experian health

The State of Claims

SURVEY 2022

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The State of Claims – 2022 was informed by a survey conducted in June 2022. Participants included 200 healthcare professionals who work in claims and are part of the decision-making process for purchases expected to improve the claims process. The sample represented primarily executive and upper management in both finance and operations.

The intent of this paper is to frame the current claims environment based on responses provided by those who are responsible for collecting reimbursement dollars from payers on a daily basis. Specifically, the survey provides directional data indicating the priority healthcare organizations assign to claims (and the associated denials), the level of concern that exists today around claims and denials, and how technology contributes to improvements.

Introduction

American healthcare relies on possibly the most complicated revenue cycle system in the world. A 2021 Commonwealth Fund report compared the healthcare system performance of 11 high-income countries. The United States placed last in nearly every category, including administrative efficiency, which underpins — or doesn't — how America pays for healthcare. In fact, the United States has ranked last as far back as the Commonwealth Fund's 2004 report. A staple of a high cost, inefficient system is a high level of complexity. Reimbursement in the United States requires patients, doctors and hospitals to prove that treatments are necessary, and as the process for doing that becomes more complicated, more time, effort and money are needed to provide that proof.

Revenue cycle management, the process that includes healthcare claims, has become more challenging in the United States. The following excerpt comes from the Journal of Vascular Surgery (Volume 50, Issue 5, 2009, pp. 1232–1238):

> … third-party insurance billing has become so complicated that we can no longer afford the delays involved in billing claims that are "not clean." Once these claims leave our office, they are subject to delays and denials that result in further research, reprocessing, and more delays. On average, a denial rate of 12% is quite common. This double effort bogs down our staff, slows the processing of current work, and results in higher accounts receivable. More importantly, the much-needed payment is delayed.

Despite being dated, the description could be inserted into any modern description of the claims process. Also, in 2009, processing claims was listed as the No. 2 most significant contributor to "wasted" healthcare dollars in the United States, estimated at $210 billion. A decade later, that amount was estimated at $265 billion. Today, obstacles continue to disrupt the claims process. Even before the COVID-19 pandemic, this was acknowledged as unsustainable. Now, healthcare is likely at a tipping point where factors including regulation, the pandemic's yet-to-be-determined impacts on population health, and national economic instability make a strong case for reducing as many revenue cycle complexities as possible.

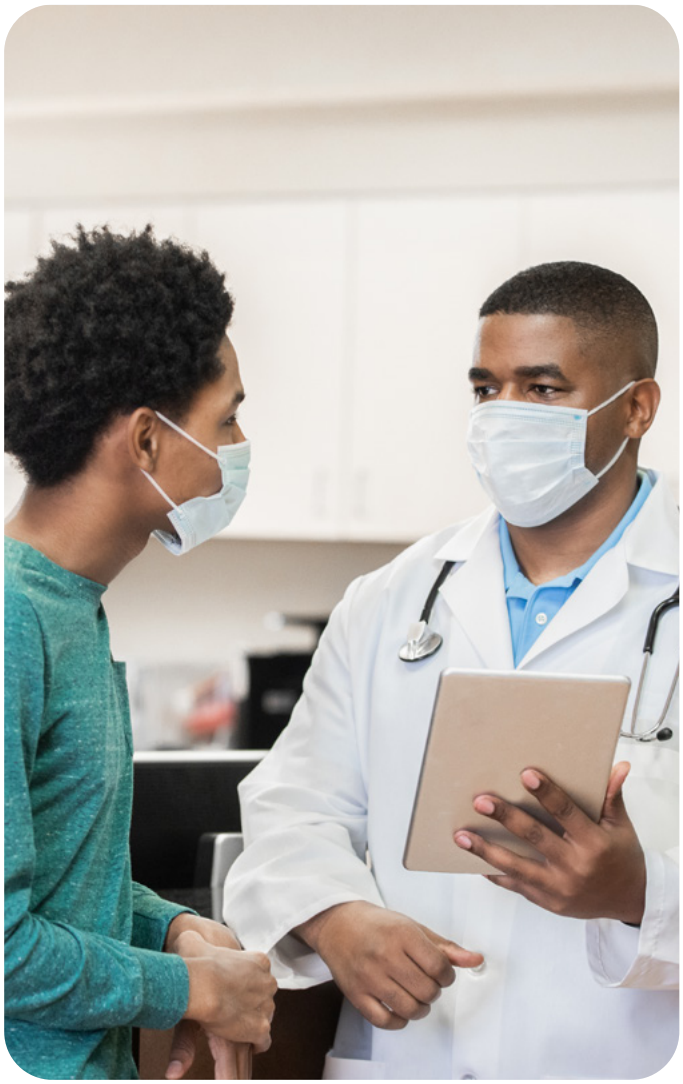
In 2009, the challenges processing claims "wasted" $210 billion. A decade later, that amount was estimated at $265 billion.

The pandemic: Accelerating both problems and solutions

The pandemic predictably added to the problems faced by those who manage claims and denials in hospitals and medical groups. While there was a sudden drop in visits throughout much of 2020, the system-wide health response and systemic changes to operations snowballed throughout the various waves of the virus. Changes to CPT codes were constant and erratic. There was the quick rise and subsequent retreat of teleservice demand and inconsistencies in coverage between Medicare and private insurers. **Experian Health recorded well over 100,000 payer policy changes** for coding and reimbursement between March 2020 and March 2022, illustrating the quickly changing landscape. Possibly more significant has been the escalation of staffing shortages from "critical" to "crisis." Like many business sectors, healthcare is struggling mightily to function as there just aren't enough people to do the work.

Juxtaposed against the struggles it generated, the pandemic had a positive impact on many operational issues, some of which were long overdue for change. For example, forcing healthcare to go all in on many types of process and technology improvements sets the system up for a better future. Numerous reports have pointed to increased provider spending on technology since 2020. In the revenue cycle space, technology spend has been used to enhance and improve outdated manual claims management and digitize multiple data collection points (though the survey data shows there is still a long way to go).

Technology also shows promise as a meaningful counterweight to the shortage of available, qualified or interested staff. Consistently labeled with the "job killer" stigma, automation and intelligent technology historically struggled to gain acceptance in the healthcare workplace, where staffing shortages were chronic long before the pandemic. Employees doubted software would complement existing staff as opposed to replacing them. However, as the pandemic shrunk staff levels and caused some to leave altogether, the few remaining had to take on more and more work. Eventually, the pandemic proved a more convincing argument than cost savings and the "better use of time" pitched by management to introduce automation.



Overall, there's optimism that healthcare may finally catch up — or at least make significant advances — by investing in technology that helps it function at a level that meets patients' experience expectations on the front end and removes much of the friction created by manual management of claims management complexities on the back end.

Executive summary

It's clear from the survey that while some claims challenges existed long before the pandemic, there's now a very different environment than existed pre-pandemic. Public and private insurance represent almost all of provider and medical group income, so anything that helps improve claim success rates is given priority status (e.g., new technology). The following are primary takeaways from the survey:

Denials are increasing. 30 percent of respondents say denials are increasing between 10 percent to 15 percent. That increase is on top of increases from previous years. The top 3 reasons?

Insufficient data analytics
62%

Lack of automation in claims/denials process
61%

Lack of thorough training
46%

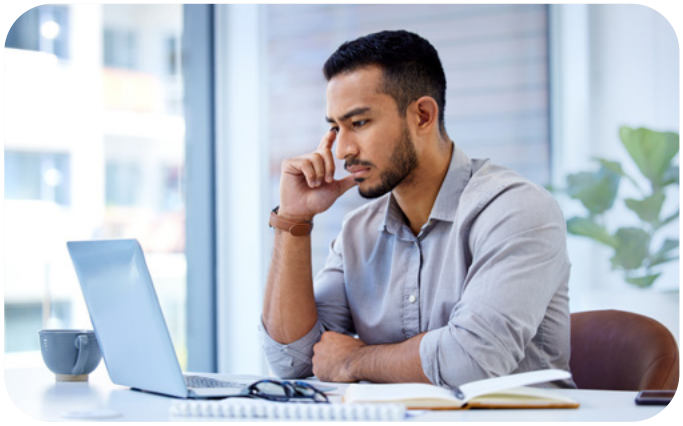
Automation is considered critical. Everyone wants "technology." In fact, 52 percent of respondents upgraded or replaced previous claims process technology in the last 12 months. However, they differ when asked who develops and maintains that technology. Artificial intelligence (AI) is a hot topic but has low penetration — possibly because there aren't that many true AI solutions out there yet for claims management.

49% Develop solutions in-house

43% Leverage the outside expertise of third-party consultants and vendors

51% Are using robotic processing automation

11% Are using AI



Everyone is looking for improved performance. Whether deploying the most sophisticated solutions or just trying to offload repetitive work from the claims team, providers want to improve the current state. The claims process, in general, isn't optimized and is ripe for disruption. In fact, 78 percent of respondents say their organizations are at least somewhat likely to replace their existing claims management solution if convinced something else can deliver better ROI. What defines better ROI? That varies as well.

Metrics used to define return on investment

Hours spent appealing/resubmitting claims
61%

Time spent appealing/resubmitting versus reimbursement totals
52%

Clean claims rate
47%

Denial rate
41%

Ultimately, automation has a meaningful impact on all of these metrics; it will likely have much more impact in the next few years. And, as the survey shows, there are many factors that demand accelerated adoption of these technologies.

The Survey: State of Claims — 2022

Denials are increasing and reducing them is priority No. 1
Providers are watching over their claim processes closely. Nearly 3 out of 4 respondents indicated that reducing denials is the highest priority. For 70 percent of respondents, claims management is more important now than it was prior to the pandemic. Respondents indicated there are a number of reasons for this, including:

- 67% Payer policy changes occurring more frequently
- 51% Reimbursement taking longer
- 43% Errors on claim submissions increasing
- 42% Denials increasing

Unfortunately, the trend is moving in the wrong direction, highlighted by the increase in denials. Of the 42 percent who say denials are increasing, the operational challenges they point to are:

Operational challenges that increase denials

Insufficient data and analytics to identify submission issues
62%

Lack of automation in claim submission/denials prevention process
61%

Lack of staff training
46%

Lack of in-house expertise
44%

Dated technology, inadequate for the work
33%

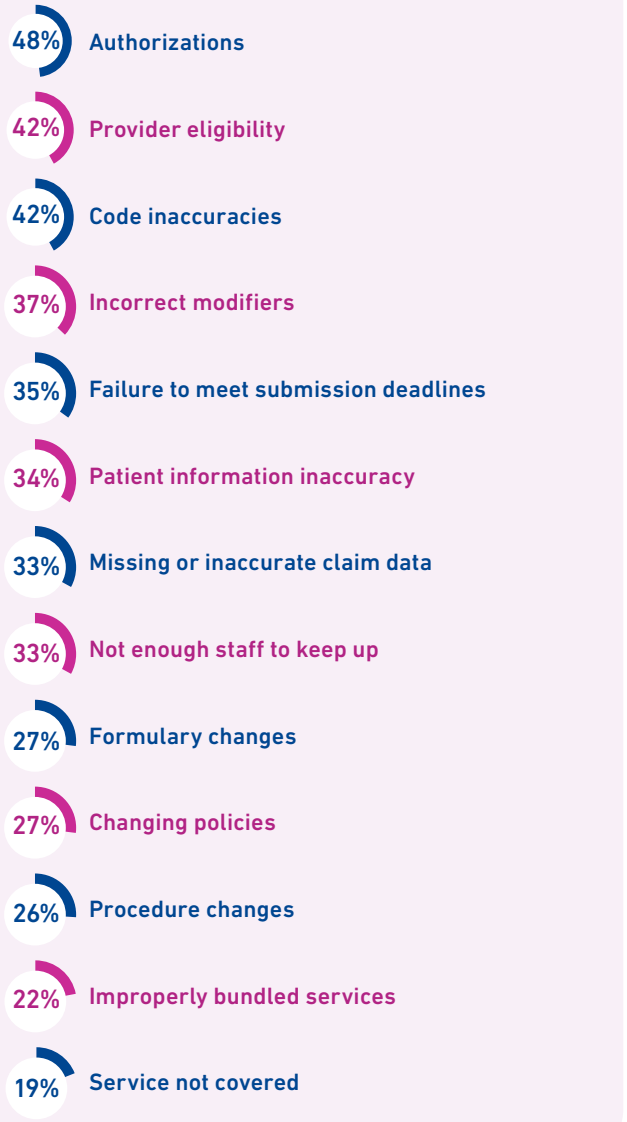
Staffing shortages
30%

Even more concerning, 73 percent said that claims are denied between 5 to 15 percent of the time. Nearly 1 in 3 see declined claims 10 to 15 percent of the time. This represents billions of dollars that will take longer than anticipated to be reimbursed — if reimbursed at all — which puts pressure on providers' cash flow. The overhead to rework and resubmit these claims can be considerable and further dilute reimbursement totals.

Reasons for denial: Why is this still happening?
The top reasons a claim is denied reflect procedural, technical and quality control issues. In rank order, respondents selected the reasons that are most frequent. (See chart 1.)

CHART 1
Top Ranked Reasons for Denials

Survey respondents ranked the TOP three reasons for denials. Percentages indicate how often the associated reason was ranked first, when selected.



more than half (53%) say the staff shortages continue to slow submission speed and undercut the efficient resubmission of denials

Of the many reasons a claim may be denied, the majority are tied closely to how well systems and individuals communicate between the payer and the provider. Historically, this has been an area with opportunity for improvement. In fact, providers are just as concerned payers may not reimburse them as they are consumers may not pay their bills (89% consumer, 88% payer).

Digging a little deeper into why these issues keep claims teams up at night, respondents gave insight into the things that contribute to denials. At the top of the list is a common challenge for all organizations: staffing. The Great Resignation is looking less like a temporary blip created by the pandemic and more like a long-term shift in employment culture and job preferences. The lack of clinical staff has been well-documented for quite a while — especially nurses — but, until the pandemic, healthcare "got by." Like many weak links exposed by COVID-19, staffing was decimated, and the domino effect hit hard and often, leaving positions empty or understaffed at many hospitals.

The shrinking of the back office has been less publicized, but for healthcare organizations, it's no less stark. A fully staffed revenue cycle team in the best of times has its hands full with collections and reimbursements. Today, the backlogs are getting longer. Of those respondents concerned with timely payer reimbursement, more than half (53%) say the staff shortages continue to slow submission speed and undercut the efficient resubmission of denials. Considering patient volume is still below pre-pandemic levels, the prospect of an increase in work as volumes recover isn't something providers are looking forward to.

The next two concerns for providers are closely related:

Inability to keep up with rapidly changing policies

Difficulty keeping track of preauthorization

Both reflect a common characteristic of payer policy: it changes a lot. That leads right into the next concern of managing limited resources to cross check claims for errors (40%). Not surprisingly, that tracks right back to the pain of staffing shortages. The next reason concerns staffing on the front end, at the admission and registration desk. Here, in the chaos of the waiting room, data on the patient is collected. It requires the patient to have all needed information and the staff checking them in to input it all correctly. Respondents indicated that they aren't that confident in the accuracy of that exchange (38%).

The last major concern has relatively recent origins. The No Surprises Act, which went partially into effect in January 2022, limits balance billing when claims are denied, raising the stakes of data error significantly. When the full regulation takes effect at some point in 2023, the challenging relationship of providers and payers will need to improve significantly — and quickly — or both will be subject to arbitration and potentially fines.

Efficiency is the currency of claims management

Another area the survey explored was efficiency. Claims management requires speed, accuracy and flexibility and relies on huge amounts of data. In the 21st century, large amounts of data are typically managed via technology; however, while technology is certainly applied to the revenue cycle and claims management, there's still a lot of manual work that could be automated.

According to survey participants, denials are most often manually reviewed and then assigned to a work queue (53%). Once in the queue, it can end up being worked on by a number of groups, which isn't necessarily inefficient, but a quarter of respondents don't agree their organizations manage denials quickly or efficiently. What constitutes "efficiency" differs as well. The primary metrics to track claims, based on respondents, are hours spent working/resubmitting denials (61%), time spent working denials versus the reimbursed amount (52%), clean claims rate (47%) and denial rate (41%).

Patient estimates may make things worse for providers

Patient estimates have proven a headache for all stakeholders, including providers, payers and patients. The pain is likely to increase with the full No Surprises Act set to take effect in 2023. Good faith estimates for self-pay and private insurance will be required and expected to be accurate within $400. Any cost beyond that will require being settled by provider and payer (if the patient doesn't agree to pay it). Disputes will be addressed by arbitration. Many experts think it will take time for this new normal to operate smoothly. In the meantime, providers are likely caught in the middle, and respondents were aware that the constraints to balance billing will increase denials and decrease reimbursements and collections.

48% of survey respondents said estimates are accurate about half the time or less.

33% of survey respondents indicated that the No Surprises Act restrictions on patient balance billing is a reason they're concerned about being reimbursed by payers.

To the outside observer, neglecting to provide estimates for the cost of care seems antiquated and even deceptive in today's consumer-driven economy. The "surprise bill" that is the namesake of the new regulation is a direct result of how difficult it is for providers to know a final cost prior to the completion of a procedure or treatment. The complexity of the claims process (and the huge amount of data associated with that) is at the root of this challenge. Corralling the variables of in- and out-of-network specialists, the various insurance coverages and codes, unforeseen complications and other factors into an accurate good faith estimate will require an unprecedented level of cooperation between providers and payers to remain in compliance.

While the regulatory "stick" is likely to be a source of chaos and difficulty for providers and payers in the short term, there's a less-obvious "carrot" in the eventual outcome. The ability to provide an accurate, transparent and easy-to-understand estimate to the patient means a number of things are already in place to submit clean claims and reduce denials. Is the patient information correct? Check! Correct coding? Check! Services covered? Check! In- or out-of-network designation? Check! Additionally, confused patients are less likely to pay their bills, so helping them understand what they owe improves the collections side of revenue cycle, too. These favorable byproducts of an accurate good faith estimate also contribute to another important objective: accurate forecasting. Reducing denials and increasing on-time patient collections brings money in the door faster, enabling more confident operational and financial planning.

While appearing far removed from claims and denials, the patient estimate — more precisely, an accurate patient estimate — sets the stage for a successful claims process. It appears providers are starting to make that connection. Respondents said their organizations had invested in technology to provide accurate estimates to reduce denials (40%). Were they motivated by the stick or the carrot? In the end, it doesn't matter if efficiencies and reimbursements increase, and costs come down.

"Better" is the goal

It's already been noted here that claims management is one of a provider organization's highest priorities. And, while comparing clinical and nonclinical priorities is an "apples to oranges" exercise, it's not a stretch to say that a low-performing revenue cycle/claims management process has a direct impact on clinical quality and outcomes, given its critical role in securing the financial resources needed to deliver clinical performance.

So, it's not surprising that many respondents indicated their organizations review the entire claims process annually (41%). In fact, 75 percent of respondents say their organizations evaluated their claims technology within the last two years, despite the pandemic. The remaining 25 percent haven't reviewed their claims technology in more than three years. Much has changed in that time, particularly with the surge in automation development designed to mitigate numerous pandemic-related issues, such as patient scheduling, registration and tasks suffering from the staffing shortage. Reasons offered for the extended absence of an evaluation include being happy with the current solution, pandemic-related budget cuts, personnel shortages (ironically), being too busy and "we plan to in the near future."

Whether or not evaluations of claims technology were maintained during the pandemic, almost all respondents indicated they had technology in place to help improve claims and reduce denials. In fact, use of technology dominated the ways respondents said they reduced denials in the previous 12 months. (See chart 2 on next page.) More than half (52%) updated or replaced their existing claims process technology — despite the pandemic! Nearly as many said they automated tracking of payer policy changes (45%), which ranked as a top reason for providers concerned about payer reimbursements. And, reflecting a holistic point of view, providers also invested in patient portals (44%), accurate estimates (40%) and digitizing the registration process (39%).

Chart 2

How providers reduced denials in the last year:

Automated tracking of payer policy changes

Began providing accurate estimates

Upgraded/replaced previous claims technology

Automated or expanded patient portal claims reviews

Digitized the registration process

The claims/denial technology investments were largely directed into two camps of resources: in-house (49%) and third-party solutions (43%). It's likely that many employ a combination of both. In fact, when asked, 50 percent indicated a preference for a combination of the two. Reasons included:

"Cooperation … can better solve the problem and put forward more comprehensive and effective solutions."

"Suppliers and in-house technologies can complement each other to achieve the optimal state."

"I prefer combined technology vendor and in-house solutions because of the in-depth knowledge and addressing the unique circumstances easily."

Respondents are also optimistic that technology can address many of the long-standing and more recent challenges facing the claims and denial process. Looking ahead six months, 74 percent of respondents expect to "probably" or "definitely" invest in more claims processing and/or denial reduction technology. More than 3 in 4 (78%) said their organizations would be either "extremely" or "somewhat" likely to replace existing technologies if presented with compelling ROI. Among those probably or definitely investing in technology, that sentiment jumps to 91 percent, underscoring how this part of the revenue cycle needs better performance. Even the potential short-term pain of replacing technology is viewed as acceptable in the quest to achieve improved claim results, lower denials and increase the success rate and total dollars recovered through resubmissions.

A word about artificial intelligence (AI)

AI is a machine's ability to perform cognitive functions we associate with humans, such as interacting with an environment, perceiving, learning and solving problems. It uses these patterns and insights to "learn" and make predictions and recommendations.

AI generates a wide variety of reactions from the healthcare C-suite, information technology specialists, revenue cycle managers and even human resource executives. Those reactions range from enthusiastic to resistant. Whatever one's perspective, AI has become part of the healthcare operations conversation. It's been used on the clinical side for decades (biomedical applications began in the 1970s), but serious use of AI to improve efficiencies and reduce denials began less than a decade ago, with the most progress made in the past few years. A small percentage of respondents said their organization uses AI now (11%). Just over half (51%) said the technology in place is advanced automation, specifically robotic process automation (RPA), which is the typical path toward AI. For those not using automation or AI, they have at least considered it (33%). Typically, automation and AI are handled by a combination of in-house and vendor resources. Unlike claims management technology in general, however, a much smaller in-house contingent manages all the automation/AI (11%) and there are more cases where only the vendor develops and implements the technology (34%).

A tipping point for claims management?

Pick your idiom — the perfect storm, the stars aligning, strike while the iron is hot — they all work. The healthcare revenue cycle is at a point where it must evolve or fall behind. In collections, providers must respond to the consumer's demand for a modern payment experience, complete with accurate estimates, multiple payment channels and personalized payment terms. On the reimbursement side, continued complexity, the pandemic's impact on staffing and technology standards, landmark regulation, and a shifting economy have left providers and payers with little choice but to reduce friction and increase efficiency in the claims process.

The survey responses noted within this paper imply that providers are making many changes necessary to become modern and data-driven participants in the healthcare revenue cycle. There's a realization that claim denial rates can't be allowed to continue rising. There's valid concern that claims management teams may never return to full strength or, going forward, post-pandemic budgets won't afford previous headcounts. **In this environment, technology is no longer viewed as a threat to jobs, but as a means to improving job satisfaction and, consequently, as a retention tool.** An automation investment can generate years of exponential ROI as it executes repetitive and error-prone tasks at speed, at scale and without error, building on its value as speed and efficiencies increase — with AI taking that to an even higher level. AI and RPA have jumped from roadmap plans to implementation, with the roadmaps now reflecting the analytical insights from these technologies.

It's not a "back of the house" problem

Providers are developing a broad, holistic view of reducing denials. The problem can't be addressed by "fixing" one thing. It starts with accurate data. Survey respondents ranked inaccurate patient data and missing/inaccurate claim data first or second as the reasons for denials 66 and 61 percent of the time, respectively. That information is collected before the patient even gets past the front desk. At a minimum, automation of processes that are data intensive and repetitive should be prioritized. Any reduction in friction and elimination of data errors increases speed to submission. The more points in the cycle that can be automated, the faster and more accurate the process gets. Layer on AI and additional efficiencies result as the technology learns to recognize patterns unique to a particular healthcare organization and the payers it contracts with. Or, in the case of denials, AI can guide staff to work the most valuable denied claims that are most likely to be approved once corrected. This means not working on what the technology identifies as high-value denials with low probability of being approved or low-value denials that aren't even worth the time spent on them. As policies change and patterns emerge in the data, the system becomes more and more accurate in its recommendations, improving efficiency, reducing time spent on re-submissions and lowering average days in accounts receivable.

Providers are the critical piece of the process and are in a position to be the catalyst for a less complicated, more efficient revenue cycle that benefits all stakeholders. Technology will be central to making that happen.

About Experian Health claims solutions

At Experian Health, we serve as a valued claims management partner, helping our clients to:

- Optimize reimbursement and improve first-time pass-through rates.
- Execute the most effective workflow for teams and confidently prioritize high-impact accounts.
- Improve productivity and cash flow with automatic claims status updates throughout the adjudication process.
- Increase reimbursements with denial analysis and automation. Gain insight into root causes for denials and act fast.

About Experian Health

At Experian Health, we serve more than 60 percent of U.S. hospitals and more than 7,700 medical practices, labs, pharmacies and other healthcare providers with data-driven platforms and insights that help our clients make smarter business decisions, deliver a better bottom line and establish strong patient relationships. We are part of Experian®, the world's leading global information services company, providing us access to deep data and analytics capabilities that complement the strong healthcare heritage rooted in our legacy companies. Our industry-leading solutions span revenue cycle management, identity management, patient engagement, and care management.

For more information, visit experian.com/healthcare-claims and follow us on LinkedIn.

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