Olive

Easing the Burden of Eligibility

Defining the problem, understanding the impact, and reviewing the solutions.

Ineligible patient insurance coverage is responsible for over 75% of all claim rejections and denials by payers. Though some insurance eligibility checks can now be completed online, many practices still waste hours on the phone with insurance companies, or searching their websites, to verify patient coverage.

This paper outlines the severe financial burden that health care systems face as a result of manual insurance eligibility verification, details the time spent by doctors, nurses, and clerical workers each week on insurance-related tasks, and highlights the immense amount of insurance paperwork that comes along with each patient visit.

Manual verification can be extremely time-consuming and frustrating, as well as a costly drain on the organization's human capital.

The importance of checking patient insurance eligibility

Practices may easily assume that when a patient schedules an appointment, the patient has already checked that their insurance covers that practice and/or the procedure or appointment type. Practices may also assume that if a patient hands them what appears to be a valid insurance card, they will be covered and that the insurance verification process can reasonably begin after the appointment.

This, however, is not always the case—some patients are not aware of verification requirements, or may not check for coverage for their particular appointment type. Additionally, if a patient's insurance provider changes, they may not realize that they are no longer covered at particular practices or for particular procedures. In some cases, patients may even present fraudulent insurance cards—causing major complications if the error is not caught immediately.

Once presented with a patient's insurance information, healthcare organizations will then begin the tedious and often time-consuming task of verifying their eligibility. This may be done online, by calling the insurance provider directly, or in some cases, not at all. If a patient passes this check, they can then be passed through the system with a bill eventually being sent to their insurance provider and/or themselves (in the case of copays).

If a patient does not pass this check, however, the organization is typically faced with three options: bill the patient the full amount of the appointment or procedure, write off the appointment or procedure, or deny the patient service (if the check is done prior to the appointment).

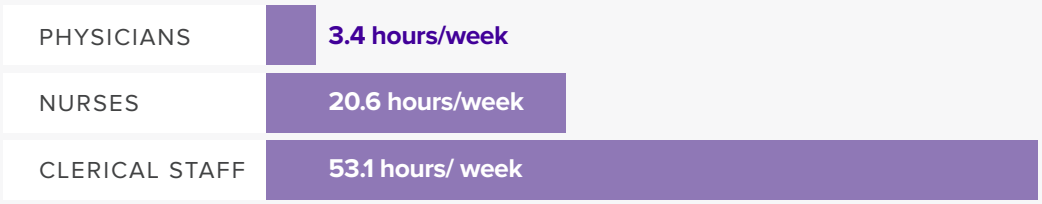
Insurance eligibility checks are a very important and necessary part of the schedule-to-appointment process, as failing to complete them can lead to further complications for the organization. Manual verification can be extremely time-consuming and frustrating, as well as a costly drain on the organization's human capital. Integrated verification tools can help, but still require a good amount of human input in order to function properly.

The cost to practices of insurance eligibility checks

Per physician, practices spend an average of $68,274 each year interacting with insurance providers.

With each patient that schedules an appointment should come a subsequent eligibility check. Typically, such a check requires obtaining the patient's insurance information, calling the insurance provider, waiting on hold, and finally verifying the patient's coverage. Insurance verification does not always fall only onto clerical staff—physicians and nurses also spend hours each week interacting with insurance providers, taking away valuable time that could be spent on patient care.

Below are the average times spent per physician in a practice on insurance company interaction.



Aside from causing healthcare employees stress and frustration, time-consuming insurance company interactions cost practices thousands of dollars each year in lost productivity. Per physician, practices spend on average $68,274 each year interacting with insurance providers. Overall, this costs the U.S. $23–$31 billion each year—a significant chunk of the national health care burden of over $3.2 trillion (as last measured in 2015).

Paperwork and human capital associated with insurance eligibility checks

In an increasingly digital world, a surprising amount of health information and data is still processed manually through paper forms. Many insurance companies still require practices to print out forms for patient visits, complete the forms by hand, and fax them back to the insurance provider. Aside from being wasteful of resources, this process is also incredibly time-consuming.

Dependent upon the care setting, time spent on paperwork can even match time of patient care. **Below are the ratios of patient care time to paperwork time:**

EMERGENCY DEPARTMENT	1 Hour Patient Care : **1 Hour of Paperwork**
HOME HEALTH CARE	1 Hour Patient Care : **48 Minutes of Paperwork**
SURGERY & INPATIENT ACUTE CARE	1 Hour Patient Care : **48 Minutes of Paperwork**
SKILLED NURSING CARE	1 Hour Patient Care : **30 Minutes of Paperwork**

Every human-caused error causes a practice both time and money to resolve.

To allow nurses and physicians to focus on patient care, healthcare organizations may hire one or more eligibility specialists, whose entire bandwidths can be dedicated to insurance eligibility verification. These employees, however, can be costly, and are naturally prone to human error. On average, an eligibility specialist earns at least $34,000 each year, not including healthcare benefits and other employer-incurred costs associated with hiring an employee. More experienced eligibility specialists earn more per year, though even they are also prone to human errors such as miskeyed or misheard information. Every human-caused error causes a practice both time and money to resolve.

Current solutions and tactics

Currently, many practices still check patient eligibility manually, either through searching an insurance company's website or by calling the insurance company directly. 38% review websites while 20% call directly, meaning that over half of all providers still spend a sizeable amount of employee time verifying patient eligibility. Inaccurate or unupdated websites, as well as frustrating phone prompts, can make these processes last up to an hour or more for a single patient in some cases.

When considering ways to streamline the insurance eligibility verification process, providers are not left with many options. Current solutions include close to real-time eligibility software that integrates with older systems, or solutions that are tied to EHR vendors. These tools can help staff run through insurance eligibility checks at a much more rapid pace than before, as they automate certain steps in the process.

These tools, however still require human input, and often, human control to carry out. While some of the eligibility process may be automated through integrated systems, employees will typically still need to input the patient's name, insurance provider, and procedure in order to begin the process. Additionally, providers must spend time and money upfront to train their staff on integration tools.

Conclusion

Patient insurance eligibility checks are a time-consuming, frustrating, and costly drain on health care systems of all sizes that can leave providers and patients equally upset. Future solutions geared towards solving these problems must aim to streamline eligibility checks in a manner that not only speeds up the process as a whole, but also improves first-time accuracy without requiring timely staff training to implement.

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