DENIED!

2024 State of Claims: Healthcare's dissatisfaction with payer reimbursements continues.

A survey by Experian Health

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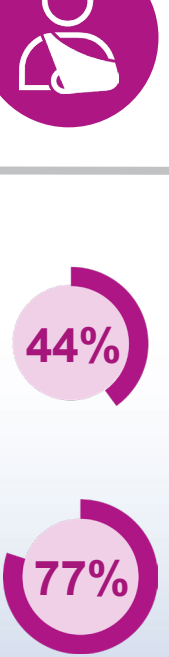
Providers' optimism is in short supply when it comes to reimbursement and collections

Times are tough. Patients are concerned about healthcare expenses. Payers are watching every dollar. Providers are caught in the middle. The result: very little confidence among respondents that anyone will pay for healthcare.

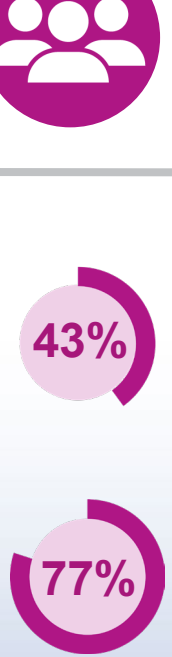
Concerned that patients will pay:



44% very to extremely concerned

77% moderately to extremely concerned

Concerned that payers will pay:



43% very to extremely concerned

77% moderately to extremely concerned

Why the concern about payer payments?

Preauthorization **(60%)** and policy changes **(51%)** are fast and furious and difficult to monitor.*

**Percentages reflect reasons providers are concerned about payer payments*

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Providers' never-ending struggle with claims and reimbursements

The challenge has worsened since June 2022 (Experian Health's State of Claims survey), implying that the decline in COVID's disruption of normal revenue cycle processes did little to reverse the trend of denials increasing.

	AGREE	
	2024*	2022†
Payer policy changes occur with more frequency	77%	67%
Claim denials are increasing	73%	42%
Reimbursement times are increasing	67%	51%
Errors in claims are increasing	55%	43%

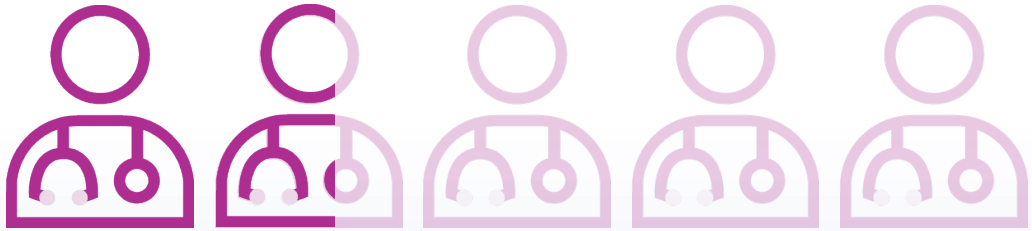
** (2024) Respondents were asked their level of agreement or disagreement*

† (2022) Qualified respondents were asked why reducing denials was a priority

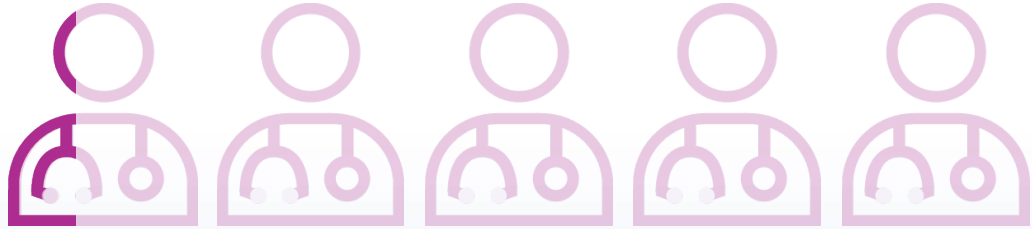
Denials continue to torment providers

Claims continue to be denied at levels that are detrimental to healthcare providers.

of respondents say claims are denied **10%** of the time, or more



of respondents say claims are denied more than **15%** of the time



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Bad data is a problem

Incomplete/incorrect data collection and authorizations are more problematic than the other top reasons for denials (coding errors, staff shortages and poor training, missing coverage, payer policies, late submissions, to name a few).

Top-ranked reasons for denials*

46%

No. 1

Missing or inaccurate data

36%

No. 2

Authorizations

30%

No. 3

Patient information inaccurate/ incomplete

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*Percentages reflect how often the choice was selected in respondents' top 3 choices.

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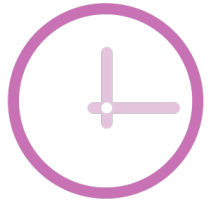
Secondary eligibility checks take time and impact efficiency

It's not unusual for initial eligibility checks to come back as incomplete. Secondary checks drag on productivity and detract from other work that needs staff attention.



43%

Respondents who say additional eligibility checks take **10** to more than **20** minutes to complete

Most often missing from initial eligibility check:

Demographics: 67%

- COB: **41%**
- Primacy: **37%**

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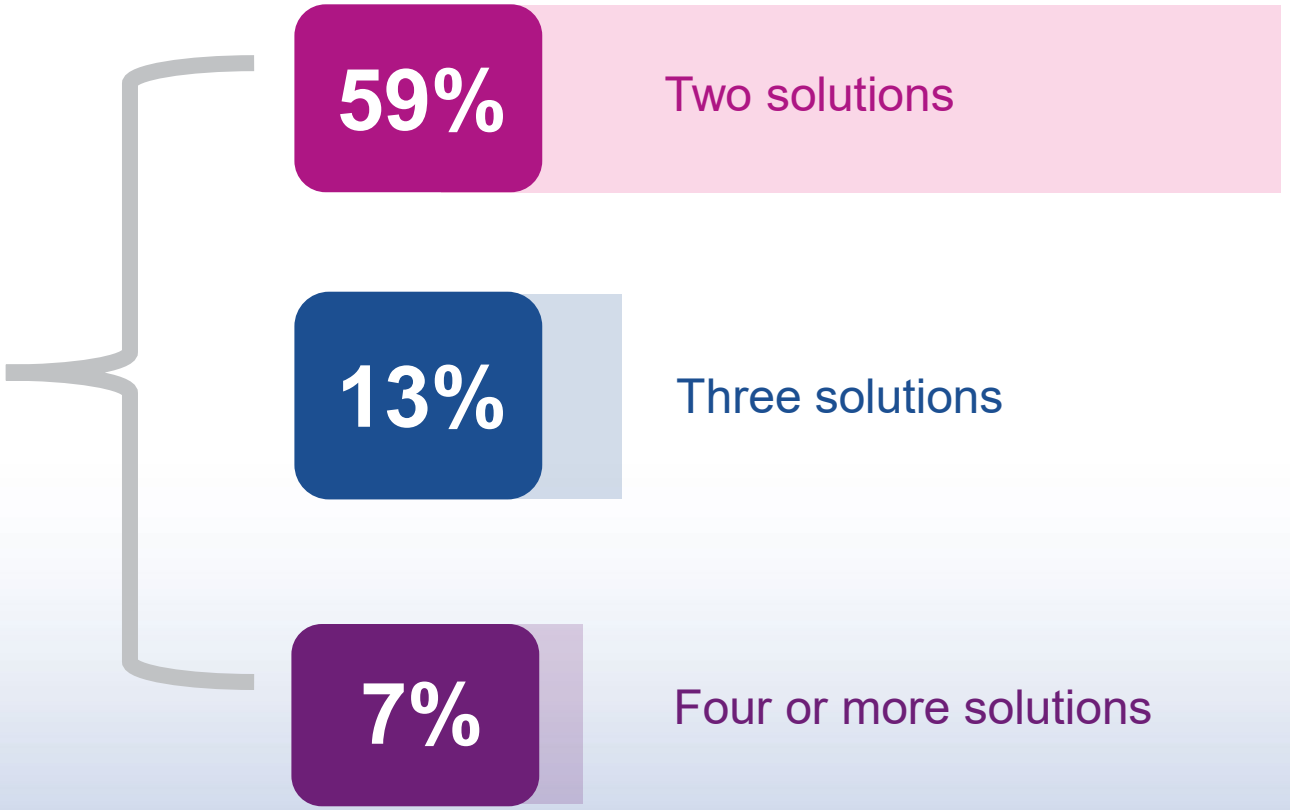
Chasing accuracy with multiple solutions

Collecting accurate information from patients at registration and intake isn't easy. Most respondents said their organizations use multiple solutions to tackle the issue, impacting productivity and patient experience.

Number of solutions used at patient intake to gather all information required for a claim submission



http:// Product: Patient Access Curator

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Nearly 50% of providers still review denials manually

If there was ever a case for automation and artificial intelligence, it's management of medical claim denials. For now, about half of providers are still using manual processes.

How claims are processed:

- **48%** Reviewed manually then assigned to manual work queue for resubmission
- **42%** Automated review assigned to manual work queue for resubmission
- **10%** Total automation of process, leveraging AI to correct the claim and resubmit

Deciding who works the denied claim.

The denial needs to be reworked and resubmitted. Who gets it?

- The individual who originally worked the claim – **26%**
- Only individuals who are responsible for denial follow up – **29%**
- It depends on denial; possibly to a follow-up team or another department – **45%**

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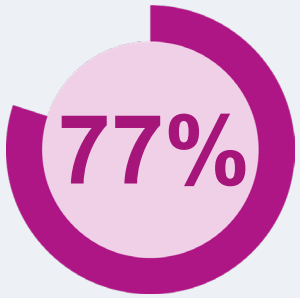
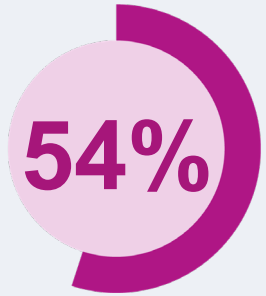
A crisis of confidence



2022 respondents who said their organizations' technology is sufficient to address existing revenue cycle management demands



2024 respondents who said their organizations' technology is sufficient to address existing revenue cycle management demands

The pressure is on.*

2024 respondents also say:

- **66%** Denials occur at a higher rate than before the pandemic
- **65%** Submitting "clean" claims is more challenging now than before the pandemic
- **42%** The economy and declining consumer confidence add urgency to payer reimbursement
- **84%** Reducing denials is a priority for the organization
- **73%** We have evaluated our claims process within the past year

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**All percentages reflect "somewhat" or "strongly agree" when respondents were asked to what extent they agreed or disagreed with the statement.*

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Healthcare's short memory: back to the old (technology) ways?

One of the positives that emerged from the pandemic was healthcare's uncharacteristic adoption of new technology to meet the immediate needs of the disruption. It appears the momentum has slowed, however.

	2024 / 2022
We're currently using some form of automation and/or AI technology	31% / 62%
We've evaluated automation technologies	41% / 33%
We've not considered/evaluated any automation technology	28% / 5%

http:// **Blog: AI and the revenue cycle**

Too much hype or not enough knowledge?

The comfort gap with new technologies plummeted in 2024. Is that adding friction to adoption?

Q. What's your confidence in understanding automation, machine learning and artificial intelligence (AI), and their roles in claims/denial management?

	2024 / 2022
"Slightly" to "not at all" confident	34% / 8%
"Extremely" or "very" confident	28% / 68%

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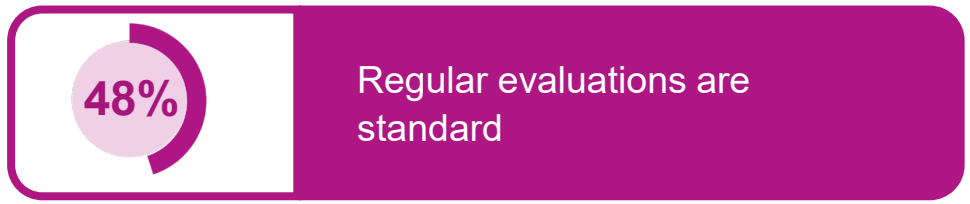
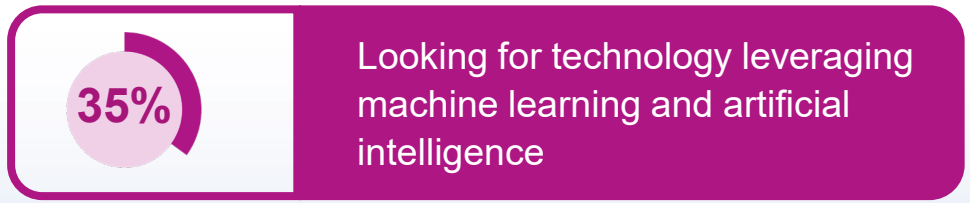
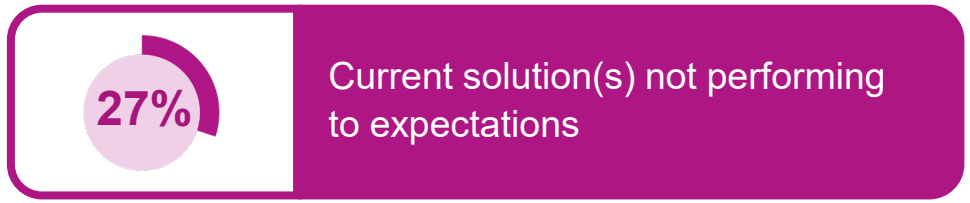
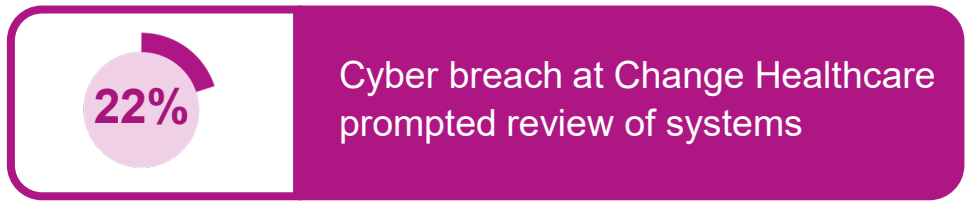
Always improving or just not happy with current performance?

At the low end, providers evaluate their claim management technology at least every three years (18%) and more commonly, annually (48%). Reasons to stay on top of things range from fine-tuning to total overhaul.









Progress has been made; more is needed

There are some indicators that technology is viewed as the best way to level the playing field, but the data also shows a retreat from the broader embrace of automation and mobile enablement that accelerated during and shortly after the pandemic. The next year could prove influential if those who have invested recently in claims management technology, or plan to in the next six months, start to turn the tide of denials. Others will be watching, and a new technological surge could result if the returns are promising.

Recently invested in claims management technology

Plan to invest in claims management technology in next six months

Learn more about automation, machine learning and artificial intelligence, and how Experian Health solutions leverage these technologies to prevent denials and quickly address denied claims. Ready for a demo? **Contact us**.

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Methodology and objective

Survey sample: This report is based on a survey of 210 healthcare staff responsible for administration in finance, billing, registration, reimbursements, claims and collections. Participants include chief officers, presidents, vice presidents, directors and administrators. The survey was fielded June 22, 2024 – July 10, 2024.

Survey objective: The survey was intended to determine the current state, reasons for the current state, actions being taken to address the challenges that exist within the claims management function of provider operations. Additionally, questions were designed to determine awareness of emerging technologies that can optimize the claims process and generate more reimbursement revenue.

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