's especially true when talking about cost, coverage, and financial risk.

Let's walk through each part of the Index and apply it to financial communication.

– HUMAN TRUTH: START WITH WHAT PATIENTS ACTUALLY EXPERIENCE

Human Truth is about acknowledging what's *real* for people, not what's convenient for you as an organization. The human truth around money in healthcare is pretty straightforward:

- 47% of adults in the U.S. are concerned about being able to afford care they need in the next year[1]

- 38% of adults in the U.S. find medical bills confusing[2]
- 58% of insured adults had a problem with their health insurance in the last year[3]
- 66.5% of people who file for bankruptcy each year cite medical debt as the cause (that's 550,000 people every year)[4]

Beginning from the realities above, you change the tone you use in communication. Instead of starting a financial conversation with, "Here's what you owe," an authentic approach might begin with something like this: "I know this part can be confusing and stressful. You're not alone in feeling that way. Let me walk you through what this means in everyday language."

You're not just processing a transaction. You're recognizing a human being in front of you who may be facing a scary and confusing health situation that's compounded by financial concerns.

If we ignore that, no amount of technical accuracy will feel authentic. People won't remember the codes and the contract language; they'll remember whether they felt seen or dismissed.

—MEANING: CONNECT MONEY TO MISSION

When we consider meaning, we look at a situation with this question in mind: *Why does this matter beyond the transaction?*

If your mission statement talks about access, community, compassion, or serving all people, then financial clarity is one of the main ways you live that mission. You cannot profess to serve everyone and then stay silent about the number-one barrier that keeps people from walking through your doors.

Authentic financial communication sounds like this: "Because our mission is to care for you, we're going to be upfront about why healthcare costs are what they are. We are going to explain where we invest and why. In addition, we are going to explain what you might owe and how we can help. We don't want fear of a bill to keep you from the care you need."

You can't magically make everything less expensive. Yet you can make sure people are informed about the clinical and financial aspects of care from the outset.

When you connect money to mission, you give your staff permission to talk about it without feeling like they're somehow betraying the organization's values. You turn awkward administrative conversations into core expressions of who you are.

—BELIEVABILITY: USE LANGUAGE THAT MATCHES THE REALITY OF THE SYSTEM

Believability is about using language that people can actually believe. It's language that lines up with how the world really works.

Healthcare is full of euphemisms that undermine believability. One of my favorites is the word "reimbursement." If you buy concert tickets for a friend and they pay me back the full cost of the tickets, that's reimbursement. If they pay you less than you paid, that's not reimbursement (and you're definitely rethinking favors for that friend), but that's what happens in healthcare. Hospitals get paid according to negotiated prices that may or may not cover the actual cost of providing care.

Words like "reimbursement" make the financial side of healthcare sound tidier and more neutral than it really is. Patients may not know the vocabulary, but they can feel the disconnect.

Believability in financial communication looks like this:

- Say *"payment"* when you mean payment.
- Say *"we're being paid less than it costs us to deliver this care"* when that's true.
- Say *"your plan doesn't cover this"* when it's about available coverage, not available care.

Believability also means not over-promising. If you truly don't know what an insurance plan will do, it's more believable to say: "I don't know exactly how your insurance will handle this, and I don't want to guess. Here's what

we do know, and here's how we can help you get a clearer answer."

People can handle uncertainty if you're honest about it. What they don't react well to is false certainty followed by a surprise.

–TRUST: STAY WITH PEOPLE THROUGH THE HARD PARTS

Trust is what you build when you start with human truth, connect the conversation to your mission, use language that reflects reality, and then show up for people when the friction in the system gets messy.

Trust around money is not created by telling people, "We care." It's created by things like this:

- Calling them before a procedure to talk about likely out-of-pocket costs
- Being available to explain a confusing bill
- Helping them navigate an insurance denial instead of pushing them away
- Admitting when you don't know and offering to help people find the answer

Sometimes, being authentic means saying, "I don't know, but I'll help you figure it out." You must follow-up on this statement of support.

Nurses and physicians spend their careers being trained to answer questions. It can feel uncomfortable to say, "I don't know yet," but think about it like making a referral to a specialist physician.

Authenticity in the money conversation should not be focused on having all the answers. A much better goal is to connect people to the financial specialists who do have them.

FROM CONFRONTATION TO COLLABORATION IN EVERYDAY MONEY CONVERSATIONS

Most financial conversations in healthcare don't happen in the C-suite. They happen at the front desk, during the check-in, on the phone, within a portal message, and at the cashier window after an appointment.

For many organizations, those conversations feel confrontational almost by default. They're full of phrases like: "Your copay is $X. You need to pay that today." "Your insurance didn't cover this. Here's your balance." "You'll have to call your insurance company. We can't help with that."

It's not that your teams are trying to be unkind. They're working within systems, under time pressure, the accountability measures you placed, and often with limited tools. They are often lower wage employees who receive daily complaints and criticism from patients and their family members. Yet the effect on the patient is the same: they feel blamed, shamed, or dismissed.

Authenticity calls us to shift from *confrontation to collaboration*.

For example, consider a common line: "Your copay is $X. How would you like to take care of that today?" On the surface, it's fine. It's polite and clear. But it can feel purely transactional, especially if the patient is struggling financially.

A more collaborative approach might sound like this: "Let me explain the different ways your care will be paid for. There is the portion insurance pays, based on a negotiated rate in our contract. Then there is your personal financial responsibility, also known as out-of-pocket responsibility. In this case, your copay today is $X. Are you able to take care of that now, or would it help to talk about options?" Or maybe, "Your copay is $X. I know costs can be a concern. If that's true for you today, let me know and we'll see what we can do."

You're still asking for payment and operating within the rules. Yet you're also acknowledging reality and inviting a conversation rather than shutting one down.

The same idea applies when you have to deliver bad news.

For example, let's say you were going to say this: "Your insurance denied this, so this is what you owe." Instead, try this: "Your insurance plan has denied payment for this service. I know that's frustrating. Here's

what they told us, and here are a couple of steps we can take together—either to appeal it or to see what options are available for you."

You haven't magically made the bill go away. But you've moved from *"This is your problem"* to *"We're in this with you."*

To make this kind of tone shift at scale, you can't rely on everyone improvising in the moment. This is where staff training and scripting matter. We're not suggesting rigid scripts that turn people into robots, but as training wheels or guardrails that give them confidence and language they can adapt to their personal style.

Good financial communication training does several things well. It explains the system at a basic level so front-line staff understand what they're talking about. It gives staff permission to acknowledge complexity and emotion, especially when accompanied by sample phrases that align with your brand voice and mission. And it clarifies what they can answer and what they should escalate.

When you put this into practice, you might train staff to use phrases like:

- "This is confusing, even for people who work in healthcare. You're not alone."
- "Let me show you how we got to this number."
- "I don't want to give you the wrong information. Let me connect you with someone who can walk you through this."
- "If this bill is a hardship, tell me, and we'll explore what options are available."

The goal isn't to have every staff member recite the same sentence word-for-word. The goal is to give them a *starting point* that feels natural, compassionate, and aligned with your values.

When people have that starting point, they are much more likely to bring authenticity and confidence to the money conversation—rather than retreating into silence or defensiveness.

BUILDING A CULTURE THAT SUSTAINS AUTHENTIC MONEY CONVERSATIONS

None of this works if authenticity around money is treated as a one-off project or a temporary campaign. It has to become part of your culture, part of your marketing, part of your ongoing narrative. That means three things.

First, you give people permission to say some version of this: "I don't know the answer to that, and I don't want to guess. The only one who can tell you exactly how they'll handle this is your insurer. But here's how we can help..."

What doesn't work is this: "You'll have to call the number on the back of your card." If you want to experience endless frustration, call the number on the back of your card. First, you need to get through the warren of IVR prompts to an actual person. Once you do, you're likely to get someone who can't answer your question and refuses to deviate from their script.

Second, you normalize talking about money inside a nonprofit mindset. Many hospitals and systems are nonprofit, and the very word "nonprofit" can create emotional resistance to talking about money. Some employees worry that discussing finances might tarnish the purity of the mission.

I (Brandon) once had a director of marketing inform me that their CFO was not concerned about revenue strategy as they work in a nonprofit system. I thanked her for the information and later asked the CFO, who quickly corrected that statement (as one might expect). But there is a director in the system who thinks differently and has spread this thought process throughout their team.

The reality is: all healthcare organizations run on money. Without adequate financial health, the mission collapses. Authentic leadership says: "We exist to care for people, and that requires us to be financially healthy. Talking about money is not a betrayal of our mission, it's part of sustaining it."

This is a new take on the old "no margin, no mission" line. Let me remind you of the full statement made by Sister Irene Kraus, a nun who became the first female chair of the American Hospital Association, "No margin, no mission. No mission, no me. No me, no you." *You* being the staff at the hospital.

And finally, replace euphemisms with clarity and train for both authenticity as well as effectiveness. Keep reminding people that financial issues are not an embarrassing side topic. They are one of the main ways people experience your brand.

Bringing authenticity to the money conversation doesn't mean you can fix every financial problem for every patient. It means you refuse to pretend the problem doesn't exist. You refuse to ignore it. You step into the discomfort with honesty, clarity, and a willingness to help people navigate a system they didn't design and can't control.

In the next chapter, we'll zoom out from individual interactions and look at the patient journey as a whole—before, during, and after care—and what it would mean to design that journey for financial transparency from the very beginning.

ENDNOTES

1 Rise Health, "Americans Are Increasingly Concerned with Health Care Costs," https://www.risehealth.org/insights-articles/article/americans-increasingly-concerned-with-health-care-costs/.

2 HealthLeaders Media, "Nearly 40% of Patients Find Medical Bills Confusing," https://www.healthleadersmedia.com/revenue-cycle/nearly-40-patients-find-medical-bills-confusing.

3 Kaiser Family Foundation, "Navigating the Maze: A Look at Health Insurance Complexities and Consumer Protections," https://www.kff.org/private-insurance/navigating-the-maze-a-look-at-health-insurance-complexities-and-consumer-protections/.

4 Cornell University ILR School, Scheinman Institute, "Healthcare Insights: How Medical Debt Is Crushing 100 Million Americans," https://www.ilr.cornell.edu/scheinman-institute/blog/john-august-healthcare/healthcare-insights-how-medical-debt-crushing-100-million-americans.

CHAPTER SIX

DESIGNING A TRANSPARENT PATIENT JOURNEY

If we really believe financial issues are access issues, then we can't treat money as something that "lives" only in a billing office or a back-end revenue cycle system. It has to be woven into the *entire* patient journey.

When we say, "patient journey," we're talking about three broad phases:

1. Before someone uses care
2. While they're actively in care
3. After the visit, when the bills and EOBs start to arrive

Those phases may sound obvious. Yet when you look at how we actually communicate about money, those three phases are usually disconnected and often completely silent.

In this chapter, we will walk through each phase and talk about what a *transparent* patient journey could look like—starting earlier than most people expect.

BEFORE CARE: HELPING PEOPLE MAKE BETTERCHOICES UPSTREAM

Most of the time when we talk about pre-care transparency, we jump straight to price estimators and financial assistance. Those items are indeed important. But the journey actually starts even earlier, in a place most providers have left almost entirely to others: insurance choice.

Whether someone is buying coverage on their own, picking from two or three options at open enrollment, or aging into Medicare, the plan they choose will have an outsized influence on where they can go, what they can afford, and how anxious they will feel about every medical decision.

And of course it goes without saying that their and your experiences will be very influenced by the plan chosen.

Right now, most of that decision-making is shaped by brokers and benefits consultants whose incentives are primarily financial. We don't mean that as a moral judgment, just a description. Their job is usually to balance cost trends, manage risk, and keep premiums in a tolerable range. It is a *financial engineering* exercise much more than an access exercise.

And it's certainly more than a quality exercise. Regardless, it is important to know that brokers are paid on a percentage of premium. It's a perverse incentive that is even more influenced by huge rewards like all-inclusive trips, higher percentages, and cars.

Providers, on the other hand, are in the access business. We see every day what happens when people pick plans that don't include their doctors, don't cover their preferred hospital, or expose them to deductibles and out-of-pocket maximums they don't really understand.

So when we think about the pre-care phase, we start here: How do we help employers and consumers make better decisions *before* anyone gets sick? Here are a few ideas about how that could look in practice.

- Educating employers about the downstream impact of benefit design—not just on cost, but on utilization, delays in care, and employee satisfaction.
- Providing simple tools and content that help people answer basic questions at open enrollment like: *Is my doctor in network? Is our children's hospital included? What would this plan mean if someone in my family needed surgery or a chronic-disease medication?*
- Being available as a resource when large local employers are considering annual benefit plan changes. Even if we're not "in the room" for those decisions, we can equip HR leaders with perspective on how different designs affect real patients.

We're not suggesting we turn every hospital into a benefit consultancy. Instead, we are suggesting that we stop pretending benefit plan selection is someone else's obligation and someone else's problem.

By the time a patient shows up for care, many of the financial constraints of their situation have already been locked in. If we want a more transparent journey, we should start upstream, where people are choosing the rules of the game without really knowing the rules.

A transparent pre-care experience would give people three things:

1. *A realistic sense of what the visit will cost them personally.* It doesn't need to be a perfect prediction, just a reasonable range grounded in real data: "For people with your plan, this kind of visit typically results in an out-of-pocket cost between X and Y."

2. *Clear paths to financial help.* If someone is likely to qualify for financial assistance, discounts, or payment plans, let's not make that a scavenger hunt. Tell them early. Let them know that if cost is a concern, there are options.

3. *Confidence that they have somewhere to turn with questions.* "If you want to talk through the financial side before your visit,

here's the number, here's the email, here's the portal link." This approach is where online price estimators and digital tools can help—but only if we design them around real people instead of compliance checkboxes.

If we communicate well, here's what a patient will hear during their pre-care journey: "We will help you choose well. We will help you understand the likely out-of-pocket costs. We will give you realistic appointment options. And we will tell you where to go with questions before anything happens."

DURING CARE: TALKING ABOUT MONEY AND MEDICINETOGETHER

Once someone is in the building (either physically or virtually), our default behavior should be to separate the clinical conversation from the financial one.

A patient sees the clinician to talk about symptoms, diagnosis, and treatment plan. Then at some point, often tacked onto the end or in a separate office, someone hands you forms, disclosures, and maybe a thick packet to read at home.

Most people don't read the packet, don't understand it if they do, and don't have a way to get clear answers if they have follow-up questions.

A transparent patient journey treats financial information as part of the *same conversation* about care, not an awkward side note.

That doesn't mean we turn physicians into billing experts, but it does mean several things.

- Clinicians are at least comfortable acknowledging that patient out-of-pocket financial responsibility is part of the decision-making process. "If you're worried about the financial side of this, you're not alone. We have people who can walk you through it."

- Front-line staff are trained and empowered to give basic, honest guidance. Not perfection, not guarantees, just clear explanations of what's known, what's unknown, and where to get more detail.
- We anticipate the most common financial questions that come with certain kinds of care and answer them proactively instead of hoping no one asks.

There is real potential here for technology to help. AI tools, if they are designed well and fed with good data, can answer routine questions about coverage, deductibles, benefit limits, and "what usually happens for people like me." They can function as a first-line concierge, freeing humans to handle the more complex, emotionally charged conversations.

All that said, technology doesn't replace the basic posture we must take. We have to be willing to say, in the exam room and at the front desk, "Money is part of this, and we are not afraid to talk about it with you."

Think of it like the old book *What to Expect When You're Expecting*. That book lowered anxiety for millions of new parents not by giving perfect predictions, but by walking them through what typically happens, what the range of normal looks like, and when they should ask for help.

We need the equivalent for "What to Expect When You're Navigating Healthcare" financially. And the point of care is exactly where that kind of guidance should be visible and accessible.

AFTER CARE: BILLS THAT CLARIFY INSTEAD OF INTIMIDATE

For many people, the most stressful part of the journey doesn't happen until *after* they've gone home.

That's when the bills arrive, and the sheer volume can feel overwhelming. They may receive multiple bills from the hospital, the physician group,

the imaging provider, the lab—each with different formats, different codes, and different unexplained balances.

Layer on top of that an Explanation of Benefits (EOB) from the insurer that enigmatically declares "This is not a bill" while looking very much like a bill. It's not an accident that people feel ambushed and scared, and occasionally angry.

A transparent post-care experience asks a simple question: "If I had never seen a medical bill before, could I understand this one?" Right now, the answer is almost always no.

So what would better look like? A few suggestions:

- One consolidated, plain-language summary of what happened, what was billed, what insurance paid, and what the patient is responsible for ... all before we flood them with line-item detail.
- Clear explanations of *why* something is owed, not just that it is owed. "This amount goes toward your deductible. Based on your EOB, you've met X of Y so far this year." Or "This is coinsurance: your plan pays 80%, you pay 20%."
- Obvious, easily reachable channels for questions: a direct number, a chat option, a specific office, not a generic call center queue where you start over every time.
- Proactive communication around large balances. If someone is going to see a shockingly high number, they shouldn't discover it alone at their kitchen table. There should be outreach, options, and a human voice attached.

Underneath all of that, there needs to be a philosophy: "We will not blindside people. If something is going to be a surprise, we will do everything we can to make it a *smaller* surprise."

It's true that every payor contract is different, every benefit design is a little different, and every clinical course or patient journey has its

own twists. The complexity is real. But complexity does not relieve us of responsibility to explain or help along the path. It simply means we have to work harder on translation.

There are encouraging signs from a handful of companies that have built digital billing and collections platforms far more patient-friendly than the traditional paper avalanche. One example is Cedar, which has developed app-based tools that present billing information in clearer, more intuitive ways. Organizations that work with firms like that tend to see better patient feedback and better collection performance.

We're not endorsing any particular vendor, just making the point that progress is possible when we design billing with human beings in mind.

DESIGNING FOR HUMANS, NOT JUST FOR SYSTEMS

Underneath the three phases—before, during, and after care—there is a deeper design challenge.

For most of the modern era, healthcare billing has been a B2B exercise. Hospitals bill insurance companies. Insurance companies determine what they will pay on claims. The patient portion was historically smaller, and in many cases, people simply paid what they were told because they had little choice and relatively less financial exposure.

Now, the exposure is huge. High deductibles, large out-of-pocket maximums, narrow networks, and aggressive denials have made the patient's financial experience central to their overall view of care.

Our communication, however, is still mostly built for the B2B world. We design statements, codes, and denial letters for payors and auditors, not for the person who is trying to figure out whether they can afford to refill their prescription and pay their rent. This is a real concern. More than 20% of people have skipped filling a prescription due to cost, while others cut pills in half or skipped doses.[1]

If we want a truly transparent patient journey, we have to accept that we are now operating in a B2C environment, whether we like it or not.

This means several practical things:

- We write for a sixth grade reading level, even if the regulations are written at a graduate level.
- We make things shorter, not longer. If it takes ten pages to explain one bill, we have a design problem, not a literacy problem.
- We pay attention to tone. A letter that reads like a legal threat will be experienced as a legal threat, even if that's not what we intended.
- We create obvious places for questions to land and for answers to come back. No one should have to make five phone calls to find the person who can answer a basic question.

And it means we start each communication with two simple questions:

1. What exactly are we trying to help this person understand or decide?
2. Why does this matter to them right now?

If we can't answer those questions clearly, the patient won't be able to either.

When we talk with leaders about designing a more transparent patient journey, we hear lots of frustration because it's complicated, every benefit plan is different, and they don't want to put themselves at risk for giving wrong information.

That's all true, and we empathize with their concerns. But remember, we do incredibly hard things in healthcare every day.

We run trauma centers, transplant programs, NICUs, and cancer centers. We manage clinical complexity that would have been unimaginable a generation ago. We don't avoid those responsibilities just because they're difficult.

The financial side of the journey is not somehow exempt from that same standard.

We may not be able to promise perfect information. We may not be able to anticipate every scenario. But we *can* be honest about what we know, clear about what we don't, and committed to walking with people through the uncertainty.

A transparent patient journey is not one where every number is known in advance. It is one where patients never feel abandoned, misled, or left alone with a stack of papers they can't decipher.

A transparent patient journey is the bar we need to set for ourselves. And if we care about access, trust, and authenticity, it's a bar we can no longer afford to ignore. It's an imperative that requires our time and investment so our employees and patients have the best experience given the circumstances.

ENDNOTE

1 Kaiser Family Foundation, "Americans' Challenges with Health Care Costs," https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.

CHAPTER SEVEN

STORYTELLING THAT BUILDS FINANCIAL CONFIDENCE

For as long as we have worked in and around healthcare, we've been pretty good at telling a certain kind of story about healthcare heroes.

We love to recount stories about the ambulance that races across town, the team in the ER that springs into action, the surgeon who operates at 2:00 a.m., and the nurse who sits at the bedside through the night. We put those stories on billboards, on websites, in annual reports, and in fundraising campaigns.

These stories are true, they're moving, and they matter. However, they almost always have a missing second half.

After the surgery, after the discharge, after the "miracle," there is almost always another chapter: the bill that arrives in the mail, the insurance denial that comes weeks later, the phone calls, the confusion, the fear that this one episode of care might upend someone's financial life.

If you've ever heard someone describe a major health event, you know how this goes. They'll tell you about the procedure and the doctors, and even the facilities, but then they will lower their voice and say, "And then I got the bill."

That part of the story is frequently where the trauma really begins. But in the healthcare world, that story almost never gets told.

This chapter is about why we *should* tell that story, and how we can go about it.

Why? Because if financial issues are access issues, then narrative isn't something that's just nice to have in our marketing. Storytelling is one of the most powerful tools we have to help people navigate a system that feels rigged against them and to build real confidence around money and care.

THE TWO LEVELS OF THE MONEY STORY

When we think about storytelling and financial confidence, we see two essential levels.

The *organizational* story is how we talk about money, mission, and stewardship as a hospital or health system. The *individual* story concerns how we talk about real people and the way they experience cost, coverage, and billing. Let's dive into each of these a bit more.

1. THE ORGANIZATIONAL STORY.

If you ask the average person in your community whether your hospital is profitable, you'll probably hear some version of, "Well obviously, it *must* be. They're building a giant new building."

However, people don't always understand what they're seeing. Hospitals don't just decide to build a new tower because someone had

a good quarter. They take on debt, just like you do with your home mortgage. And just like a homeowner, they have to plan for maintenance, upgrades, and ongoing repairs.

We tend to talk about this in abstract, technical language: capital expenditures, bond ratings, debt coverage ratios. The community hears "We're building a $300 million tower" and assumes the hospital has $300 million sitting in a bank account.

The story we should be telling sounds more like this: "We're taking out a mortgage to build the facilities this community will need for the next thirty years. We will be paying for this long after most of us are retired. That's why we have to be careful, and that's why a positive operating margin matters."

Hospitals and health systems are some of the oldest institutions in American communities. Many have been around for fifty, seventy, or even a hundred years or more. There are very few organizations in our economy that live that long. That longevity creates a different kind of responsibility.

In other words, you're not planning for the next quarter. You're planning for the next generation. That's the difference between providers and payors.

When we tell that kind of story clearly—how we use money, how we invest, how we take on risk to serve people over decades—it changes the way people interpret our financial decisions. We must share our priorities and how they reflect changing community needs. They stop assuming "new building equals greed" and start seeing that there is an intentional, mission-driven reason for taking on debt.

Yet that is only half of the whole story. The other part is what people experience personally every time they use their insurance card.

2. THE INDIVIDUAL STORY

Most people don't have a clear understanding of how their insurance works. They don't understand deductibles, co-insurance, out-of-pocket maximums, or step therapy. They just know that they're one serious medical event away from a bill that could change their lives.

Everybody has a story around this. Some examples:

- A friend with type 1 diabetes who spent weeks fighting for prior authorization so they can get their life-sustaining medication
- A family that received a six-figure bill for a hospitalization and spent months trying to understand if any of it was accurate
- A patient who did everything right, followed their doctor's orders, and then learned after the fact that a key element of their care "wasn't covered"

These kinds of stories spread in living rooms, parking lots, church lobbies, and especially on social media. They shape how people feel about healthcare as a whole. They create fear and anxiety without anything to offset it, such as clear communication, education, and authentic messaging.

If we want to build financial confidence, we can't ignore those experiences. We have to name them and show people what is possible on the other side.

TELLING THE WHOLE STORY, NOT JUST THE CLINICAL HALF

Right now, our storytelling about care looks something like this:

"Mary had a heart attack. She came to our ER. Our team acted quickly. She had a successful procedure and is now back home with her family."

That's all true, and of course it's good. But in the real world, Mary's story doesn't end there. There's a second act:

"Then she got the bill. She had no idea what it would be. She didn't understand why any of it cost what it did. Mary spent hours on the phone with the insurance company and with the hospital, and she lay awake at night wondering if she could keep her house."

We don't have to fictionalize this. That's the lived experience of millions of people.

We're not suggesting that we start publishing people's itemized bills with our marketing campaigns. Yet we can absolutely tell stories that include:

- What a typical episode of care actually costs.
- What a typical patient with a given plan ends up paying.
- How we helped a patient navigate that process.
- What financial assistance, payment arrangement, or coaching we offered along the way.
- What people can expect from us in the process.

We often hide behind the complexity. We say, "Every patient is different, every plan is different. We can't possibly tell you what this will cost." And on one level, that's true. But we have an enormous amount of data at our fingertips.

For example, we can easily know facts and figures such as how many hip replacements we did last year, the range of out-of-pocket costs for people with different insurers, how many of those patients accessed financial assistance or needed extended payment plans, and so much more.

Nothing stops us from saying something like this:

"We performed 1,500 hip replacements last year. For patients with Plan A, the typical out-of-pocket cost ranged from X to Y. For patients with Plan B, it ranged from A to B. Here's how we help people plan for that."

Is that a perfect prediction? No. But it narrows the uncertainty dramatically, and narrowing uncertainty is one of the most important things we can do for people.

We don't use stories to promise exact numbers. We use stories to answer the question, *"Am I about to step off a curb... or off a cliff?"* There is a world of difference between a $200 bill, a $2,000 bill, and a $20,000 bill. People will make very different decisions depending on which universe they think they're in.

And that brings us to the heart of the matter: people's decisions about whether to seek care at all.

FINANCIAL CLARITY DETERMINES WHETHER PEOPLE GET CARE

We like to think that when something really serious happens, cost becomes irrelevant. If it's life or death, we imagine that everyone says, "Just do whatever you have to do."

Sometimes that's true. If someone tells you that you are going to die without a certain treatment, you're far more likely to say, "I don't care what it costs. Do it." But that's not the reality for most of the people we serve, most of the time. And it certainly isn't true as it relates to elective care.

For anything short of "you're going to die this week," finances now play a huge role in access. Consider items such as orthopedic procedures, cancer treatments, chronic disease management, mental health services, or complex surgeries that affect quality of life more than immediate survival.

Many people will live in pain, delay decisions, or avoid care altogether if they're terrified of the financial consequences. That's not speculation. National surveys show that 93% of physicians say care has been delayed

due to prior authorization requirements, and 82% said it sometimes leads to canceled care.[1]

In addition, 47% of patients who needed a prior authorization in the last two years reported that it was somewhat or very difficult.[2] Those are people who went through with it. Almost 40% of insured adults are cancelling scheduled care due to cost.

As we mentioned in the introduction, during COVID, people were afraid to go to the hospital for fear of getting the virus. Remember that what we shared about New York during the pandemic wasn't unique to New York.

Today, the fear keeping people away from the hospital is financial. People are asking, "Is this pain really worth the risk of a five-figure bill?" They are self-diagnosing the severity of their illness based on their perceived financial exposure, not their clinical reality.

Even in the cases where the preventative visit is covered at 100% with no copay, the labs ordered may be a different story. Thus, the family with a total income of $60,000 in the last quarter nowhere near their out-of-pocket max of $12,000 waits until next year.

That's where storytelling can be incredibly powerful. What if we shared stories like these?

- A patient who delayed care and paid a higher price later.
- A patient who got care earlier because we helped them understand and plan for the cost.
- A patient who accessed financial assistance they didn't know existed.
- A patient who picked a better plan that was more appropriate for their needs

Those kinds of stories help people see that they're not alone in their fear, and that there are ways forward.

STORIES ABOUT THE SYSTEM

And what about telling honest stories around what's broken in the system? Let's take step therapy and prior authorization as a couple of good examples.

Step therapy is the practice of requiring patients to try cheaper, often less effective treatments before the insurer will approve the therapy their doctor actually recommends. It's particularly common in areas like orthopedics, cancer, autoimmune disorders, and high-cost medications, but it shows up in other areas too.

On paper, it sounds reasonable: "Let's try the cheaper option first." In practice, it often means months of delay, ineffective treatment, and tremendous stress for the patient. The physician may already know that the less expensive steps won't work, but the insurer doesn't want to approve the most expensive option until a checklist has been completed.

My personal favorite is when a patient with a history of success with a brand drug receives their insurance through an employer who has switched insurance companies. The new insurance company tries once again to get the patient to try the generic even after the patient turns in all the paperwork ahead of time.

Or consider prior authorization for diagnostic imaging. We shared a personal story of a family member earlier with an MRI. In other cases, the radiology benefit management company tries to steer the patient to a cheaper free-standing facility for the MRI. The image is unreadable or problematic as the MRI is 18 years old.

The plan ends up paying for two scans—one at the imaging center and one at the hospital. And of course, the patient then has two financial impacts rather than one. This example happened to hundreds of patients in the southeast before the payor finally allowed the hospital to be the only scan.

Here's another anecdotal example.

A friend with debilitating back pain saw a surgeon who ordered an MRI and recommended surgery. The insurance company denied the prior authorization because they didn't have evidence of recent physical therapy and cortisone injections. She had tried both in the past with no relief, but the documentation was insufficient for the insurer. So, our friend endured months of additional, ineffective and costly therapies before finally qualifying for the original surgery.

The point of telling these stories isn't to vilify one insurer. It's to help patients understand the environment they're walking into. It's to normalize their frustration and to show them that when they run into these barriers, they're not crazy, and they're not alone.

Storytelling, when we do it well, makes the system legible. It communicates, "Here's what happened to this person. Here's what they faced. Here's what helped. Here's what you can ask for if you find yourself in a similar situation."

STORYTELLING AS A DAILY PRACTICE, NOT JUST A CAMPAIGN

You don't need a Super Bowl ad to change how people feel about money and care. You need a steady stream of honest, relatable stories. You need a new narrative, with new messages delivered through new challenges. You need an authentic approach to discussing money in a very emotional and personal process.

That might look like:

- Short videos of patients (or actors representing composite stories) talking about how they navigated a big bill, with our help.
- Articles in the community newsletter walking through a "day in the life" of someone dealing with an insurance denial, and what resources the hospital provided.

- Social posts that break down a real scenario: "Here's what it looked like for a typical patient to have a knee replacement here—clinically and financially."
- Internal stories that celebrate staff who helped a patient understand their insurance before a procedure, not just after a problem.

The goal isn't to create polished corporate fairy tales where everything is perfect. It's to show people that the system is complicated, that the fear they feel is reasonable, and that we are committed to helping them navigate both the clinical and the financial journey as part of the same experience of care.

If storytelling is going to build financial confidence, it has to be specific, honest, and integrated. It has to show real tradeoffs, real numbers, real frustrations, and real resolutions.

Most importantly, it has to send a clear message: "You're not the first person to go through this. You won't be the last. And we won't leave you to figure it out by yourself."

In the next chapter, we'll turn from the stories we tell to the systems we build—looking at how we design and train our teams so that financial communication is not just compelling on paper, but consistent in every patient interaction.

ENDNOTES

1 *American Journal of Managed Care*, "AMA Survey Highlights Growing Burden of Prior Authorization on Physicians and Patients," https://www.ajmc.com/view/ama-survey-highlights-growing-burden-of-prior-authorization-on-physicians-patients.

2 Kaiser Family Foundation, "Public Finds Prior Authorization Process Difficult to Manage," https://www.kff.org/patient-consumer-protections/kff-health-tracking-poll-public-finds-prior-authorization-process-difficult-to-manage/.

PART THREE

THE OPPORTUNITY— LEADING THE NEXT ERA OF AUTHENTICITY

CHAPTER EIGHT

UNIFYING MARKETING, FINANCE, AND MISSION

If you've made it this far in the book, you've probably felt two conflicting things at the same time.

On one hand, you see how broken the financial experience of healthcare has become. You've lived it personally. You've heard the stories from friends, family, patients, or colleagues. You probably were asked to get involved even though it wasn't the system you worked for. You know that money is now one of the biggest barriers to care.

On the other hand, you sit inside an organization that feels complicated, political, and stretched thin. You might think, *"Yes, we should do better with financial transparency, but I don't control the billing office... or the payor contracts... or the website... or the call center scripts."*

This chapter is about that tension. Financial transparency must become a shared responsibility that is owned by leadership, expressed through

mission, executed by operations and revenue cycle, and communicated by marketing.

When those parts of the organization are aligned, you get something rare in healthcare: an organization that feels coherent to the people it serves. This is a truly holistic approach to care and access.

WHO OWES PATIENTS TRANSPARENCY?

When we talk about financial transparency, we're focusing on any health services organizations that directly provide care to patients and bill some form of insurance for it.

That includes:

- Hospitals and health systems
- Large physician groups and multispecialty practices
- Diagnostic centers and imaging centers
- Ambulatory surgery centers
- Urgent care and retail clinics
- Digital health companies
- Dental practices and oral health providers

If you are providing care and sending a claim, or you know a claim will be sent because of what you do, you're part of the financial experience of healthcare.

Some organizations have a simpler job than others. A single-specialty gastroenterology (GI) group operates with a much narrower set of billing codes than a full-service hospital. A radiology practice has a shorter list of services than an academic medical center with a 80,000-line chargemaster. If you run a pure cash-pay service with posted prices, your financial story is almost straightforward by comparison.

Yet working inside a complicated system doesn't erase responsibility. In fact, the more complex you are, the more important this becomes.

When you can hospitalize almost any kind of patient, for almost any kind of condition, and send almost any kind of bill, the potential for confusion and mistrust multiplies.

The good news is that there is a hidden opportunity here. Organizations that tackle the hardest problems with honesty earn loyalty from more sophisticated consumers over time. People recognize when you're willing to talk about the thing everybody else avoids.

They may not like every answer, but they'll remember that you didn't hide, and that you tried your best to serve them. Authentic brands get rewarded with loyalty and patient retention, and that has significant benefits over the long term. In addition, those loyalists tell a much different story themselves in their social settings.

EVERYTHING STARTS AT THE TOP: MISSION, BOARD, AND CEO

Like most things in a large organization, financial transparency matters when it is important to the people at the very top.

If the CEO and the board see this as a core expression of the mission, the organization will follow suit. If they see it as a nice-to-have, a line item, or a risky PR experiment, it will quietly fade the moment something else more urgent appears on the agenda.

Leadership has to be willing to say three things out loud:

- **"Transparency is important."** Not just in a memo, but in board meetings, town halls, strategic plans, and performance evaluations. We must believe it.
- **"We know this is hard."** The complexity of payors, codes, benefit designs, and regulations is real. Pretending otherwise only alienates the people who have to actually execute on this. Empathy is key.

- **"We're going to do it anyway, and we will not wait for perfect."** The fact that you can't solve the entire problem on day one is not a license to do nothing. Don't let perfect be the enemy of good, and know that every day we delay is a day someone may be delaying care as a result.

We have sat in plenty of rooms where someone proposes a sensible step toward financial clarity and the answer is, "That's a great idea, but it's way too complicated for us." If we applied that same logic consistently, we'd never perform a complex surgery, negotiate a payor contract, or implement new procedures.

Healthcare is full of things that are hard and worth doing. Health insurance and financial literacy belongs on that list.

Once leadership has set the expectation, the real work begins with two people who don't always see themselves as natural partners: the Chief Financial Officer (CFO) and the Chief Marketing Officer (CMO). You cannot build authentic financial communication without both.

Finance understands the numbers, the constraints, the payor contracts, and the risks. Marketing understands the audience, the language, the channels, and the emotional reality of patients and families.

Most CFOs will not naturally speak in a way normal people understand. Most CMOs cannot, on their own, build content that is accurate, compliant, and aligned with the financial realities of the organization. When they work together, you have a great shot at clarity that is both *truthful* and *human*.

This partnership cannot be fully delegated. Yes, directors and managers will do much of the execution. But the CFO and CMO themselves need a regular rhythm of collaboration. They need to signal that this work is important to the C-suite, and is therefore important to their teams.

Some ideas:

- Joint working sessions where finance explains the "why" behind pricing, contracts, and bad debt, and marketing pushes for accessible language and usable examples.
- Shared ownership of key financial communication initiatives: price estimators, FAQ pages, pre-care education, billing redesign, patient portal messaging, and more.
- Agreement on what the organization will and won't say publicly, and what it will commit to improving over time.

Think of this as the first governance model for financial transparency: a key partnership at the executive level that can't be brushed aside when things get busy. This change won't be easy, but it will make the work for your teams easier in the long run—and hopefully more rewarding for everyone involved.

FROM SILOS TO SHARED METRICS: ALIGNING AROUND AUTHENTICITY AND TRUST

Historically, marketing and revenue cycle are measured on completely different scorecards.

Revenue-cycle leaders are measured on days in A/R, denial rates, cash collections, bad debt, charity care, and coverage discovery. Marketing is measured on brand awareness, campaign performance, digital engagement, service-line volumes, and sometimes net promoter scores. Mission is measured on things like community benefit, equity, and adherence to values.

Financial transparency lives at the intersection of all three. If you want it to flourish, you need shared metrics that cut across these silos. That's where the Authenticity Index can evolve to include a financial dimension.

Let's review the four core elements:

1. Human truth: Are we speaking to the real experiences and fears people have?
2. Meaning: Does what we're saying matter to their lives and decisions?
3. Believability: Do people find our claims credible? Or do they sound like spin?
4. Trust: Over time, does our behavior match our words?

Financial communication touches each of these. To measure it, you can start small.

You can begin by adding a few questions to your brand tracking or community surveys:

- "On a scale from 0–10, how well do you feel you understand the cost of healthcare in general?"
- "How well does [Hospital/System] help you understand your costs before you receive care?"
- "How much do you trust [Hospital/System] to be honest about billing and insurance?"

Then track the responses over time, not just in the aggregate, but among key segments:

- People with high-deductible plans
- People with Medicaid or dual eligibility
- Patients who have had an inpatient stay in the last 12 months
- People who have used your charity-care or financial-assistance programs

These become your trust metrics around money. Marketing can drive awareness and comprehension. Finance can drive the underlying policies

that make those messages true. Mission can hold everyone accountable to the organization's stated values.

On the revenue side, you can also begin to track metrics like these:

- Changes in surprise-bill complaints or billing-related grievances.
- Avoided bad debt—instances where earlier education or financial-auth assistance allowed patients to plan and pay, rather than default.
- The utilization of financial assistance and payment plans among people who previously would have simply avoided care.
- Referral patterns, especially from employers and community partners, who may steer people toward systems they regard as more transparent and trustworthy.

The point isn't to invent the perfect dashboard on day one. It's to move from, *"We should say something about this"* to *"We are measuring whether our words are changing anything."*

START SMALL AND REPORT BACK

Here is one of the most practical pieces of advice we can offer: *Start small, but don't pretend that "small" is "everything."*

In hospitals, somewhere around five percent of services are truly "shoppable" in the way consumer advocates imagine—outpatient imaging, basic lab work, some elective procedures, and routine visits. It makes all the sense in the world to start your transparency work there. These services are easier to price consistently, easier to explain, and easier to build tools around. Yet you can't stop there, and it's not helpful to act as if you've solved the problem once you publish a shoppable-services tool.

It's more helpful to be explicit: "We're starting with these services because they're the easiest to estimate accurately. Over the next XX months, we will expand this to more complex procedures, and we'll report our progress to the community every quarter."

That kind of statement does two things. First, it sets a clear expectation that this is the beginning, not the end. And second, it creates a form of public accountability that makes it harder to quietly walk away when the work gets messy or challenging.

Then, follow through. Give updates and share what you've learned. Admit where you've fallen short or discovered new challenges. People tend to be forgiving when they believe you're being straight with them.

The bottom line is that when marketing, finance, and mission operate in isolation, patients feel it. The messages say one thing, the bills say another, and the stated values of the organization float somewhere above the whole things, uninvolved.

When you bring them together, you get a mission that acknowledges that money is not separate from care, a marketing function that tells the whole story (not just the flattering half), and a finance function that sees clarity as a strategic asset, not a threat.

Best of all, you get a community that starts to see you as a place that tells the truth ... even when the truth is complicated. That is the definition of Authenticity.

In the chapters ahead, we'll move from structures and metrics to the behaviors that make all of this real in front-line interactions. No matter how elegant your governance model is, patients experience your commitment to transparency one conversation at a time.

CHAPTER NINE

FROM COMPLIANCE TO COMPETITIVE ADVANTAGE

If you work in healthcare long enough, you learn a simple rule about new regulations. They almost always arrive wrapped in the language of consumer protection. And they usually feel like a burden to the people who have to comply. Worst of all, they always seem to benefit the payors, but that's a subject for another day.

Price-transparency laws have been no exception. Most organizations we talk to see them as one more box to check, or one more set of files to publish. While that may be true, it also represents an incredible opportunity to turn what you *must* do into something that builds trust, attracts employers and patients, and differentiates you in a market where most organizations still shrug and do the bare minimum.

In order to see that more clearly, we need to understand what these laws have actually done, and just as important, what they haven't.

HOW DID WE GET HERE?

For most of my career, talking about your negotiated rates in public wasn't just taboo, it was illegal.

Contracted prices between a hospital and a health plan were treated as trade secrets covered under antitrust law. If you went to an industry conference, the first slide was often the same: the lawyers would stand up and say, "No one will discuss their rates. No one will compare pricing. Don't even hint at it."

If you wanted to know where you stood in the market, you didn't ask your competitors what they were paid. You hired a firm to triangulate it for you. They'd analyze claims, apply proprietary models, and tell you, "On this bundle of services, you're roughly at the 25th percentile," without ever revealing exact rates for specific competitors. The system was designed to keep pricing strategies opaque.

Then came price-transparency laws. The first wave required providers (primarily hospitals) to publish their prices. Not list prices, but the contracted rates they'd negotiated with commercial insurers for certain services. In theory, this was going to empower consumers to shop.

Yet in practice, three things happened:

1. At first there were no meaningful penalties, so a significant number of hospitals simply didn't comply.
2. When penalties arrived, they were modest enough that some organizations still treated them as a cost of doing business.
3. The hospitals that did comply produced massive machine-readable files. These data sets were so large and complex that only people with serious processing power and technical skills could meaningfully use them.

We don't say this lightly: those early hospital transparency files are, from a consumer's perspective, almost useless.

You could be the most motivated patient in the world and still have no practical way to open, sort, interpret, and compare those files across hospitals. They're valuable in a narrow sense for analysts and negotiators, but they didn't suddenly make care shoppable for real people.

The second wave of regulation shifted the burden to payors.

Health plans were required to publish what they actually pay different hospitals and providers. Instead of Hospital A showing a blended payment rate, the insurer could say, "Here are the specific rates we pay each of these providers for each service."

This is both more aligned with how people think—"I have United/Blue Cross/Aetna. Where should I go?" It's also more useful because it gives a payor-level view across multiple hospitals.

Those payor files are still huge. They still require sophisticated tools to analyze, and they still contain errors and gaps. Yet compared to the original hospital-provided files, they're useful for anyone negotiating contracts or benchmarking position in the market. Most recently, in a farm state, the largest plan has almost nothing published for outpatient services.

So where did we land? Now we have a regulatory regime that has generated enormous B2B data sets. Analysts, consultants, and negotiators can mine that data to understand relative pricing and leverage it in rate negotiations.

If your conclusion is, *"Well, then it's useless for our patients,"* you're only half right. On its own, yes, it's useless. But as raw material for something better? That's where the opportunity begins.

TURNING COMPLIANCE INTO TRUST TOOLS

Right now, most organizations treat price-transparency compliance as a technical project. They publish the required, machine-readable files, build or license a basic price-estimator tool, and make sure they won't get fined.

That's the compliance mindset. Do what the law or regulation requires, nothing more.

A competitive-advantage mindset asks different questions like these:

- How can we use this data to answer the question patients actually want to know: *"What will this cost me?"*
- How can we translate payor-level files into simple, understandable ranges for real people?
- How can we use our compliance work to strengthen relationships with employers and community partners?

For example, imagine using your payor transparency data to build something more meaningful than a checkbox estimator. Maybe something like this—for the fifty most common elective procedures and diagnostic tests, you create simple, plan-specific ranges: "For patients with Employer Plan X, the out-of-pocket cost for a knee MRI at our system typically ranges from $180–$350."

Then you can connect that with some context: "In the last year, we performed 2,400 knee MRIs for patients with this insurance coverage. Here's what most people paid, and here's how we can help you manage that cost."

Finally, you present it through stories, FAQs, and decision guides—not just an impersonal tool hidden three clicks deep on your website.

Nothing in the regulations *forces* you to do this. The law and regulations are satisfied once you publish the raw data. But if you stop

there, you've done nothing to actually help patients. The organizations that will stand out are the ones that communicate, "We had to publish the data. But we chose to make it clear and easy to use."

WHY HEALTH INSURANCE AND FINANCIAL LITERACY BECOMES A PREMIUM

All of this begs a simple but important question: What is the upside of taking health insurance and financial literacy seriously? Where does it benefit you? Let's look at four specific ways.

1. WITH EMPLOYERS AND SELF-INSURED PLANS

Roughly 70% of people in the U.S. with commercial health insurance are covered by self-insured employers.[1] In those arrangements, the employer isn't buying an off-the-shelf plan from an insurance company, they are the risk bearing entity paying the claims, with a not-insignificant markup by the payor who acts as third party administrator. The insurance company is mostly an administrator or a vendor.

Those employers care very deeply about the unit price of services, the total cost of care over time, and whether their employees are avoiding necessary care. Chronic illnesses, temporary health problems, and mental health struggles cost U.S. employers $150 billion annually in presenteeism due to lost productivity and efficiency. They lose an additional $225 billion in unplanned absences and temporary replacement labor.[2]

All in all, it's in an employer's best interest to encourage employees to seek care early. Not only is the treatment likely to be easier and less expensive, the return to productive work is faster.

Most employers don't have the bandwidth or expertise to turn payor transparency files into actionable strategy. They rely on brokers and benefits consultants who are often compensated by the very insurers they're supposed to evaluate.

This is where a provider that embraces transparency in service of health insurance and financial literacy can stand out. Imagine being the system that comes to employers and communicates the following:

- "Here's how your employees are using care in our system."
- "Here's what they are paying out of pocket now."
- "Here's where your insurance company's policies and practices are impacting your employees' access to care."
- "Here's how we can redesign benefit structures and pre-care education so they get appropriate care at lower personal out-of-pocket risk."

When that is the case, you move from being a vendor to being a strategic partner because you're helping them manage both health outcomes and financial anxiety. That is a genuine competitive advantage.

2. WITH CONSUMERS

On the consumer side, we don't yet have a mountain of research proving that transparent systems always win market share—because so few organizations lean-in to health insurance and financial literacy. No one really does this at a truly high level yet.

However, we do know that people are terrified of surprise bills, and they avoid care when they're afraid of what it will cost. And when they are asked, they overwhelmingly say they would like to know their likely out-of-pocket costs in advance.

So even if we can't yet point to a definitive study, the common-sense question still remains: If you had to choose between two hospitals — one that made it easy to understand your financial responsibility, and one that didn't—which one would *you* instinctively trust more?

3. WITH TALENT

Does financial transparency help you recruit clinicians and staff? We don't fully know yet. But again, we don't think it's a large leap to imagine

that physicians and nurses would rather work in a place where patients are less blindsided and irritated.

It's also pretty safe to assume that front-desk and revenue-cycle staff would rather work somewhere that doesn't ask them to be the bad guy in every conversation. After all, people attracted to mission-driven work appreciate organizations that treat money as part of care, not an afterthought.

If you can say to candidates, "Our patients know what to expect—financially and clinically," that's significant. It's a subtle but meaningful differentiator between your organization and others the candidate might be considering.

4. WITH REGULATORS AND POLICY MAKERS

There is also a quieter advantage with legislators and regulators. If you're the organization that complies fully and also goes beyond the required minimum, you are probably going to be viewed in a more favorable light when new rules are put in place. They can't always make life easier, but they can definitely make life harder.

Of course, that doesn't mean you'll never have a tough audit or a contentious payor negotiation. But it does mean you show up as a good-faith actor in a space where many others are dragging their feet. All of this helps to support more appropriate legislation that protects those who need it rather than those with the deeper pockets.

WHERE THE ADVANTAGE GROWS

If the first phase of price transparency has given us enormous, unwieldy data sets, the next phase will be about how we interpret and deliver that information. Here are a few trends that are not only worth watching, but also shaping as you consider how you can make a positive contribution to this issue.

1. PERSONALIZED COST ESTIMATION

We all know that we live in a volatile environment when it comes to healthcare pricing. Deductibles reset every year, people move in and out of different phases of their benefits, and out-of-pocket maximums and copay structures are all over the map.

It's no longer good enough to rely on static price lists. A much better goal is moving toward personalized estimation. Imagine a tool that gives a patient something like this: "Based on your plan, your remaining deductible, and typical utilization patterns for this procedure, here's what you are likely to owe. And here are the main ways that could change."

That kind of estimation requires linking payor data, your own historical billing data, and real-time eligibility and benefits verification.

Is this technically challenging? Of course. But it's also exactly what consumers expect in every other part of their financial life. Whoever cracks that in a way that's both accurate and understandable enough will have a major edge.

2. HEALTH INSURANCE AND FINANCIAL LITERACY CONTENT HUBS

Right now, financial information on most healthcare websites lives in two unloved places: a generic billing FAQ written in legal jargon, and a price estimator behind a login.

We have a real opportunity to create financial-literacy hubs that treat money with the same seriousness as clinical topics:

- Plain-language explanations of deductibles, coinsurance, out-of-pocket maximums
- Stories that walk through real examples: "What it costs Jane to have her baby at our hospital." This example is especially important if the OB is not employed by the hospital
- Guides for choosing a plan during open enrollment, with questions to ask brokers and HR

- Step-by-step checklists for what to do if you get a denial or a bill you don't understand

You already have the raw material: price-transparency data, revenue-cycle experience, and patient questions. Turning that into a coherent, public-facing resource is another way to move from compliance to advantage.

3. AI TOOLS FOR BILLING CLARITY

AI will not magically fix the healthcare system. But it can absolutely help navigate it. We can envision a near future where:

- Patients can upload or paste a bill and ask, "What is this, and does it make sense?"
- They can ask, "What might this procedure cost me at different facilities in my plan network?"
- Front-line staff use AI-powered "copilots" to quickly surface likely costs, coverage issues, and plain-language explanations during live conversations.

The raw data required for those tools is exactly what the transparency rules are forcing into the open. On its own, that data is unusable. But when it's layered with intelligence and good design, it becomes a navigation system.

If you're a provider organization that leans into this early by building or partnering on tools that make your own billing and pricing more understandable, you send a strong signal: "We know this system is complicated. We're not pretending otherwise. But we're going to help you make sense of it."

That's not just compliance. That's differentiation in a way that goes beyond branding and business, to making a real difference in patients' lives.

THE SHIFT THAT MATTERS

We know that price-transparency laws are not going away. If anything, they'll get more prescriptive over time. Files will get bigger, penalties will get sharper, and definitions will get tighter.

While you might be able to influence the pace and intensity, you don't control that. What you do control is the posture you take toward the communication.

You can see transparency as a box to check or you can see it as a strategic lever. It's a chance to align your brand, your mission, and your financial reality in a way that very few organizations in your market are willing to do.

The first path keeps you out of trouble. But the second path builds trust, strengthens employer relationships, makes life better for your staff, and sets you up to use future tools in a way that compounds over time.

Compliance is the baseline, but competitive advantage is available to anyone willing to build on top of it.

The question isn't whether you will comply with transparency rules. You don't really have a choice. Instead, the real question is whether you will be brave and imaginative enough to turn those rules into something your community actually experiences as care.

ENDNOTES

1 Statista, "Share of Workers Covered by Self-Funded Health Insurance Plans," https://www.statista.com/statistics/985324/self-funded-health-insurance-covered-workers/.

2 Uprise Health, "Absenteeism vs. Presenteeism," https://uprisehealth.com/resources/absenteeism-vs-presenteeism/.

CHAPTER TEN

THE LEADERSHIP IMPERATIVE

If you are a CEO, CFO, or senior leader in healthcare, you already live in a world of competing urgencies.

You are balancing workforce shortages, payor pressures, clinical quality, safety, growth strategies, regulatory change, technology investments, and the daily reality of keeping the doors open. Against that backdrop, one more initiative can feel like the proverbial straw that breaks the camel's back.

So when someone says, "You need to take ownership of financial transparency," it is understandable if your first instinct is to think, *I don't have the bandwidth for another project.*

We suggest something different: this isn't "one more thing." It is a lens through which you see *everything else* you are already responsible for. Because if we take seriously what we have explored in this book, then financial clarity is not a side project.

Financial clarity is central to your mission *and* your ability to compete. And like any work that cuts across departments, it will not happen unless leadership champions it and holds teams accountable for the progress.

START IN AN UNEXPECTED PLACE: LEARN THE SYSTEM AGAIN

The first step for most executives is not to launch a task force or sign a consulting contract. It is to admit, quietly and honestly, that you probably understand your organization's finances much better than you understand the patient's financial reality.

Most CEOs we know can walk you through their income statement and balance sheet. They know their organization's payor mix, days cash on hand, margins by service line, and debt structure.

Far fewer can answer questions like these:

- What does a typical commercially insured patient actually experience financially when they have a baby or surgery at our hospital?
- How many of our patients set up payment plans? How many default?
- How often are people delaying or canceling recommended care because of financial concerns?
- What does an average year of healthcare expenses look like for a family of four in our community?

If you want to lead on this issue, you have to re-learn the system from the outside in. But how do you do that on a practical level?

A great way to start is by asking your CFO and head of managed care to brief the board not only on your contracts and margins, but on what those arrangements look like from the patient's perspective. You can also invite revenue-cycle leaders, front-line registrars, financial counselors, and social workers to share what they see and hear every day.

You cannot afford to have board members be uneducated in these facets of healthcare.

You might also consider sitting down with a stack of real bills, EOBs, and denial letters and forcing yourself to read them as if you were a frightened patient who doesn't speak your language. This exercise will probably be a real wake-up call.

And if you serve on a board, it means asking for education that goes beyond "Are we financially stable?" to "How is our financial structure impacting access, anxiety, and trust?"

Before you can champion financial clarity, you have to be able to feel, from a patient's perspective, how unclear and scary things are now.

MAKE FINANCIAL LITERACY A STRATEGIC PRIORITY, NOT A SIDE PROJECT

Once you see the problem, the next move is to give it some real status.

In most organizations, that means embedding financial literacy in the same category as quality, safety, and patient experience. If your strategic plan has pillars, this belongs in one of them. If your board has standing committees, this work should have a clear home and regular reporting.

You might set a simple, memorable vision such as "No patient in our system should be blindsided by a bill" or "Every patient will know, in advance, what to expect financially."

That vision should show up in multiple places:

- Your messaging about mission and values
- Your internal town halls and leadership retreats
- Your performance dashboards and scorecards

When the CEO says publicly, "Financial clarity is a core part of how we care for our community," it becomes much harder for anyone to dismiss this as "just a marketing gimmick" or "just a revenue-cycle project."

And when the CFO echoes that message ("We will succeed financially *because* we are honest and proactive, not in spite of it") you align two of the most powerful voices in the organization. Now let's look at a few ways you can do this on a practical level.

PRACTICAL WAYS LEADERS CAN CHAMPION THIS WORK

Championing is more than enthusiasm. It is commitment and behavior. Below are several ways you can show that it matters in your organization.

1. PUT IT ON THE AGENDA AND KEEP IT THERE.

Ask for regular updates on how many patients are using price estimators or financial-counseling services. Dig into trends in bad debt, charity care, and payment-plan participation. Take a look at patient feedback related to billing and cost explanations

If it shows up only once a year, people will treat it as a campaign. If it shows up quarterly, it becomes part of how you run the organization. If it shows up weekly and monthly, it's part of your mission.

2. CREATE A CROSS-FUNCTIONAL LEADERSHIP GROUP.

Consider bringing together people from several departments or areas: finance and revenue cycle, marketing communications, patient access and registration, clinical leaders from key service lines, and IT and digital teams.

Charge them with designing a more transparent patient journey, as we discussed in earlier chapters: pre-care, point of care, post-care. Give them air cover, time, and a clear mandate to improve clarity, reduce surprises, and then report back.

3. ALIGN INCENTIVES AND ACCOUNTABILITY.

If leaders are earning bonuses solely on margin and volume, you will get behavior that maximizes margin and volume. But if you add metrics

related to improvement in patient understanding of costs or employer satisfaction with your financial communication, you send a different signal. You are saying, "We care how we make money, not just how much we make."

4. INVEST IN TOOLS AND TRAINING, NOT JUST TECHNOLOGY.

Price estimators, patient portals, and AI chat tools only help if staff know how to introduce and support them. You can empower (and budget for) training front-line staff to talk about money with empathy and confidence. And you can provide coaching for clinicians on how to acknowledge financial concerns in the exam room. They don't need to be billing specialists, but they need to know how to refer people to them.

The culture shifts when the CEO shows up in those trainings and makes it clear that those initiatives matter.

5. MODEL THE LANGUAGE YOURSELF.

Don't talk about reimbursement internally or externally as if you're a passive recipient of someone else's generosity. Talk honestly about prices, contracts, and the reality that some patients cost the system more than it is paid to care for them.

Explain, in plain language, why that is true and how you are trying to manage it without harming access. If you are willing to speak clearly in public, others will feel more permitted to speak clearly in private.

FINANCIAL CLARITY AS A MORAL AND MARKET IMPERATIVE

Let's briefly dig into an important, but often overlooked question: is this work a moral imperative?

We believe it is.

We now know that many people delay or avoid care recommended by their physician because they are afraid of what it might cost. We also know that medical debt and financial strain are linked to anxiety, depression, and, in some cases, deaths of despair.

And sometimes, those surprise bills can be the "last straw" for families living on the edge. Only 63% of households can cover an expense of $400 using cash or an equivalent. The remaining households have to sell something, borrow and pay over time, or default on the payment.[1]

If the way we handle money is causing people to suffer, or to skip care that would extend or improve their lives, it is hard to argue that this is a neutral issue. It is not just an administrative inconvenience. It is a form of harm.

When we ask clinicians to "first, do no harm," that oath does not stop at the edge of the billing office. The financial side of healthcare is part of the care experience.

You can't claim to be serious about your mission to heal and serve your community if you ignore the very thing that keeps thousands of people from walking through your doors.

At the same time, even if you are skeptical of moral language, the marketing case is strong.

If people are more likely to choose you when they understand what care will cost ... if employers are more likely to partner with you when you can help them manage financial risk ... and if staff are more likely to feel proud of working in a place that doesn't routinely traumatize people with confusing bills ... then financial clarity is not philanthropy. It is strategy.

The beauty of this rare situation is that the ethically right thing to do and the strategically smart thing to do are the same thing. You don't often get that kind of alignment in healthcare. When you do, you should seize it.

WHAT COULD THIS LOOK LIKE?

Let's zoom out and imagine what it might look like if leaders took this seriously across an entire system.

Patients would:

- Choose plans and providers with a clearer sense of what their decisions mean financially
- Receive cost expectations early and often, in language they can understand
- Enter surgery, procedures, and hospital stays with fewer unknowns hanging over their heads
- Spend less time fighting denials and more time recovering

Clinicians would:

- Feel less caught in the middle between patients and payors
- Have simple ways to introduce financial resources without feeling like they've become accountants
- See fewer patients who waited too long to seek care because of money

Employers would:

- View your organization as a partner in managing both health and cost, not just a vendor sending large bills
- Have better data for designing benefits that encourage appropriate care instead of quietly discouraging it
- Hear fewer complaints from employees about surprise bills and confusing coverage

Your organization would:

- Compete not just on "hotel services" and clinical reputation, but on clarity and trust
- Build a brand that is harder for competitors to imitate, because it is rooted in culture, communication, and long-term commitment

- Stand in front of regulators, legislators, and community leaders as a system that chose to act before it was forced

That is the vision: a world where financial honesty is inseparable from clinical care. Not a glossy campaign, not a one-time initiative, but a defining characteristic of what it means to be an authentic healthcare provider.

A CALL TO ACTION: START THE CONVERSATION OTHERS AVOID

If you have read this far, you are already in a small minority. You are paying attention to a topic many leaders quietly hope will go away.

But it won't. The question is not whether financial issues will shape access, trust, and outcomes. They already do. The question is who will step into the gap.

You do not have to solve the entire system. You do not have to wait for payors to change or Congress to act. You only have to do what leaders always do when faced with a complex, imperfect environment.

Learn the terrain. Set a clear direction. Align people and resources around that direction. Take the first imperfect steps, then keep going.

Be the system that talks honestly about cost, because silence is already costing more than you think.

The organizations that will thrive in the next decade are the ones whose leaders understand that authenticity is not a tagline. It is the daily choice to tell the truth about how care is financed, what it means for patients, and what you are doing to make that experience less frightening.

That is the leadership imperative.

ENDNOTE

1 Board of Governors of the Federal Reserve System, "Economic Well-Being of U.S. Households in 2023," https://www.federalreserve.gov/publications/2024-economic-well-being-of-us-households-in-2023-expenses.htm.

CONCLUSION

HEALING THE FINANCIAL DIVIDE

If there is one idea we hope stays with you after this book, it is this:

Financial issues are access issues.

Financial issues are not an unfortunate side note. They are not a separate domain reserved for billing teams. Financial decisions are woven into every decision people make about whether to seek care, where to seek it, and how they feel about the experience afterward.

We have built a healthcare environment in which:

- Patients routinely choose doctors and hospitals based more on in-network status and out-of-pocket cost exposure than on clinical quality.
- Out-of-pocket obligations are large enough to cause real fear and hardship.
- Denials, prior authorizations, and surprise bills are so common that nearly everyone has a story.

Against that backdrop, it is tempting to throw up our hands and blame the system. It is, after all, a system that isn't really a system, but a patchwork of public and private payors, regulatory regimes, benefit designs, and local practices that often contradict each other.

In this book, we haven't argued that you can fix all of that, or even that you should try. Instead, we have presented the case that you can tell the truth about it. We believe that telling the truth is both an ethical obligation and a strategic advantage.

Authenticity, as we have defined it, is not softness. It is not about clever positioning or sounding caring in your advertising. Authenticity is the willingness to name the realities of cost and coverage plainly and acknowledge how those realities affect your patients. It also means taking responsibility for the parts you can influence, even when you did not create the problem.

That kind of authenticity is not just a marketing tactic. It is a leadership responsibility.

When you design a more transparent patient journey, you are not simply improving your brand. You are making it easier for people to step into care instead of avoiding it. When you reframe the money conversation from confrontation ("You owe...") to collaboration ("Here's what this will cost, and here's how we'll walk you through it"), you are reducing fear instead of adding to it.

And when you use real human stories to demystify billing and insurance, you are doing more than content marketing. You are helping people see themselves in the system and ask better questions.

There is great power in aligning marketing, finance, and mission. When that happens, you stop treating financial transparency as a compliance exercise and start treating it as a way to live out your purpose in public.

And when you, as a leader, say, "We will not accept a world where our patients are routinely harmed by confusion and silence," you are stepping into the moral dimension of this work.

Because at the end of the day, this really is about harm. My friend, Nate Kaufman, talks about "administrative harm" as a consequence of the health insurance industry, and it's an apt term.

Why? Because financial confusion harms people. It keeps them in pain longer than they need to be. Confusion worsens chronic conditions and creates stress that echoes through families, workplaces, and communities. It pushes some people into debt and despair. We cannot, in good conscience, pretend that is someone else's problem.

The good news is that the path forward does not require perfection. You do not need a flawless price estimator or a perfectly coordinated national policy to begin. You simply need to start the conversations your competitors are afraid to have:

- With your board and executive team: "What is our responsibility here, and how will we own it?"
- With your patients: "Here is what we know, here is what we don't know yet, and here is how we will help you navigate the uncertainty."
- With your community partners and employers: "Let's look honestly at what healthcare costs and how we can minimize harm while maximizing access."

Trust is not built in a single campaign or policy change. It is built one honest financial conversation at a time.

No single action will transform the system. But each act, big or small, signals a different way of showing up in healthcare—one where being authentic means not just how we tell our story, but how we handle the most sensitive topic in the room: *money*.

If you choose to lead in this space, you will not only differentiate your organization. You will also make it a little more likely that the next person who needs care will walk through your doors earlier, less afraid, and better prepared.

That is what this work is about.

It's not transparency for its own sake. Rather, it is transparency in service of health insurance and financial literacy. It comes down to the possibility of a healthcare experience where people are not forced to choose between their health and their financial health. And where the systems that care for them are honest enough to say, "We see the problem, and we are doing everything we can to help you face it."

One conversation at a time.

APPENDIX

AUTHENTIC LEADERSHIP IN PAYOR–PROVIDER DISRUPTION

Payor–provider disputes are one of the most visible—and emotionally charged—moments in healthcare. When contracts break down, patients often find themselves caught between two large institutions, trying to understand what it means for their care, their doctors, and their finances.

We have seen every version of this issue play out across the country – more than 2,100 negotiations in 49 states. We've seen payors flex their muscles and batter hospitals and other provider groups into submission. And we've seen smart, prepared provider groups turn the tables and create enormous pressure on a payor to settle with reasonable rates and contract language.

This appendix is not about negotiating tactics or assigning blame. It's about leadership, communication, and responsibility. Specifically, it explores how healthcare organizations can educate and support

patients during periods of disruption—and how the work done long before a dispute ever arises determines whether those efforts are trusted or ignored.

When they are handled well, these moments can reinforce credibility and protect access. But handled poorly, they can undo years of trust in a matter of weeks.

WHY PAYOR–PROVIDER DISPUTES ARE MOMENTS OF TRUTH

Payor–provider contract disputes are not just operational or financial events. They are moments of truth for patients.

From the inside, these disputes are usually about rates, unit prices, risk sharing, and sustainability. From the outside, they feel very different. Patients experience them as uncertainty: *Will I still be able to see my doctor? Will my costs go up? Do I need to change hospitals? Did I do something wrong?*

Most people do not understand how provider contracts work—and they shouldn't be expected to. What they *do* understand is disruption, fear, and the sense that decisions are being made without them in mind. When organizations fail to acknowledge that emotional reality, they unintentionally communicate indifference, even when that is not their intent.

These moments matter because they concentrate everything we've discussed in this book into a very short window of time. Trust is tested. Credibility is evaluated. And the stories patients tell themselves—and each other—about who is "on their side" get written quickly.

Too often, organizations treat these disputes as temporary crises to be managed quietly until they pass. But patients don't experience them as temporary. They experience them as personal. And once trust is

damaged, it rarely resets just because a contract is eventually signed.

That's why payor–provider disputes reveal something essential: whether an organization has built enough credibility, clarity, and goodwill *before* the disruption to be believed *during* it. The work of authentic communication doesn't begin when negotiations break down. It begins months or years earlier.

Let's take a look at how to educate patients without alarming them, how to activate them without manipulating them, and how to communicate in ways that protect access while reinforcing trust.

WHAT PATIENTS ACTUALLY NEED TO KNOW

One of the biggest mistakes organizations make during payor–provider disputes is assuming patients either need *everything* or *nothing* explained to them. In reality, they need something much more specific: context.

Patients do not need a seminar on managed care contracting. They don't need rate sheets, actuarial logic, or legal positioning. What they need is a clear, calm explanation of what is happening, what might change, and what it means for *them*—without panic, blame, or spin.

In these moments, education should answer a small set of practical questions in plain language. *Is my doctor still in network today? What could change if no agreement is reached? How would that affect my costs or my ability to receive care? Are there exceptions for ongoing treatment? What should I do right now, and what can wait?*

When organizations fail to answer these questions directly, patients fill in the gaps themselves—often with worst-case assumptions fueled by social media, employer rumors, or insurer messaging. Silence creates anxiety. Vague reassurances create mistrust. Overly aggressive language creates fear.

Authentic education respects emotional reality without amplifying it. That means acknowledging uncertainty without dramatizing it. It

means saying, "Here's what we know today, here's what we don't know yet, and here's how we'll keep you informed," rather than pretending everything is under control when it isn't.

And the tone matters as much as content. Patients should never feel like they're being recruited into a fight or asked to take sides they don't understand. The goal is not to win an argument. Instead, it's to preserve access, continuity, and confidence. The goal is to empower patients and their families to stand up for themselves.

When education is done well, it stabilizes people. It lowers anxiety. And it creates the foundation for trust-based action if circumstances require it later.

HELPING PATIENTS USE THEIR VOICE

There is a crucial difference between *educating* patients and *activating* them. This is where many organizations get uncomfortable. Education says, "Here's what's happening." But activation says, "Here's how you can respond if you choose to."

The discomfort comes from fear of crossing a line. Leaders worry about appearing political, coercive, or self-serving. They worry about regulatory scrutiny. They worry about being accused of turning patients into pawns in a negotiation.

Those concerns are understandable. But they often lead to an overcorrection: organizations stop at empathy and explanation, leaving patients informed but powerless. And that is not authentic communication.

Activation, when done ethically, is not about telling people what to think or do. It's about helping them understand that *they already have a voice*—and showing them how to use it effectively.

Patients are not neutral bystanders in payor–provider disputes. They are the ones whose access, continuity, and financial exposure are at stake.

Yet most have no idea that their employers, insurers, and regulators actually listen to them, sometimes far more than they listen to providers.

We believe authentic activation starts by naming that reality. It sounds like this: "If this potential change matters to you, there are steps you can take to make your perspective known. We can't make decisions for you, but we can help you understand your options."

That framing preserves agency. It avoids pressure. And it respects autonomy. From there, activation should be practical, not performative.

For patients on employer-sponsored insurance, that may mean encouraging them to talk to their HR or benefits team. Most employees don't realize that their employer—not the insurer—is often the ultimate decision-maker in plan design. Helping patients understand that dynamic can be empowering. It reframes the situation from "I'm stuck" to "I have a channel."

For patients on Medicare Advantage or exchange plans, activation may involve helping them understand enrollment windows, switching options, or appeal rights. Not as a sales pitch. Not as a threat. Simply as information they're entitled to have.

In some cases, activation may include pointing patients to regulators, insurance commissioners, or legislators—again, not to advocate for a specific outcome, but to ensure their experience is heard.

What activation should never look like is a call to arms. It's not:

- "Flood the insurer with complaints."
- "Blame the payor for everything."
- "If you care about us, you'll take action."

That kind of messaging erodes trust and credibility. Patients can sense when they're being emotionally leveraged. Instead, ethical activation follows three principles:

- First, it is optional. Patients are never made to feel responsible for resolving the dispute.
- Second, it is informational. The organization provides clarity, not scripts.
- Third, it is supportive. Patients are guided, not pushed.

One of the most important things organizations can say during these moments is also one of the simplest: "You're not alone in navigating this. If you want help understanding what to do next, we're here." That sentence changes the dynamic. It turns fear into agency. It transforms a confusing corporate conflict into a human decision-making process.

And it does something else that's easy to overlook—it reinforces trust long after the dispute is resolved.

Even if the contract is settled quietly, patients remember how they were treated during the uncertainty. They remember whether they were respected as adults capable of making informed choices—or treated like liabilities to be managed.

Activation done well doesn't inflame tensions. It deepens relationships. But it only works if it's grounded in the work that happens the rest of the year—which is where we turn next.

THIS ONLY WORKS IF YOU'VE EARNED IT

Everything we've described here depends on one foundational truth: you cannot suddenly become authentic when a crisis hits. Payor–provider disputes don't create trust. They *reveal* it.

If an organization has spent the rest of the year avoiding financial conversations, hiding behind jargon, or deflecting responsibility onto insurers, patients will sense the shift immediately. Activation will feel opportunistic. Education will feel strategic rather than sincere. Even accurate information will be met with skepticism.

On the other hand, organizations that have consistently talked about cost, coverage, and financial responsibility—clearly, calmly, and without defensiveness—enter these moments with credibility already established.

Patients think, *They've been honest with me before. I trust them now.* That trust is what makes education land. It's what makes activation ethical rather than manipulative. And it's what allows an organization to say, "Here's what's happening, and here's how you can respond," without it sounding self-serving.

This is why authentic marketing around payor–provider issues cannot be a standalone tactic. It is the downstream expression of everything that comes before it: transparent billing, empathetic financial conversations, clear language, and leadership that treats money as part of care—not a separate, uncomfortable topic.

When financial honesty is woven into everyday operations, moments of disruption don't require a new playbook. They require consistency.

And that consistency does something powerful. It signals to patients, employers, regulators, and staff that this organization doesn't disappear when things get hard. It stays present. It tells the truth. And it respects people enough to let them decide what to do with it.

That's not just good crisis communication. It's what authentic leadership looks like when it matters most.

WOULD YOU REVIEW THIS BOOK?

If you enjoyed reading this book, would you kindly take a few moments to leave a review wherever you purchased it (and perhaps even Goodreads.com)?

We are grateful for your support. Thank you!

ABOUT THE AUTHORS

Brandon Edwards is chief executive officer and founder of Unlock Health, the largest marketing agency in the U.S. serving healthcare providers and the innovator who created the modern approach to payor/provider contract dispute communications nearly 25 years ago.

Brandon has spent his career in healthcare marketing and managed care strategy and contracting, beginning in 1995 when he joined a marketing agency that served certain hospitals, and more directly in 1997 when he joined Tenet Healthcare. He has spent his career focused on the business of healthcare, at the intersection of payor and provider in the most complex industry in the country.

A featured speaker at industry events, he is also the author of four books, including 2025's *Authentic Healthcare Marketing: Build Trust, Engage Patients, and Succeed in the Post-Truth Era.* He led the most awarded healthcare marketing agency in the industry's history as CEO from 2009 to 2022, with recognition as Agency of the Year or Best Agency to Work For (or both) thirteen times in thirteen years.

Brandon lives in Nashville, Tennessee with his wife and the smartest French Bulldog in the world. A graduate of UCSB and UCLA's Anderson School, Brandon has three adult children.

Kevin Thilborger currently serves as the Chief Managed Care Officer and Chief Revenue Strategy Officer of Unlock Health. He leads the Managed Care, Value-Based Care, Strategic Communications, Change Management and Reimbursement Strategy/Transformation practices as well as sits on the advisory councils for new strategic investments for the firm.

Prior to his current role, he worked with organizations to transform their revenue strategies from traditional fee-for-service toward capitation, including overall performance improvement in administrative functions. He has worked with all sizes of health plans and health systems including multi-state Academic Medical Centers, across the United States. He has also advised and implemented changes in national, regional, and local health plans in Medicare, Medicaid, and commercial business.

He has over 25 years of health care industry experience working for medical groups, insurance carriers, and consulting firms on turn-around strategies, managed care negotiations, new product development, direct-to-employer arrangements, and overall operations improvements.

Money has become one of the biggest barriers to care. And uncertainty about money is causing the same kind of barrier.

Patients delay screenings, decline procedures, and avoid treatment because they don't understand what it will cost — or whether they can afford it. Even when people desperately need care, they often avoid it out of fear.

In this timely and unflinching book, Brandon Edwards and Kevin Thilborger argue that financial issues are access issues and that healthcare organizations can no longer afford to stay silent. Building on the principles of Authentic Healthcare Marketing, the new book The Price of Care offers a practical framework for transparent, empathetic financial communication that aligns mission, marketing, and finance around trust, helping patients understand how healthcare actually works.

ISBN 979-8-234-00686-8
90000>
9 798234 006868