

TOTAL ECONOMIC IMPACT

The Total Economic Impact™ Of Experian Health Patient Access Curator™

Cost Savings And Business Benefits Enabled By Patient Access Curator

A FORRESTER TOTAL ECONOMIC IMPACT STUDY COMMISSIONED BY EXPERIAN HEALTH, AUGUST 2026

The Forrester logo is displayed in white, serif, all-caps font within a black rectangular box. The box is positioned on the left side of a large, abstract graphic that features flowing, organic shapes in various shades of green and teal, set against a black background.

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Executive Summary

As health systems face increasing pressure to improve financial performance while navigating workforce shortages and growing payer complexity, inefficiencies in coverage intelligence remain a persistent source of revenue cycle friction.¹ Manual eligibility processes, incomplete coverage visibility, and inconsistent payer coordination of benefits (COB) can drive denials, reimbursement delays, revenue leakage, and unnecessary administrative work.² Adopting a more automated and proactive approach to patient intake enables organizations to identify active coverage, establish accurate payer responsibility, and resolve insurance-related issues before claims are submitted. This approach can accelerate reimbursement, reduce operational burden, improve revenue capture, and create a more consistent financial experience for patients and staff.

Patient Access Curator™ (PAC) is a patient access solution that coordinates the decisions made during patient intake, where many downstream revenue cycle issues begin. Rather than functioning as a traditional eligibility solution, PAC uses AI decisioning to automatically validate and curate patient demographics, insurance coverage, COB, Medicare Beneficiary Identifier (MBI), and related payer information, which can reduce manual decision-making and improve data accuracy before claims are created. By getting patient and insurance information correct at the start of the revenue cycle, PAC can help healthcare organizations prevent denials, protect revenue, accelerate reimbursement, and improve operational efficiency. Experian Health commissioned Forrester Consulting to conduct a Total Economic Impact™ (TEI) study and examine the potential benefits and financial impacts enterprises may realize by deploying PAC.³

Key Statistics

\$11.5M

Benefits PV

\$50.4M

Revenue protected through reduced COB, eligibility, and registration denials over three years

\$82.2M

Accelerated cash collections over three years

To better understand the benefits and risks associated with this investment, Forrester interviewed five decision-makers with experience using PAC. For the purposes of this study, Forrester aggregated the experiences of the interviewees and combined the results into a single composite organization: a US-based integrated health system that generates \$5 billion in annual revenue, employs 20,000 people, serves approximately 700,000 patients annually, and manages a large revenue cycle operation spanning inpatient, outpatient, emergency, surgical, and professional billing across multiple care settings.

Prior to using PAC, the interviewees reported that their organizations relied on a combination of legacy eligibility verification systems, manual registration processes, insurance discovery tools, and contingency-based vendors for insurance discovery as well as to recover reimbursement after denials. These environments validated submitted insurance information but could not proactively identify missing coverage, determine COB, or automatically correct inaccurate payer information. As a result, organizations frequently discovered coverage issues only after claims had entered the revenue cycle, requiring manual investigation, claim rework, and downstream recovery efforts.

Interviewees explained that these limitations contributed to eligibility, COB, and registration-related denials; revenue leakage from unidentified coverage; inconsistent patient access processes; and rising operational costs associated with manual coverage verification and recovery activities. Organizations sought a more automated and proactive approach to coverage

intelligence that could improve coverage accuracy, reduce denials, protect revenue at patient intake, and standardize workflows across teams. They also aimed to reduce reliance on outsourced claims, denial management resources, and contingency-based insurance discovery vendors.

After the investment in PAC, the interviewees' organizations reduced denials related to eligibility, COB, and registration; accelerated reimbursement; improved staff productivity; and lowered third-party revenue cycle costs. These improvements not only enhanced operational efficiency and reimbursement accuracy but also provided greater visibility into coverage issues, created standardized and scalable workflows across the enterprise, and enabled teams to focus on higher-value patient access and revenue cycle activities.

Key Findings

Quantified benefits. Quantified benefits for the composite organization include:

- **A 40% reduction in COB denials, a 35% reduction in eligibility denials, and a 20% reduction in registration-related denials.** The composite uses PAC to automatically identify active and previously unknown coverage, determine payer primacy, and validate and correct coverage information at patient intake before inaccurate data can move downstream and impact the claim. This enables it to prevent denials caused by terminated coverage, incorrect payer selection, incomplete coverage information, and COB errors, protecting \$50 million in revenue over three years before claims enter downstream billing and follow-up processes. For the composite, this yields a three-year, risk-adjusted total PV of \$2.2 million.
- **A 30% increase in confirmed self-pay patient identification by Year 3.** By automatically exhausting available insurance discovery sources and confirming whether billable coverage exists, PAC enables the composite organization to engage patients earlier in the financial clearance process and pursue the appropriate next step in confirming insurance coverage with greater confidence. Rather than delay action while manually investigating coverage questions, staff can more quickly initiate patient responsibility discussions and preservice collection activities. These improvements help the composite organization collect copays, deductibles, and self-pay balances earlier in the patient journey and reduce uncertainty surrounding coverage status. For the composite, this yields a three-year, risk-adjusted total PV of \$67,000.
- **A 5% reduction in accounts receivable (AR) days.** The composite accelerates reimbursement by using PAC to identify active coverage, establish payer primacy, and validate and correct incomplete, inaccurate, or conflicting coverage information at patient intake. By addressing coverage discrepancies before submitting claims, the composite organization generates cleaner claims that move through billing and adjudication processes with fewer delays, allowing it to receive payment sooner and improve cash flow performance. For the composite, this yields a three-year, risk-adjusted total PV of \$3.6 million.
- **An 80% reduction in time spent on insurance discovery activities for back-end revenue cycle teams by Year 3.** PAC automates the composite's eligibility verification, insurance discovery, payer COB, and coverage updates across its patient access and revenue cycle workflows. Its front-end teams spend less time researching and correcting coverage information, while its back-end revenue cycle teams spend less time conducting manual payer research and coverage investigations. By reducing insurance-related work queues, eliminating routine coverage tasks, and simplifying workflows, the composite organization enables staff to focus on higher-value activities and accelerates the productivity of new revenue cycle hires. For the composite, this yields a three-year, risk-adjusted total PV of \$4.7 million.
- **A 45% reduction in outsourced claims and denial management costs by Year 3.** PAC enables the composite organization to identify active coverage, automate insurance discovery, determine payer COB, and resolve insurance-related issues earlier in the patient journey. By reducing the volume of eligibility, insurance discovery, and claims follow-up activities requiring manual intervention, the composite organization decreases its reliance on outsourced claims and denial management resources while eliminating the need for contingency-based insurance discovery vendors. These improvements reduce third-party revenue cycle costs and allow the organization to manage more coverage-related activities internally. For the composite, this yields a three-year, risk-adjusted total PV of \$960,000.

Unquantified benefits. Benefits that provide value for the composite organization but are not quantified for this study include:

- **Strong operational and optimization support from the Experian Health team.** The composite organization benefits from Experian Health's collaborative approach to operational performance reviews, denial analysis, payer investigations, and workflow optimization. Ongoing engagement with operational, technical, payer, and electronic health record stakeholders helps identify root causes of coverage-related issues, accelerate issue resolution, and support continuous improvement across patient access and revenue cycle processes.
- **Improved employee satisfaction.** By using PAC to consolidate eligibility verification, insurance discovery, COB determination, and other coverage-related activities into a single workflow, the composite reduces administrative burden and simplifies registration processes. PAC also minimizes the manual decision-making traditionally required of registrars by automatically identifying coverage, determining payer primacy, and guiding the appropriate next action. As a result, the composite organization's front-end teams spend less time researching coverage information and navigating multiple systems, creating a more efficient and streamlined work experience.
- **Improved patient satisfaction.** More accurate coverage intelligence and payer selection at patient intake help the composite organization reduce billing discrepancies and minimize situations in which patients must clarify insurance information after they receive services. By identifying coverage earlier and improving billing accuracy, the organization creates a more consistent financial experience for patients and reduces billing-related complaints.
- **Improved collaboration across front-end and back-end teams.** The composite standardizes coverage intelligence processes and gains greater visibility into insurance-related issues, which improves coordination between patient access, registration, training, and revenue cycle functions. This enables the composite organization to communicate workflow changes more effectively, align teams around common processes, and support ongoing operational improvement efforts.
- **Reduced human error in coverage selection and registration processes.** The composite leverages PAC's ability to automatically identify coverage, determine payer COB, and return appropriate insurance information within registration workflows. This reduces its reliance on manual interpretation and individual judgment, which in turn improves consistency in coverage intelligence, reduces avoidable errors in registration, and increases confidence in the accuracy of insurance information used throughout the revenue cycle.

The financial analysis that is based on the interviews found that a composite organization experiences benefits of \$11.5 million over three years.

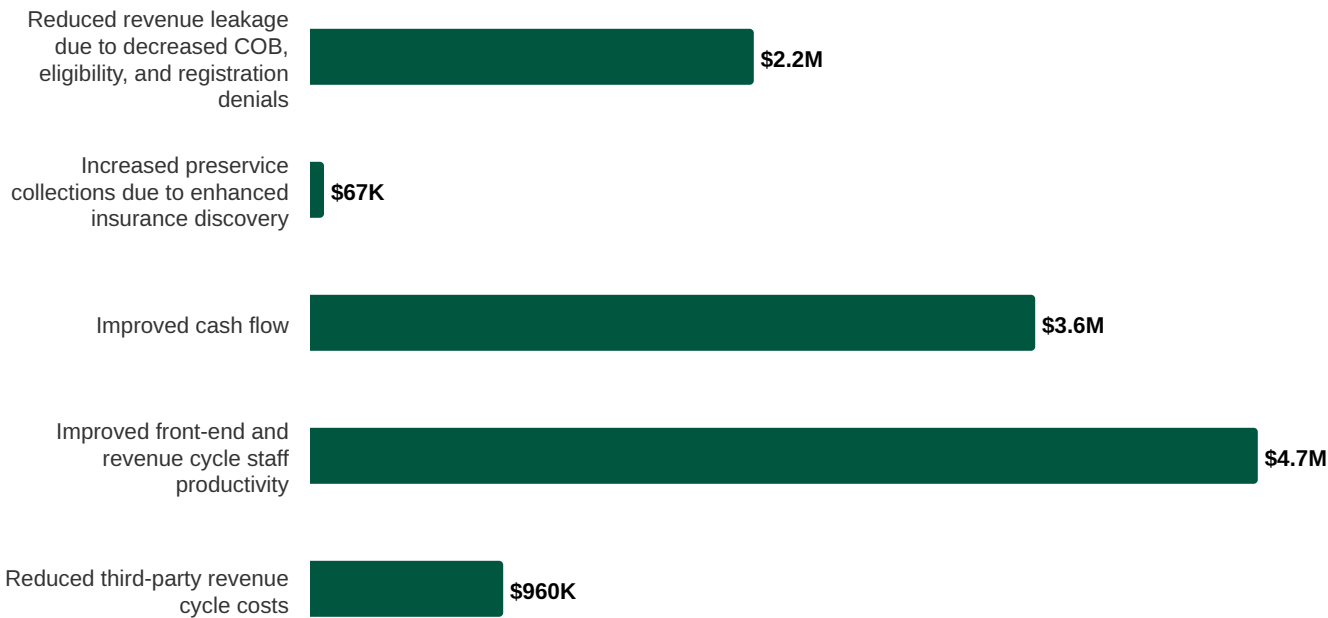
"The savings from reduced denials alone have helped pay for the cost of the solution. That's a powerful outcome and one of the reasons we're continuing to invest in PAC."

Senior director of revenue cycle, multiregional health system

“Since implementing PAC, we’ve gone from significantly underperforming our peers on eligibility denials to approaching top-quartile performance. With the right insurance information upfront, we’re submitting cleaner claims, getting paid faster, and driving meaningful reductions in denials.”

Senior director of revenue cycle, multiregional health system

Benefits (Three-Year)



The Experian Health Patient Access Curator Customer Journey

Drivers leading to the Patient Access Curator investment

Interviews				
Role	Industry	Employees	Revenue	
Director of revenue cycle operations	Regional health system	8,000	\$5.5B	
Cash applications supervisor				
Director of system patient access and financial clearance	Regional health system	2,500	\$1B	
Senior director of revenue cycle	Multiregional health system	35,000	\$6B	
Senior director of patient finance	Multiregional health system	42,000	\$10B	

Key Challenges

Before investing in PAC, the interviewees' organizations relied on legacy eligibility verification platforms, manual registration workflows, insurance discovery tools, and outsourced recovery services to manage patient coverage and revenue cycle operations. These environments validated submitted insurance information but rarely identified missing coverage, determined COB, or proactively corrected inaccurate payer and patient information. Staff typically had to resolve coverage issues manually, often after a claim had already moved downstream in the revenue cycle.

The interviewees noted how their organizations struggled with common challenges, including:

- High rates of eligibility, COB, and registration-related denials driven by incomplete coverage information and inaccurate payer COB.** Interviewees explained that their legacy eligibility platforms validated submitted coverage but often lacked the ability to automatically identify additional insurance, detect inactive coverage, or accurately determine COB across multiple payers. As a result, their organizations frequently experienced eligibility denials related to inaccurate coverage information, COB denials caused by incorrect payer order, and registration-related denials stemming from incomplete or inaccurate patient and insurance data.
 - The director of revenue cycle operations at a regional health system said: "High denial rates were the bane of our existence. In some cases, payer files weren't updated, which resulted in inaccurate coverage information and contributed to denials even when staff were relying on the information that was available."
- Revenue leakage and rising operational costs from missed coverage and fragmented recovery processes.** Interviewees explained that incomplete insurance identification frequently resulted in patients being classified as self-pay or underinsured despite having active billable coverage. As a result, reimbursement opportunities were missed, delayed, or placed at risk. To identify and recover that revenue, their organizations often relied on a combination of internal recovery efforts, outsourced claims and denial management resources, and contingency-based insurance discovery vendors. Interviewees described these downstream recovery processes as costly, labor-intensive, and indicative of a broader reliance on reactive revenue recovery rather than proactive coverage identification.
 - The senior director of revenue cycle at a multiregional health system said: "We were looking for something that could do more than just tell us whether a patient's insurance was active. If they didn't have that insurance, we needed to know what coverage they did have. We were looking for a discovery capability on the front end, and our prior eligibility solution wasn't able to provide that."

- **Heavy reliance on human judgment for coverage intelligence and payer COB.** Interviewees described environments where accurate coverage intelligence depended largely on the knowledge and judgment of individual registrars and revenue cycle staff. Employees were expected to interpret complex payer responses, identify missing or inactive coverage, determine when additional investigation was required, and establish the correct billing order. This manual approach created variability in outcomes, increased the potential for human error, and made revenue cycle performance dependent on staff experience rather than standardized and scalable processes.
 - The director of revenue cycle operations at a regional health system shared: “We were looking to automate workflows with PAC because we previously had a lot of manual processes in place. We have hundreds of registrars across the system, and that’s a lot of people to educate and to make understand what they’re looking at and to make the right decision every time. We didn’t want to be counting on an individual to determine the right outcome.”
 - The senior director of revenue cycle at a multiregional health system said: “We didn’t want to simply replace our eligibility solution with another tool that gave us the same information. Before PAC, when insurance information wasn’t available through eligibility checks, staff often had to verify coverage by going to payer websites or making phone calls. That process was time-consuming and created the potential for inconsistent coverage [information].”
- **Reactive revenue cycle processes that identified coverage issues after service was delivered.** Interviewees explained that legacy eligibility platforms primarily validated submitted coverage rather than proactively identifying additional insurance coverage or correcting coverage issues at patient intake. As a result, missing insurance, inaccurate coverage information, and payer primacy issues were often discovered only after patient encounters had occurred and claims had entered downstream billing workflows. Revenue cycle teams then relied on billing indicators, manual investigation, insurance discovery activities, and claim rework processes to identify missed insurance and resolve coverage discrepancies before reimbursement could occur.
 - The director of revenue cycle operations at a regional health system explained: “[Before PAC], we would send self-pay patients to our prior eligibility platform to see if they had coverage. Messages would come back with a billing indicator in our [electronic health record system] and our team worked those accounts based on the billing indicator.”

The director continued: “Previously, we got a yes or no answer on coverage and then ran a cleanup process later in the revenue cycle to identify insurance that had been missed. Insurance discovery was largely a downstream activity.”
- **Lack of standardized patient access workflows across teams and facilities.** Interviewees explained that different facilities and teams often followed slightly different registration, coverage verification, and payer COB practices. Staffing shortages, employee turnover, and organizational growth made it increasingly difficult to ensure consistent execution across locations. Leadership teams wanted to reduce reliance on individual expertise by embedding best-practice coverage intelligence directly into patient access workflows and creating a more consistent operating model across the enterprise.
 - The senior director of revenue cycle at a multiregional health system said: “One of our goals was to find a solution that provided clearer insurance information and more automation. We wanted the data coming back from eligibility requests to automatically populate our registration system rather than relying on different employees to manually review and update coverage information. We knew a more automated approach would create a more consistent process across teams and make it easier to manage at scale.”
- **Financial, compliance, and cost-control risks associated with inaccurate coverage information.** Interviewees explained that inaccurate coverage information, incorrect payer selection, and unresolved COB issues increased administrative rework and created compliance risks beyond denials and reimbursement delays. They also described the difficulty of controlling costs in environments that relied on transaction-based eligibility checks, insurance discovery activities, and contingency-based recovery arrangements to compensate for incomplete coverage visibility. As margin pressures intensified, interviewees’ organizations sought a more predictable and cost-effective approach to managing coverage accuracy and reimbursement outcomes.

- The senior director of patient finance at a multiregional health system explained: “Prior to PAC, organizations often incurred additional costs to run insurance discovery and Medicaid eligibility checks. We wanted a solution that could support those insurance discovery activities without requiring separate transactions, vendors, or additional fees every time we needed to verify coverage.”

Investment Objectives

The interviewees’ organizations searched for a solution that could:

- Reduce eligibility, COB, incorrect payer, and registration-related denials by improving the accuracy of coverage information before claims are submitted.
- Reduce revenue leakage and cost to collect by identifying active coverage for self-pay and underinsured patients and decreasing reliance on outsourced claims and denial management resources and contingency-based insurance discovery vendors.
- Automate coverage intelligence by embedding payer intelligence, insurance discovery, and COB decisioning into registration workflows.
- Shift from denial recovery to denial prevention by resolving coverage and payer COB issues at patient intake.
- Create standardized, scalable patient access operations with consistent coverage intelligence across facilities and staff experience levels.
- Improve productivity across patient access and revenue cycle teams by reducing the manual effort spent investigating, correcting, and following up on eligibility and coverage issues.
- Improve financial control and reduce operational risk by increasing confidence in coverage accuracy and billing compliance.

“My question was always, why wait until an account is nearing bad debt to run insurance discovery? Why not do it upfront? That’s what we wanted PAC to do.”

Senior director of revenue cycle, multiregional health system

Composite Organization

Based on the interviews, Forrester constructed a TEI framework, a composite company, and a benefits analysis that illustrates the areas financially affected. The composite organization is representative of the interviewees’ organizations, and it is used to present the aggregate financial analysis in the next section. The composite organization has the following characteristics:

- **Description of composite.** The composite organization is a US-based integrated health system generating \$5 billion in annual revenue and employing 20,000 people. It operates a large and complex revenue cycle environment spanning inpatient, outpatient, emergency, surgical, and professional billing across multiple care settings, serving 700,000 patients annually that generate 21 million hospital and professional claims each year.

Before investing in PAC, the composite organization relied on a legacy eligibility verification platform, manual coverage verification processes, contingency-based insurance discovery vendors, outsourced claims and denials management resources, and postservice follow-up activities to identify missing coverage and recover reimbursement. These fragmented

processes provided limited visibility into missing coverage and payer COB, resulting in eligibility, registration, COB, and incorrect payer denials, revenue leakage, delayed reimbursement, and significant manual effort to identify coverage, correct billing issues, and recover payments. The organization sought to improve coverage accuracy, reduce manual intervention, standardize patient access workflows, and shift from downstream denial recovery to proactive denial prevention by focusing on automating accurate patient intake.

- **Deployment characteristics.** The composite organization deploys PAC within its patient access and registration workflows to automate eligibility verification, insurance discovery, COB and payer primacy, MBI discovery, and demographic validation and correction. The composite integrates PAC directly into its registration and revenue cycle environment, where PAC identifies and corrects coverage issues at the front end of the revenue cycle by analyzing payer responses, establishing payer primacy, uncovering previously unidentified coverage, and automatically updating patient and insurance information with minimal staff intervention.

The deployment supports 800 front-end patient access users across scheduling, preregistration, registration, check-in, and financial clearance functions as well as 80 back-end revenue cycle users responsible for billing, claim follow-up, insurance discovery, and denial management activities. The organization adopts PAC as part of a broader effort to standardize coverage processes, reduce manual decision-making, improve reimbursement outcomes, and shift resources from reactive denial recovery to proactive denial prevention. Front-end teams use PAC to improve coverage accuracy and resolve payer issues before claims are submitted. This proactive approach helps prevent denials upstream, reducing the need for manual insurance investigations, claim follow-up activities, and rework later in the revenue cycle.

KEY ASSUMPTIONS

- \$5 billion annual revenue
- 20,000 employees
- 700,000 patients served annually
- 21 million hospital and professional claims
- 800 front-end users
- 80 back-end users
- Uses PAC for eligibility verification, insurance discovery, COB determination, MBI discovery, and demographic curation

Analysis Of Benefits

Quantified benefit data as applied to the composite

Total Benefits						
Ref.	Benefit	Year 1	Year 2	Year 3	Total	Present Value
Atr	Reduced revenue leakage due to decreased COB, eligibility, and registration denials	\$898,837	\$898,837	\$898,837	\$2,696,510	\$2,235,274
Btr	Increased preservice collections due to enhanced insurance discovery	\$21,830	\$27,287	\$32,745	\$81,861	\$66,998
Ctr	Improved cash flow	\$1,443,836	\$1,443,836	\$1,443,836	\$4,331,507	\$3,590,605
Dtr	Improved front-end and revenue cycle staff productivity	\$1,396,108	\$1,840,046	\$2,494,784	\$5,730,938	\$4,664,256
Etr	Reduced third-party revenue cycle costs	\$312,375	\$416,500	\$442,000	\$1,170,875	\$960,273
Total benefits (risk-adjusted)		\$4,072,985	\$4,626,505	\$5,312,201	\$14,011,691	\$11,517,406

Reduced Revenue Leakage Due To Decreased COB, Eligibility, And Registration Denials

Evidence and data. Interviewees said that before implementing PAC, eligibility, COB, and registration-related denials were a significant source of revenue leakage because denied claims often required extensive rework and, in some cases, were ultimately written off rather than collected. Interviewees identified coverage, missing insurance coverage, incorrect payer selection, and COB errors as common root causes. They explained that their legacy eligibility platforms primarily validated the insurance information submitted by registrars and provided limited ability to identify inactive coverage, uncover additional insurance, or determine the correct payer order.

With PAC, their organizations automatically identified active and additional coverage, established payer primacy, and updated coverage information before claims were submitted. As a result, interviewees reported fewer eligibility denials related to inactive or incorrect coverage, fewer COB denials caused by inaccurate payer primacy, and fewer registration-related denials stemming from incomplete coverage information. In turn, this reduced preventable denials, improved billing accuracy, and protected revenue at the front end of the revenue cycle rather than relying on downstream denial recovery activities.

- The senior director of revenue cycle at a multiregional health system said: “We knew we had a lot of denials related to terminated insurance, incorrect payers, and COB issues. We needed a way to automatically identify inactive coverage, find the correct payer, and establish the right payer order before claims were submitted. Since implementing PAC and refining our workflows, we’ve achieved a significant reduction across those denial categories.”

The senior director continued: “Once coverage and payer primacy were being updated automatically, changes made by registrars became the exception and no longer the norm. Previously, staff were more likely to manually update coverage information, but with the correct information already loaded into the system, there was less need to make changes. As teams became more comfortable relying on the automated process, we started to see a decrease in denials.”

- The cash applications supervisor at a regional health system said: “Staff have told me that it’s better at locating coverage, identifying more accurate coverage, and finding information they wouldn’t have found on their own. The messages that come back help them make good decisions and understand what action needs to be taken, which improves the accuracy of coverage information before claims are submitted.”

- The director of system patient access and financial clearance at a regional health system said: “Our COB denials have definitely trended down across both professional and hospital billing. Some denial activity is outside of our control because payers occasionally deny claims for reasons that don’t always make sense, but overall we’ve seen a clear improvement and less rework associated with those claims.”

The director continued: “A big part of that improvement comes from insurance discovery. We may enter one insurance plan, but PAC can identify additional coverage, including secondary insurance and other billable coverage that we didn’t previously have visibility into. For self-pay accounts, it searches for coverage automatically, and we’ve also configured it to perform additional discovery before accounts move to collections to identify coverage that may have been missed earlier. That helps ensure we’re billing the right payer and reducing avoidable denials.”

Modeling and assumptions. Based on the interviews, Forrester assumes the following about the composite organization:

- The composite organization experiences 30,000 COB denials annually and reduces these denials by 40% with PAC.
- The composite organization experiences 15,000 eligibility denials annually and reduces these denials by 35% with PAC.
- The composite organization experiences 7,000 registration-related denials annually and reduces these denials by 20% with PAC.
- The average denied claim value is \$3,000.
- Thirty percent of denied claim value would otherwise result in revenue leakage because not all denied claims are successfully corrected, appealed, and reimbursed.
- The composite organization’s operating margin is 6.3%.

Risks. Forrester recognizes that these results may not be representative of all experiences. The following factors may impact this benefit:

- Volume of COB, eligibility, and registration-related denials before PAC.
- Average value of denied claims.
- Percentage of denied claims that ultimately result in revenue leakage.
- Operating margin.

Results. To account for these risks, Forrester adjusted this benefit downward by 15%, yielding a three-year, risk-adjusted total PV (discounted at 10%) of \$2.2 million.

40%

Reduction in COB denials

“PAC is finding coverage that we didn’t know existed. By identifying coverage we previously didn’t have visibility into, it’s helping us find more billable coverage than we were able to locate before.”

Director of system patient access and financial clearance, regional health system

Reduced Revenue Leakage Due To Decreased COB, Eligibility, And Registration Denials

Ref.	Metric	Source	Year 1	Year 2	Year 3
A1	COB denials before PAC	Composite	30,000	30,000	30,000
A2	Reduction in COB denials with PAC	Interviews	40%	40%	40%
A3	COB denials eliminated with PAC	A1*A2	12,000	12,000	12,000
A4	Eligibility denials before PAC	Composite	15,000	15,000	15,000
A5	Reduction in eligibility denials with PAC	Interviews	35%	35%	35%
A6	Eligibility denials eliminated with PAC	A4*A5	5,250	5,250	5,250
A7	Registration denials before PAC	Composite	7,000	7,000	7,000
A8	Reduction in registration denials with PAC	Interviews	20%	20%	20%
A9	Registration denials eliminated with PAC	A7*A8	1,400	1,400	1,400
A10	Average denied claim value	Composite	\$3,000	\$3,000	\$3,000
A11	Percentage of denied claim value resulting in revenue leakage	Composite	30%	30%	30%
A12	Total revenue protected	(A3+A6+A9)*A10*A11	\$16,785,000	\$16,785,000	\$16,785,000
A13	Operating margin	Composite	6.3%	6.3%	6.3%
At	Reduced revenue leakage due to decreased COB, eligibility, and registration denials	A12*A13	\$1,057,455	\$1,057,455	\$1,057,455
	Risk adjustment	115%			
Atr	Reduced revenue leakage due to decreased COB, eligibility, and registration denials (risk-adjusted)		\$898,837	\$898,837	\$898,837
Three-year total: \$2,696,510			Three-year present value: \$2,235,274		

Increased Preservice Collections Due To Enhanced Insurance Discovery

Evidence and data. Interviewees reported that PAC helped their organizations improve preservice collections by providing earlier and more complete visibility into patients’ coverage status. Through enhanced insurance discovery capabilities, PAC automatically searched for active and previously unidentified coverage, allowing organizations to distinguish between patients who were truly self-pay and those with billable insurance that had not yet been identified. Interviewees explained that replacing manual insurance investigation activities with PAC’s automated insurance discovery, which uses AI, reduced uncertainty surrounding coverage status and enabled financial clearance teams to act with greater confidence. As a result, their organizations were able to engage self-pay patients earlier; collect copays, deductibles, and self-pay balances before service

was rendered; and route patients into appropriate preservice collection workflows without delaying action due to uncertainty about whether coverage existed.

- The senior director of revenue cycle at a multiregional health system said: “As more patients used self-registration, e-check-in, and kiosk-based check-in, we no longer had to worry as much about insurance information being incorrect or needing to be confirmed later because it had already been verified before the patient arrived. Having accurate coverage information upfront allowed us to move forward with the right registration, financial clearance, and patient responsibility discussions much earlier in the process.”

The senior director continued: “PAC helps us determine whether a patient truly is self-pay. Once we know exactly what coverage a patient has, or doesn’t have, we can take the next step, whether that’s another insurance option, Medicaid, financial assistance, or a payment plan. That allows us to engage patients earlier and start the right financial process before balances move downstream.”

Modeling and assumptions. Based on the interviews, Forrester assumes the following about the composite organization:

- The composite organization serves 700,000 patients annually.
- Five percent of patients are classified as self-pay before PAC.
- With PAC, the composite increases confirmed self-pay patient identification by 20% in Year 1, 25% in Year 2, and 30% in Year 3.
- The average preservice collection value per self-pay patient is \$55. This represents copays, deductibles, self-pay balances, and other patient responsibility amounts collected before service.
- The composite organization’s operating margin is 6.3%.

Risks. Forrester recognizes that these results may not be representative of all experiences. The following factors may impact this benefit:

- Annual patient volume.
- Percentage of patients classified as self-pay before PAC.
- Average preservice collection value.
- Operating margin.

Results. To account for these risks, Forrester adjusted this benefit downward by 10%, yielding a three-year, risk-adjusted total PV (discounted at 10%) of \$67,000.

30%

Increase in self-pay patients identified with PAC by Year 3

“Before PAC, if coverage was rejected, it was hunt-and-peck to figure out what other options a patient might have. PAC exhausts all of that discovery up front. Instead of simply knowing whether a patient’s insurance is active, we know what coverage they have and what options are available to them. That visibility helps us move forward with the right financial discussions much sooner.”

Senior director of revenue cycle, multiregional health system

Increased Preservice Collections Due To Enhanced Insurance Discovery

Ref.	Metric	Source	Year 1	Year 2	Year 3
B1	Patient volume	Composite	700,000	700,000	700,000
B2	Self-pay patients before PAC, as a percentage of patient volume	Composite	5%	5%	5%
B3	Self-pay patients before PAC	B1*B2	35,000	35,000	35,000
B4	Increase in self-pay patients identified with PAC	Interviews	20%	25%	30%
B5	Additional self-pay patients captured with PAC	B3*B4	7,000	8,750	10,500
B6	Average preservice collection value per self-pay patient	Composite	\$55	\$55	\$55
B7	Operating margin	A13	6.3%	6.3%	6.3%
Bt	Increased preservice collections due to enhanced insurance discovery	B5*B6*B7	\$24,255	\$30,319	\$36,383
	Risk adjustment	±10%			
Btr	Increased preservice collections due to enhanced insurance discovery (risk-adjusted)		\$21,830	\$27,287	\$32,745
Three-year total: \$81,861			Three-year present value: \$66,998		

Improved Cash Flow

Evidence and data. Interviewees reported that PAC helped accelerate reimbursement by improving the accuracy, completeness, and primacy of insurance information before claims entered the revenue cycle. By identifying active coverage, establishing payer primacy, and resolving coverage issues at patient intake, PAC enabled their organizations to submit cleaner claims and reduce reimbursement delays associated with coverage discrepancies and claim corrections. Interviewees explained that claims moved through billing and adjudication processes more efficiently, reducing the time between service delivery and payment. As a result, their organizations accelerated cash collections, reduced AR days, and strengthened cash flow performance.

- The senior director of revenue cycle at a multiregional health system said: “We weren’t getting many of the capabilities that we’re getting from PAC today. The return has come from reducing denials, reducing the time spent on claim follow-up, and ultimately getting paid sooner on those claims through higher clean-claim rates. Those are the metrics we use to demonstrate the ROI of the investment to the business.”

The senior director continued: “The value isn’t just the time savings; it’s also the speed of receiving the dollars. When we reduce denials, we reduce claim follow-up and get paid sooner on those claims. Whether payment arrives in one month

versus much later makes a difference because every delay creates additional work to track, follow up on, and resubmit claims.”

This interviewee added: “We’ve made significant progress on our AR days. Having cleaner insurance information and fewer eligibility-related denials help claims move through the process with fewer delays. When we reduce denials, we naturally see the impact reflected in our AR performance.”

Modeling and assumptions. Based on the interviews, Forrester assumes the following about the composite organization:

- The composite organization generates \$5 billion in annual revenue.
- The composite maintains an average AR balance equivalent to 40 days of revenue.
- With PAC, the composite reduces average AR days by 5%.
- The composite organization’s cost of capital is 6.2%.

Risks. Forrester recognizes that these results may not be representative of all experiences. The following factors may impact this benefit:

- Annual revenue.
- Average AR days in the prior environment.
- Cost of capital.

Results. To account for these risks, Forrester adjusted this benefit downward by 15%, yielding a three-year, risk-adjusted total PV (discounted at 10%) of \$3.6 million.

5%

Reduction in AR days

“We’re spending less time working individual claims and more time addressing issues before they create delays. That has allowed us to push hundreds of millions of dollars in claims out the door more quickly. Claims that once sat in work queues for days or weeks are now moving through the revenue cycle faster, which helps us get paid sooner.”

Senior director of revenue cycle, multiregional health system

“When you have fewer denials, you’re getting paid sooner. Cleaner insurance information means claims move through the process with fewer delays, and that helps drive AR days down.”

Senior director of revenue cycle, multiregional health system

Improved Cash Flow					
Ref.	Metric	Source	Year 1	Year 2	Year 3
C1	Annual revenue	Composite	\$5,000,000,000	\$5,000,000,000	\$5,000,000,000
C2	Average daily revenue	C1/365 days	\$13,698,630	\$13,698,630	\$13,698,630
C3	Average AR days before PAC	Composite	40	40	40
C4	Reduction in AR days attributable to PAC	Interviews	5%	5%	5%
C5	AR days reduced with PAC	C3*C4	2	2	2
C6	Accelerated cash collections	C2*C5	\$27,397,260	\$27,397,260	\$27,397,260
C7	Cost of capital	Composite	6.2%	6.2%	6.2%
Ct	Improved cash flow	C6*C7	\$1,698,630	\$1,698,630	\$1,698,630
	Risk adjustment	15%			
Ctr	Improved cash flow (risk-adjusted)		\$1,443,836	\$1,443,836	\$1,443,836
Three-year total: \$4,331,507			Three-year present value: \$3,590,605		

Improved Front-End And Revenue Cycle Staff Productivity

Evidence and data. Interviewees said that before implementing PAC, front-end staff regularly worked in insurance-related queues and corrected registration issues after the fact because coverage problems were often identified only after accounts had moved downstream in the revenue cycle. With PAC, eligibility and coverage information was identified and populated into the registration system automatically, in some cases running in the background ahead of a patient's scheduled visit, so that registrars could confirm coverage rather than manually research and enter it themselves. Interviewees said this reduced the volume in insurance-related work queues, minimized manual coverage corrections, and enabled front-end teams to spend less time resolving routine coverage issues and more time addressing exceptions and patient-facing activities.

Interviewees also described productivity gains for back-end revenue cycle teams. Before PAC, staff often conducted manual coverage searches across multiple payer websites to verify insurance information and identify billable coverage. With PAC's insurance discovery capabilities returning coverage information automatically, staff spent less time performing manual searches and could redirect that time toward higher-value follow-up and analysis activities. Interviewees further noted that PAC simplified coverage intelligence workflows by reducing the need for manual payer research and interpretation. As a result, new revenue cycle hires learned insurance discovery processes faster and reached full productivity sooner than with prior manual approaches.

- The senior director of revenue cycle at a multiregional health system shared: "We started running automated batches against Medicaid pending, bad debt, and charity accounts to identify insurance coverage and update those accounts when coverage was found. After proving that process worked, we expanded it to scheduled visits by running eligibility checks 24 hours before the appointment. If a patient's coverage had changed since scheduling, the information was updated automatically. The process runs in the background without staff involvement, which takes the burden off registrars. By the time the patient arrives, the coverage information is already populated in the registration system, and the registrar simply confirms that it is correct."

The senior director continued: "As registration and insurance quality improved, we saw a reduction in insurance-related work queues. Instead of spending time correcting registration and coverage issues after the fact, our teams were able to focus on

identifying root causes and fixing problems upstream. Team members who had been working insurance-related queues could be redirected to resolving more complex issues.”

- The director of revenue cycle operations at a regional health system said: “PAC creates the coverage for us and adds it into our registration system when coverage is found. A lot of this is handled before the patient even arrives, so it can be fixed ahead of time. When the patient is registered, the coverage is already filled in, which takes work off our front-end staff.”

The director continued: “Before PAC, back-end staff often had to conduct manual coverage searches through payer websites, which usually took several minutes per account. With [PAC], the information is returned in less than 30 seconds. That eliminates a significant amount of manual search time for the team over the course of a week.”

- The cash applications supervisor at a regional health system shared: “[In the prior environment], the workflow was very different and staff often had to search multiple websites to verify coverage information. With [PAC], much of that information can be located automatically, which saves time and makes the process easier to learn.”

This interviewee continued: “PAC is easier to understand than the way we used to do it. As new team members have come into the back-end function, we’ve found they can learn the process more quickly and become productive sooner.”

- The senior director of patient finance at a multiregional health system said: “If the correct COB information is identified upfront, you’re filing the claim in the proper order and it becomes a clean claim. The team doesn’t have to touch it. For high-confidence accounts, PAC automatically uploads the insurance information into the system instead of creating a work queue for someone to review and update manually.”

The senior director continued: “From a registration standpoint, the correct insurance information is automatically populated so we don’t have to review and resolve coverage work queues. On the back end, we’re identifying the correct coverage and payer order upfront instead of filing a claim only to learn later that the wrong insurer was billed.”

This interviewee concluded: “We’ve seen benefits from fewer denials because there is less work for team members to perform. With a clean claim, you don’t have a second touch, you don’t have additional follow-up, and you don’t have to send multiple claims or supporting documentation. It gets paid the first time.”

- The director of system patient access and financial clearance at a regional health system said: “We’re spending much less time going into payer portals to look up coverage information because responses come back quickly through PAC. Front-end staff no longer have to stop what they’re doing, navigate to a separate system, and then return to the registration workflow. While we had some initial alert-fatigue challenges, we’ve addressed them over time, and the process is now much more efficient.”

The director continued: “We expanded PAC to support registration, central scheduling, preregistration, and check-in workflows. The solution is easy to use from a functionality standpoint, which helped us train staff quickly. Insurance determination is often complex, but PAC simplified the process and reduced the learning curve for new team members.”

Modeling and assumptions. Based on the interviews, Forrester assumes the following about the composite organization:

- The composite organization employs 800 front-end staff.
- With PAC, front-end staff productivity improves by 5% in Year 1, 7% in Year 2, and 10% in Year 3.
- The average fully burdened annual salary for a front-end staff member is \$62,000.
- The composite organization employs 80 revenue cycle staff.
- Before PAC, each revenue cycle staff member performed 10 insurance discovery searches per day, with each insurance discovery search requiring 3 minutes.

The Total Economic Impact™ Of Experian Health Patient Access Curator

- With PAC, time spent on insurance discovery activities decreases by 70% in Year 1, 75% in Year 2, and 80% in Year 3.
- The average fully burdened hourly rate for a revenue cycle staff member is \$36.
- The composite organization hires 12 revenue cycle staff annually.
- Before PAC, onboarding each new revenue cycle hire took eight weeks.
- With PAC, the composite reduces onboarding time by 50%.
- For this benefit, the composite has a productivity recapture rate of 50%, which means resources spend half of the saved time on activities that generate business value, but not all reclaimed time is dedicated to value-added work.

Risks. Forrester recognizes that these results may not be representative of all experiences. The following factors may impact this benefit:

- Number of front-end and revenue cycle staff.
- Time spent performing eligibility verification, insurance discovery, and onboarding activities in the prior environment before PAC.
- Fully burdened compensation for front-end and revenue cycle staff.

Results. To account for these risks, Forrester adjusted this benefit downward by 15%, yielding a three-year, risk-adjusted total PV (discounted at 10%) of \$4.7 million.

10%

Productivity lift for front-end staff due to automated eligibility and coverage verification by Year 3

“Having the right insurance information at the right time means there’s less for our teams to touch downstream. We can fix issues at registration because we have visibility into what’s causing them, and that has improved our clean-claim performance. It’s allowed our teams to move beyond insurance-related issues and focus on understanding why other claims are ending up in hold work queues. That is the value of PAC.”

Senior director of revenue cycle, multiregional health system

Improved Front-End And Revenue Cycle Staff Productivity					
Ref.	Metric	Source	Year 1	Year 2	Year 3
D1	Front-end staff	Composite	800	800	800
D2	Productivity lift due to automated eligibility and coverage verification	Interviews	5%	7%	10%
D3	Average fully burdened annual salary for a front-end staff member	Composite	\$62,000	\$62,000	\$62,000
D4	Productivity recapture	TEI methodology	50%	50%	50%
D5	Subtotal: Front-end staff productivity gains	D1*D2*D3*D4	\$1,240,000	\$1,736,000	\$2,480,000
D6	Revenue cycle staff	Composite	80	80	80
D7	Coverage discovery searches per day before PAC	Composite	10	10	10
D8	Coverage discovery time per search before PAC (minutes)	Composite	3	3	3
D9	Productivity lift for coverage discovery with PAC	Interviews	70%	75%	80%
D10	Coverage discovery search time reclaimed with PAC (hours)	(D6*D7*365 days*D8*D9)/60 minutes	10,220	10,950	11,680
D11	Average fully burdened hourly rate for a revenue cycle staff member	Composite	\$36	\$36	\$36
D12	Subtotal: Revenue cycle staff productivity gains	D10*D11	\$367,920	\$394,200	\$420,480
D13	New revenue cycle hires	Composite	12	12	12
D14	Training time before PAC (weeks)	Composite	8	8	8
D15	Reduction in revenue cycle staff onboarding time	Interviews	50%	50%	50%
D16	Revenue cycle onboarding time reclaimed (hours)	D13*D14*40 hours*D15	1,920	1,920	1,920
D17	Average fully burdened hourly rate for a revenue cycle staff member	D11	\$36	\$36	\$36
D18	Productivity recapture	TEI methodology	50%	50%	50%
D19	Subtotal: Faster revenue cycle staff onboarding	D16*D17*D18	\$34,560	\$34,560	\$34,560
Dt	Improved front-end and revenue cycle staff productivity	D5+D12+D19	\$1,642,480	\$2,164,760	\$2,935,040
	Risk adjustment	↓15%			
Dtr	Improved front-end and revenue cycle staff productivity (risk-adjusted)		\$1,396,108	\$1,840,046	\$2,494,784
Three-year total: \$5,730,938			Three-year present value: \$4,664,256		

Reduced Third-Party Revenue Cycle Costs

Evidence and data. Before implementing PAC, interviewees said their organizations relied on a combination of outsourced claims, denial management resources, and contingency-based insurance discovery vendors to identify missing coverage and resolve insurance-related issues after patient encounters occurred. These third-party partners often performed functions such as insurance discovery, coverage verification, eligibility follow-up, COB resolution, and denial recovery that internal teams were unable to complete efficiently using legacy tools and manual workflows.

Following PAC deployment, interviewees described a shift toward identifying and correcting coverage issues earlier in the patient journey. By automating insurance discovery with AI-based decisioning, identifying active insurance before claims were submitted, determining payer COB, and creating coverage automatically within registration workflows, PAC reduced the volume

of accounts requiring manual downstream intervention. As a result, interviewees' organizations reduced the eligibility, insurance discovery, and claim follow-up work they routed to external partners and, in some cases, eliminated specialized insurance discovery vendors altogether. Interviewees explained that these improvements reduced outsourced revenue cycle labor costs and third-party insurance discovery expenses while increasing organizations' ability to manage coverage-related activities internally.

- The director of revenue cycle operations at a regional health system said: "We're always looking to reduce the amount of work that has to be sent to external vendors. Since implementing PAC, the volume of eligibility and insurance discovery work handled by our vendor has decreased pretty significantly. We're continuing to improve our autocreated coverage rates because the more coverage we can identify and create upfront, the less work has to be routed to a vendor. [...] Autocreation of coverage with PAC is really the best way to eliminate what would otherwise have to go out for manual review and resolution."
- The senior director of revenue cycle at a multiregional health system shared: "The volume of eligibility and insurance-related claims requiring follow-up has gone down, so there are fewer issues falling into the work queues. That has reduced the amount of follow-up work that needs to be performed, which means we rely less on third-party resources supporting those activities because there's simply less work for them to handle."
- The senior director of patient finance at a multiregional health system explained: "Before PAC, we relied on multiple vendor partners for eligibility verification and insurance discovery. Different vendors were performing insurance discovery at various stages of the revenue cycle, including identifying Medicaid coverage and resolving COB-related issues before claims were submitted. Since implementing PAC, we've been able to eliminate one of those vendor relationships."

Modeling and assumptions. Based on the interviews, Forrester assumes the following about the composite organization:

- Before PAC, the composite spends \$600,000 annually on third-party claims and denial management services.
- With PAC, the composite reduces outsourced claims and denial management costs by 30% in Year 1, 40% in Year 2, and 45% in Year 3.
- Before PAC, the composite spends \$250,000 annually on contingency-based insurance discovery vendor services.
- With PAC, the composite reduces contingency-based insurance discovery vendor spend by 75% in Year 1 and 100% in Years 2 and 3.

Risks. Forrester recognizes that these results may not be representative of all experiences. The following factors may impact this benefit:

- Outsourced claims and denial management spend before PAC.
- Contingency-based insurance discovery vendor spend before PAC.

Results. To account for these risks, Forrester adjusted this benefit downward by 15%, yielding a three-year, risk-adjusted total PV (discounted at 10%) of \$960,000.

45%

Reduction in outsourced claims and denials management costs with PAC by Year 3

Reduced Third-Party Revenue Cycle Costs					
Ref.	Metric	Source	Year 1	Year 2	Year 3
E1	Third-party claims and denials management spend before PAC	Composite	\$600,000	\$600,000	\$600,000
E2	Reduction in outsourced claims and denials management costs with PAC	Interviews	30%	40%	45%
E3	Subtotal: Third-party claims and denials management cost savings	E1*E2	\$180,000	\$240,000	\$270,000
E4	Contingency-based coverage discovery vendor spend before PAC	Composite	\$250,000	\$250,000	\$250,000
E5	Reduction in contingency-based insurance discovery vendor spend with PAC	Interviews	75%	100%	100%
E6	Subtotal: Contingency-based insurance discovery vendor cost savings	E4*E5	\$187,500	\$250,000	\$250,000
Et	Reduced third-party revenue cycle costs	E3+E6	\$367,500	\$490,000	\$520,000
	Risk adjustment	15%			
Etr	Reduced third-party revenue cycle costs (risk-adjusted)		\$312,375	\$416,500	\$442,000
Three-year total: \$1,170,875			Three-year present value: \$960,273		

Unquantified Benefits

Benefits that provide value for the composite organization but are not quantified for this study include:

- Strong operational and optimization support from the Experian Health team.** Interviewees described Experian Health as a collaborative partner that worked closely with their organizations to optimize workflows, troubleshoot issues, and improve operational performance after deployment. Rather than limiting interactions to support requests, interviewees said Experian Health regularly participated in operational reviews, denial analysis discussions, and payer investigations to help identify root causes and recommend corrective actions. Interviewees also noted that Experian Health worked directly with payers and electronic health record stakeholders when issues arose to help accelerate issue resolution and reduce the burden placed on internal teams. Several interviewees emphasized that this level of engagement differed significantly from their experiences with other technology vendors.

The director of system patient access and financial clearance at a regional health system said: “The difference with PAC, and Experian Health in general, is that it feels much more like a partnership. We meet regularly to review operational performance and denials, and Experian Health helps us identify trends, investigate unusual activity, and determine whether issues are isolated incidents or broader patterns. It’s a completely different approach.”

The director continued: “What I also appreciate is that they engage directly with our operational teams, not just leadership. Coordinators, leads, and managers are all part of the discussions, which allows us to identify issues, evaluate potential changes, and continuously improve workflows. Their involvement extends beyond eligibility to COB, Medicare-related processes, and the entire coverage intelligence workflow.”

This interviewee also shared: “One thing I appreciated was that Experian Health included our electronic health record stakeholders in discussions when issues arose. If we needed to determine whether a problem originated with the payer, Experian Health, or another system, they helped bring the right parties together. When we encountered payer-related issues, Experian Health would join calls with us, help analyze how the information was being transmitted, and work directly with the payer to drive resolution. That level of technical engagement created a strong partnership and helped us solve problems more efficiently.”

The senior director of revenue cycle at a multiregional health system said: “We identified an issue where a payer’s third-party

verification process was returning an incorrect subscriber ID. Because we were using automated filing, that information was populated into our system, claims were submitted with the wrong subscriber ID, and we received eligibility denials. We brought the issue to Experian Health, and they were able to trace the transactions, validate the issue with the payer, and help drive a resolution. That was significant because it eliminated a major source of denials and rework. More importantly, Experian Health's ability to identify the root cause helped the payer recognize that the issue wasn't isolated to our organization. Their visibility into the data helped drive a resolution that benefited multiple organizations."

- **Improved employee satisfaction.** Interviewees reported that PAC simplified many of the registration and coverage verification activities that front-end staff previously performed manually. By consolidating eligibility verification, insurance discovery, COB determination, and other coverage-related activities into a single workflow, PAC reduced administrative burden and made registration activities easier to perform. PAC also reduced the manual decision-making required of registrars by automatically identifying coverage, determining payer primacy, and guiding the appropriate next action. As a result, employees spent less time researching coverage information and navigating multiple systems, improving the day-to-day experience for patient access teams.

The director of revenue cycle operations at a regional health system said: "A lot of the work is done before it gets to the front end. PAC gives us capabilities like coverage verification, MBI lookup, COB and primacy determination, and demographic updates all in one query. When I've talked to people on the front end, they find it so much easier and better for registration. That's a big deal when you have hundreds of people using it. Having people happier with the process really helps with employee engagement."

- **Improved patient satisfaction.** Interviewees noted that PAC helped create a better patient experience by improving the accuracy of insurance information before services were rendered and claims were billed. By identifying coverage earlier and ensuring claims were submitted to the appropriate payer, organizations reduced billing discrepancies and minimized situations that required patients to clarify insurance information after the fact. Interviewees explained that more accurate billing helped reduce confusion and improve the overall financial experience for patients. Some organizations also observed reductions in billing-related complaints after implementing PAC.

The director of system patient access and financial clearance at a regional health system said: "If we mark someone as self-pay and then find active coverage and feel confident in that information, that's one less phone call we have to make. I definitely think that helps the patient experience."

The director of revenue cycle operations at a regional health system shared: "Overall, our patient complaints have gone down since implementing PAC. Through our customer service teams, we've continued to see the percentage of complaints that are billing-related decrease over time."

"Getting the right coverage information upfront is critical to creating a positive patient experience. When a service is billed to the correct insurance company, the explanation of benefits matches the bill the patient receives from us. The more accurate coverage information we have at the time of service, the more likely we are to bill the right payer and create a better experience for the patient."

Senior director of revenue cycle, multiregional health system

- **Improved collaboration across front-end and back-end teams.** Interviewees reported that PAC helped improve coordination between patient access, registration, training, and revenue cycle teams by creating more standardized coverage intelligence processes and improving visibility into insurance-related issues. Because coverage intelligence activities became more

automated and consistent, interviewees' organizations found it easier to communicate workflow changes, address operational issues, and align staff around common processes. Interviewees also noted that front-end and back-end teams worked more closely together to monitor performance, manage updates, and improve registration quality.

The director of revenue cycle operations at a regional health system said: "We work closely with the team responsible for front-end training. When there are updates, new information, or messages that we want the front end to look at, we communicate those changes across teams. If they need to make a change, they let us know, and vice versa. There's ongoing communication between the front end and back end."

- **Reduced human error in coverage selection and registration processes.** Interviewees explained that before PAC, coverage identification and insurance selection often depended on manual review and interpretation by registrars. Staff were required to evaluate insurance information, determine the appropriate coverage selection, and make decisions that could vary based on individual experience and judgment. PAC reduced these challenges by automatically identifying and returning the appropriate coverage information within registration workflows. As a result, organizations improved consistency in coverage intelligence, reduced avoidable registration errors, and increased confidence in the accuracy of insurance information used throughout the revenue cycle.

The senior director of patient finance at a multiregional health system said: "The team doesn't have to determine which insurance plan to select because PAC automatically pulls that information back. It's not just about time savings; it's about reducing human error in the decision-making process. Instead of staff having to look at an insurance card and decide which coverage to choose, PAC returns the correct information for them. It helps with compliance risk because you don't have that human intervention where someone has to interpret the information and decide which coverage to select."

"We've continued to meet with Experian Health every other week to review technical issues, troubleshoot challenges, and investigate root causes. That level of partnership and technical engagement has been a tremendous help for us."

Senior director of revenue cycle, multiregional health system

Flexibility

The value of flexibility is unique to each customer. There are multiple scenarios in which a customer might implement PAC and later realize additional uses and business opportunities, including:

- **Continuous optimization of patient access workflows.** Interviewees noted that PAC is not a "set it and forget it" solution. As their organizations refined workflows, payer mappings, coverage rules, and automation strategies, they worked closely with Experian Health teams to optimize performance and address emerging requirements. This ongoing collaboration helped interviewees' organizations continue improving coverage accuracy and denial prevention outcomes over time while adapting to evolving payer and operational needs.

The director of system patient access and financial clearance at a regional health system said: "We use [PAC] in several different ways. If we enter a patient as self-pay, PAC will go out and look for coverage. It can identify secondary coverage that we weren't aware of, and we've even configured it to run before accounts are sent to collections to see whether there is coverage that may have been missed earlier or whether Medicaid was approved retroactively."

- **Expanded denial prevention and coverage optimization opportunities.** Interviewees explained that after establishing PAC as the foundation for coverage intelligence, their organizations continued identifying new opportunities to automate coverage-

related workflows and improve reimbursement outcomes. They noted that as payer requirements, patient access models, and organizational priorities evolve, PAC provides a solution that can support additional automation, insurance discovery, and denial prevention use cases. Interviewees' organizations can refine payer mappings, coverage rules, and workflow configurations over time to increase automation rates, improve coverage accuracy, and address emerging operational needs. Several interviewees described ongoing opportunities to expand PAC into additional workflows and decision points across the revenue cycle, which allowed their organizations to uncover new reimbursement opportunities and drive further operational improvements over time.

The director of system patient access and financial clearance at a regional health system said: "We use [PAC] in several different ways. If we enter a patient as self-pay, PAC will go out and look for coverage. It can identify secondary coverage that we weren't aware of, and we've even configured it to run before accounts are sent to collections to see whether there is coverage that may have been missed earlier or whether Medicaid was approved retroactively."

Flexibility would also be quantified when evaluated as part of a specific project (described in more detail in [Total Economic Impact Approach](#)).

TEI Framework And Methodology

From the information provided in the interviews, Forrester constructed a Total Economic Impact™ framework for those organizations considering an investment in Patient Access Curator.

The objective of the framework is to identify the benefit, flexibility, and risk factors that affect the investment decision. Forrester took a multistep approach to evaluate the impact that Patient Access Curator can have on an organization.

Due Diligence

Interviewed Experian Health stakeholders and Forrester analysts to gather data relative to Patient Access Curator.

Interviews

Interviewed five decision-makers at organizations using Patient Access Curator to obtain data about benefits and risks.

Composite Organization

Designed a composite organization based on characteristics of the interviewees' organizations.

Financial Model Framework

Constructed a financial model representative of the interviews using the TEI methodology and risk-adjusted the financial model based on issues and concerns of the interviewees.

Case Study

Employed fundamental elements of TEI in modeling the investment impact: benefits, flexibility, and risks. Given the increasing sophistication of financial analyses related to IT investments, Forrester's TEI methodology provides a complete picture of the total economic impact of purchase decisions. Please see [Appendix A](#) for additional information on the TEI methodology.

Glossary

Total Economic Impact Approach

Benefits

Benefits represent the value the solution delivers to the business.

Flexibility

Flexibility represents the strategic value that can be obtained for some future additional investment building on top of the initial investment already made. The ability to capture that benefit has a PV that can be estimated.

Risks

Risks measure the uncertainty of benefit estimates given: 1) the likelihood that estimates will meet original projections and 2) the likelihood that estimates will be tracked over time. TEI risk factors are based on “triangular distribution.”

Financial Terminology

Present value (PV)

The present or current value of (discounted) benefit estimates given at an interest rate (the discount rate).

Discount rate

The interest rate used in cash flow analysis to take into account the time value of money. Organizations typically use discount rates between 8% and 16%.

Appendixes

APPENDIX A

Total Economic Impact

Total Economic Impact is a methodology developed by Forrester Research that enhances a company's technology decision-making processes and assists solution providers in communicating their value proposition to clients. The TEI methodology helps companies demonstrate, justify, and realize the tangible value of business and technology initiatives to both senior management and other key stakeholders.

APPENDIX B

Endnotes

¹ Source: [Healthcare Leaders: How To Thrive Through Volatility, 2026, Forrester Research, Inc., May 29, 2026.](#)

² Source: [Transform Revenue Cycle Management With A Shared Vision To Build Value, 2026, Forrester Research, Inc., April 7, 2026.](#)

³ Total Economic Impact is a methodology developed by Forrester Research that enhances a company's technology decision-making processes and assists solution providers in communicating their value proposition to clients. The TEI methodology helps companies demonstrate, justify, and realize the tangible value of business and technology initiatives to both senior management and other key stakeholders.

Disclosures

Readers should be aware of the following:

This study is commissioned by Experian Health and delivered by Forrester Consulting. It is not meant to be used as a competitive analysis.

Forrester makes no assumptions as to the potential benefits that other organizations will receive. Forrester strongly advises that readers use their own estimates within the framework provided in the study to determine the appropriateness of an investment in Patient Access Curator. For any interactive functionality, the intent is for the questions to solicit inputs specific to a prospect's business. Forrester believes that this analysis is representative of what companies may achieve with Patient Access Curator based on the inputs provided and any assumptions made. Forrester does not endorse Experian Health or its offerings. Although great care has been taken to ensure the accuracy and completeness of this model, Experian Health and Forrester Research are unable to accept any legal responsibility for any actions taken on the basis of the information contained herein. The interactive tool is provided 'AS IS,' and Forrester and Experian Health make no warranties of any kind.

Experian Health reviewed and provided feedback to Forrester, but Forrester maintains editorial control over the study and its findings and does not accept changes to the study that contradict Forrester's findings or obscure the meaning of the study.

Experian Health provided the customer names for the interviews but did not participate in the interviews.

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