PITON Global

EXECUTIVE WHITE PAPER · WP-29

INSURANCE VERIFICATION · PHILIPPINES

The eligibility-accuracy standard: the executive economics of insurance verification outsourcing to the Philippines.

An analysis of why verifications processed is a volume vanity metric, how eligibility accuracy and up-front completeness — never verification throughput — decide the true cost of a patient-access operation once eligibility denials, rescheduled care, and patient-collections leakage are counted, and the vendor-selection discipline that catches the coverage before the visit.

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ABOUT THIS SERIES — VOLUME 29

Every verification proposal is priced per verification processed, because throughput is easy to count. This volume is about the only eligibility outcome the visit and the claim actually depend on: coverage checked accurately and completely before the patient arrives — active plan, covered benefit, prior authorization secured, and patient responsibility confirmed — so nothing denies after the care is delivered. The gap between running an eligibility check and getting it right is where downstream denials live. The full series lives at piton-global.com.

THE PITON-GLOBAL LEADERSHIP TEAM

About the authors

John Maczynski

Chief Executive Officer

John has bought verification capacity for three decades, and learned that the fast team that clears eligibility checks and gets them wrong is the most expensive one a health system can hire — because every missed benefit, unsecured authorization, or stale plan is a denial after the care is delivered, a visit rescheduled at the desk, and a patient balance that never gets collected. His standing question ignores the productivity report: of the verifications you ran, how many were accurate and complete before the patient arrived? Applied at PITON-Global, that question is what clients get on every verification sourcing decision — personally, with no account layer in between.

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Chief Strategy Officer

Ralf has spent twenty-five years running Philippine patient-access floors, and he judges a verification team by its eligibility accuracy and downstream denial rate, not its checks-per-day: whether the coverage was caught complete before the visit, or came back as a denial after it. The verification contract in Section 3 codifies what he learned rebuilding teams that cleared eligibility fast and missed the authorization. He now reads verification providers the way he once ran them — from the eligibility-denial log backward.

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PITON Global

ABOUT PITON-GLOBAL

PITON-Global is a buyer-side advisory practice, Manila-based since 2001, that has never operated a delivery floor or taken a placement commission. Its stock-in-trade is knowing the Philippine provider market at the operating level — 1,000+ mapped operations, re-verified continuously, including each verification team's real eligibility accuracy and downstream denial performance rather than its checks-per-

day headline — and converting that knowledge into a shortlist of six to ten genuinely qualified partners per engagement. Buyers from Tripadvisor, Garmin, TSYS, HealthPartners, Yetipay, Workrise, and Norman Disney & Young have run their searches through the practice.

SECTION 01

Executive summary

-58%
Fully-loaded cost per accurate verification vs. US onshore

99%+
Eligibility-accuracy rate on vetted teams, up from 88–93%

-66%
Reduction in eligibility-related denials on vetted teams

6.1×
First-year ROI, reconstructed case (Section 6)

A verification engagement is bought on the price per check and paid for on the eligibility it gets wrong. The vendor reports four hundred thousand verifications processed at a fraction of the onshore cost; the health system finds the denials for plans that had already termed, the authorizations nobody secured before the procedure, the benefits that were never checked, and the patient balances that walked out the door uncollected because no one confirmed the cost up front. The operation hit its verifications-processed number and the health system inherited an eligibility-denial backlog, a schedule full of reschedules, and patient revenue it never captured. The gap between running an eligibility check and getting it right is where the real cost of cheap verification hides, because an inaccurate verification is not throughput delivered — it is a denial deferred to after the care.

The Philippines is where insurance verification is delivered with the most eligibility-accuracy discipline, because a deep, payer-literate, detail-trained talent pool can run the before-the-visit checking, prior-authorization capture, and patient-cost confirmation that accuracy demands. Five findings:

1 **Verifications processed is the industry's most flattering number.** Any team can run a check and mark it done. Vetted teams are measured on outcome: eligibility accuracy, up-front completeness, and downstream denial rate. Weak providers quote a low per-check price the health system repays in denials, reschedules, and uncollected patient balances. Section 2 shows the gap.

2 **The complete check before the visit, not the fast one, is the product.** Coverage that holds up at claim time comes from confirming the active plan, the covered benefit, the prior authorization, and the patient responsibility before the patient arrives — not from clearing a queue. Teams that verify complete prevent the denial; teams that verify fast and partial defer it to after the care, when it costs the most.

3 **A missed authorization is a guaranteed denial.** Care delivered without a required prior authorization or against a termed plan denies almost every time, and the revenue is rarely recovered. Vetted teams hold eligibility accuracy above 99% precisely because the tail — the unsecured auth, the stale plan — converts directly into written-off care.

4 **The denial and the reschedule, not the keystroke, are what cost.** A verification done wrong costs the denied claim, the appeal, the rescheduled visit, and the patient balance that goes uncollected — many times the per-check saving. Teams that verify accurately up front prevent those denials and confirm patient cost early, and that protected revenue — not the offshore rate alone — is where the case study's return is built.

5 **Contract on the accurate verification, not the processed one.** The contracting failure of verification is paying per check and hoping the coverage was right. Vetted deals price against eligibility-accuracy floors, up-front-completeness targets, and downstream-denial ceilings, making correctness the team's problem, which is where it belongs.

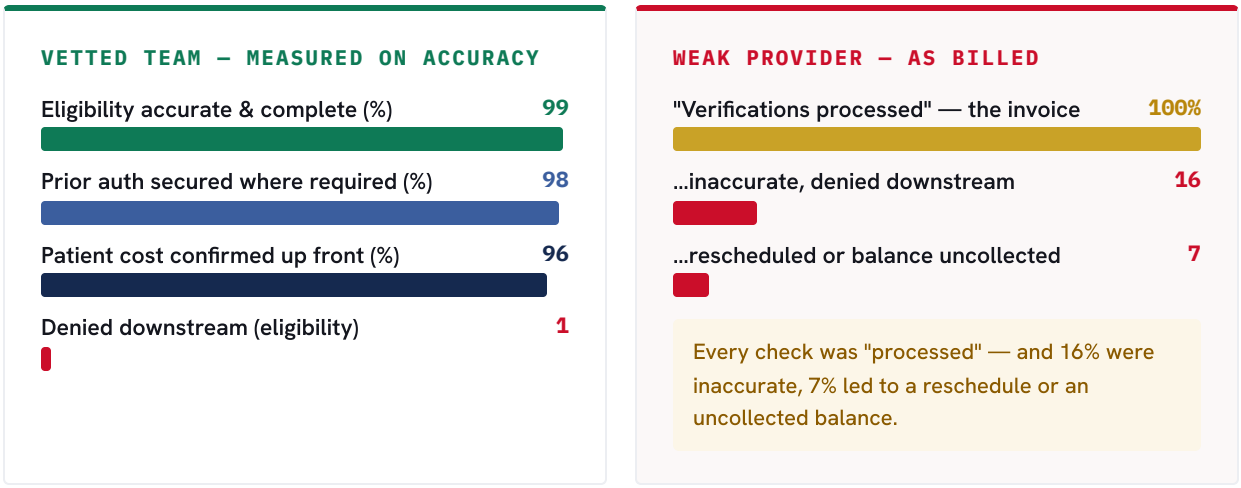
The intended reader is a patient-access director, revenue-cycle leader, or practice administrator buying verification per check and paying for it in eligibility denials, reschedules, and uncollected patient balances. Sections 2–4 separate the teams that verify accurately from the teams that clear volume; Sections 5–7, the method and the proof.

SECTION 02

The volume mirage: verifications processed versus accurate eligibility

Figure 1 shows one month of a health system's verifications two ways: as the productivity report a weak vendor bills, and as the eligibility-accuracy reality the downstream claims experience. The verifications-processed number is identical in spirit to a chatbot's containment rate — a figure engineered to look like output while eligibility denials, reschedules, and uncollected balances accumulate underneath.

FIG. 1 — ONE MONTH OF VERIFICATIONS: ELIGIBILITY-ACCURACY QUALITY VS. REPORTED PRODUCTIVITY



Left: PITON-Global engagement instrumentation, 2025–26, eligibility audited. Right: composite of pre-engagement vendor reporting reviewed in diligence.

The economics follow the accuracy, not the check count. On the left, ninety-nine percent of verifications are accurate and complete and ninety-eight percent of required authorizations secured, so claims pay clean and no visit reschedules at the desk; on the right, a cheap per-check price gets sixteen percent wrong and sends seven to reschedule or write-off, paying in eligibility denials, lost slots, and uncollected balances at once. A low per-check price that produces inaccurate eligibility is not a saving; it is denied revenue and lost patient collections, deferred to after the care. The eligibility-accuracy audit — accuracy rate, auth-capture rate, downstream denial rate — is the cheapest due-diligence instrument in this paper.

SECTION 03

The verification contract: check it before the visit, catch what the payer requires, confirm the patient cost

Figure 2 lays out the three clauses of a working verification contract — the machinery a floor read verifies before any per-check price is believed.

FIG. 2 — THE VERIFICATION CONTRACT, AS OPERATED ON VETTED TEAMS

CHECK IT BEFORE THE VISIT

Every patient's active plan, coverage dates, and covered benefit are confirmed against the payer before the appointment, not at the desk — so no one is seen against a termed or wrong plan. Eligibility is settled ahead of the care, where a problem can still be fixed.

CATCH WHAT THE PAYER REQUIRES

Every prior authorization, referral, and pre-cert the payer requires is identified and secured before the service, and a missing requirement is escalated rather than assumed. The requirement is met at the source, so the claim does not deny for a rule nobody checked.

CONFIRM THE PATIENT COST

The patient's deductible, co-pay, and co-insurance responsibility is calculated and communicated before the visit so it can be collected at or before the point of care — with an accuracy report the health system can read. A confirmed patient cost is one that gets collected, which is the only outcome patient revenue actually feels.

↓ yields ↓

THE ACCURATE VERIFICATION

99%+ ELIGIBILITY ACCURACY | AUTHS SECURED | PATIENT COST CONFIRMED

Coverage is confirmed complete before every visit, authorizations are secured, and patient cost is set for collection at the point of care — so eligibility denials fall, the schedule stops churning, and patient balances get collected. The operation gets cheaper per accurate verification and cleaner downstream at the same time, which is the entire promise of outsourcing verification to people who measure eligibility accuracy, not checks processed.

Operating parameters from PITON-Global patient-access engagements, 2025–26.

In diligence, the contract is tested from the claim's side: pull a sample of verified encounters and re-check the eligibility against the payer to measure true accuracy; trace the eligibility-denial log back to the verifications that missed; review whether patient cost was confirmed before the visit. Perhaps one team in ten survives it cleanly. Steps 3 and 5 of the framework exist to find that one before the contract does — because everything in Table 3 of Section 6 depends on eligibility accuracy, not verifications processed.

SECTION 04

Cost and performance: cost-per-accurate-

verification economics and benchmarks

TABLE 1 — FULLY-LOADED COST PER ACCURATE VERIFICATION: THREE OPERATING MODELS (2026)

OPERATING MODEL	COST / ACCURATE	VS. US BASELINE
US onshore in-house verification team	$6.70	baseline
Low-cost offshore verification mill (per-check)	$4.55	−32%
Vetted Manila team — before-visit, complete, confirmed	$2.81	−58%

Basis: PITON-Global engagement pricing 2025–26; cost per accurate verification = fully-loaded operating cost divided by verifications completed accurately (inaccurate/incomplete excluded); the verification mill looks cheap per check but downstream denials, reschedules, and uncollected balances lift its true cost per accurate verification; US comparator fully-loaded in-house cost.

TABLE 2 — INSURANCE-VERIFICATION BENCHMARKS, VETTED VS. BASELINE (2025–26)

METRIC	VETTED TOP TIER	BASELINE	EXECUTIVE READING
Eligibility-accuracy rate	99%+	88–93%	The only verification number claims follow
Prior-auth capture rate	98%+	82–90%	Secured now, or denied later
Eligibility-denial rate vs. baseline	−66%	baseline	"Check it before the visit" — held or not
Verified before the visit (%)	98%+	70–85%	Fixed ahead, or discovered at the desk
Point-of-service collection rate	+34%	baseline	Collected up front, or chased later

Source: PITON-Global patient-access engagement data 2025–26; baseline = typical pre-engagement operations billed on verifications processed.

The strategic read: the verification mill's −32% per check is a false economy — downstream denials, reschedules, and uncollected balances lift its true cost per accurate verification far above the per-check gap, and revenue denied after the care is rarely recovered. The vetted Manila team's −58% is real because it is measured where the value is: the coverage confirmed accurately, before the visit, with the patient cost

set to collect. Buy on verifications processed and you buy the right column of Figure 1; buy on cost-per-accurate-verification and you buy eligibility accuracy — the same discipline every volume in this series keeps arriving at from a different door.

SECTION 05

Sourcing discipline: the 7-Step Vendor Vetting Framework, applied to eligibility

Verification diligence adds one hard requirement to every step: a per-check price is real only when the eligibility accuracy behind it survives a re-check against the payer. The funnel below is representative of a 30–60-seat patient-access search.

FIG. 3 — THE 7-STEP FRAMEWORK AS AN ELIGIBILITY FUNNEL

	STEP	WHAT IT ELIMINATES IN A VERIFICATION SEARCH	FIELD REMAINING
1	**Requirements definition**	Throughput-first scoping: fixes the eligibility-accuracy floor, the up-front-completeness target, the auth-capture standard, and the downstream-denial ceiling the operation must meet by payer mix	1,000+
2	**Market mapping**	Verification mills: operations that bill check volume and treat downstream denials as the client's problem, and generalist floors with no payer or patient-access depth	~44
3	**Capability screening**	Teams without the machinery: audited eligibility-accuracy history, a before-the-visit workflow, a prior-authorization capture process, and payer-portal coverage across your book	~13
4	**Compliance & security audit**	Weak data governance: HIPAA and PHI protection, access controls on the eligibility and EHR systems, HITECH breach discipline, SOC 2 scope covering the verification stack	~8
5	**Operational diligence**	The re-check: re-verify a sample of encounters against the payer for true accuracy; trace the eligibility-denial log to the misses; interview on how they handle an ambiguous benefit or a required auth	4–6
6	**Competitive RFP & negotiation**	Per-check pricing: finalists bid against eligibility-accuracy floors, up-front-completeness targets, and downstream-denial ceilings — all carrying credits for verifications that deny after the care	2–3
7	**Transition & launch governance**	Cold cutover: the team calibrates against your payer mix and systems on a sample before it owns the queue, with the eligibility-accuracy floor certified before steady state, PITON-Global embedded buyer-side	1

Field-remaining counts represent a 30–60-seat patient-access search, PITON-Global engagements 2024–26.

The standing guarantees hold: **vendor neutrality** — PITON-Global operates no verification floors, runs no eligibility checks, and takes no placement economics, so the shortlist reflects audited eligibility-accuracy performance, not inventory; **right-sizing** — teams for whom your operation is a flagship account. Six to ten genuinely qualified providers, delivered within 48–72 hours, free to the buyer, competing through a fully transparent, fair, comprehensive, and highly competitive RFP.

SECTION 06 · ANONYMIZED CASE STUDY

Re-basing the operation on eligibility accuracy: a 40-seat patient-access rebuild, reconstructed

Engagement IV-043 is a US multi-specialty health system — running roughly 780,000 eligibility verifications a year across scheduled, referred, and same-day encounters — that had offshored insurance verification to a per-check vendor. The check price was excellent; the accuracy was not: eligibility accuracy sat near 90%, prior authorizations were missed, eligibility-related denials ran high, and point-of-service collections were weak because patient cost was rarely confirmed up front. The patient-access director wanted the arbitrage without the downstream denials. Identifying details are anonymized under NDA.

SELECTION (WEEKS 0–8, RE-CHECKS)

Requirements fixed a 99% eligibility-accuracy floor, a 98% before-visit target, a 98% auth-capture standard, and a downstream-denial ceiling, with a mandatory patient-cost-confirmation workflow. Mapping produced 44 claimants; the machinery screen — audited accuracy history, before-visit workflow, auth capture, payer-portal coverage — left 13; the HIPAA-and-compliance audit left 8. Blind re-checks of each finalist's verified encounters against the payer shortlisted 5. A Manila team won priced against eligibility accuracy and downstream denials, with a re-check written into the reporting spec.

TRANSITION (MONTHS 2–7, CALIBRATED FIRST)

The team calibrated against the system's payer mix and scheduling systems on sample encounters and cleared the before-visit backlog before owning production verification; the accuracy floor was certified in month 3. The re-check-and-education loop fed training from day one. By month 7 eligibility accuracy reached 99.2%, before-visit verification hit 98%, eligibility-related denials fell 66%, and point-of-service collections rose 34%. PITON-Global chaired the eligibility review board to steady state.

TABLE 3 — IV-043 FIRST-YEAR VALUE BUILD-UP (US$)		
VALUE COMPONENT	YEAR 1	BASIS
Labor arbitrage on the 40-seat verification operation	$1.20M	75.0k productive hrs × ($25.60 − $9.60)
Recovered revenue (eligibility denials prevented)	$0.52M	Net collections restored by higher eligibility accuracy
Patient collections captured up front	$0.28M	Point-of-service collections lift on confirmed patient cost
Reschedule & rework reduction	$0.13M	Fewer desk reschedules and denial rework vs. baseline
Gross value created	**$2.13M**	
Less: engagement & transition costs	($0.35M)	Calibration, before-visit backlog work-down, EHR/eligibility integration; advisory fee $0 (provider-paid model)
Net value ÷ cost = first-year ROI	**6.1×**	$2.13M ÷ $0.35M

Figures rounded; accuracy, denial, and collection effects audit-verified. Method in Methodology & notes.

Fifty-six percent arbitrage, forty-four percent from prevented eligibility denials, captured patient collections, and reduced reschedules — a typical split for the series, earned because the operation was re-based on eligibility accuracy rather than check volume. Every line traces to a diligence step: the accuracy floor to Step 1, the accuracy-based pricing to Step 6, the before-visit workflow to Step 3's contract. The patient-access director's line at the year-one review: "The check price barely moved. What moved is that claims stopped denying for coverage we should have caught before the visit."

SECTION 07

The executive playbook: governance for the first 180 days

A verification transition succeeds when the team is measured and paid on eligibility accuracy and downstream denials — client in command throughout.

DAYS 0–30

Define accuracy, contract on it

Set the eligibility-accuracy floor, the before-visit and auth-capture targets, and the downstream-denial ceiling with patient-access leadership before launch, and document the patient-cost-confirmation workflow by payer. Contract against eligibility accuracy and downstream denials — never per check alone — with floors and ceilings carrying credits. Stand up the eligibility re-check as the program's arbiter of truth.

DAYS 30–90

Calibrate, clear the before-visit backlog

Calibrate the team against your payer mix and scheduling systems and clear the before-visit backlog before it owns production; certify the accuracy floor and auth-capture loop. Switch on the patient-cost-confirmation workflow from day one. Publish the eligibility dashboard: accuracy rate, before-visit rate, auth-capture rate, eligibility-denial rate, point-of-service collections.

DAYS 90–180

Own production, certify steady state

Hand production verification to the team only after it holds the accuracy floor and downstream-denial ceiling. Review the eligibility board monthly with the eligibility-denial log on the table. Certify steady state on two months at floor including a payer-policy change cycle; hand over on documented criteria; keep the quarterly re-check standing.

THE FIVE FAILURE MODES WE ARE HIRED TO PREVENT

Paying per check while eligibility denials pile up · verifying at the desk instead of before the visit · missing a required prior authorization · never confirming patient cost up front · owning production before eligibility accuracy is proven. All five are settled at selection and contract.

The verification argument, in one sentence: a processed check is activity and an accurate verification is coverage confirmed before the care, and a vetted Philippine team delivers −58% cost per accurate verification with a 99%+ eligibility-accuracy rate and eligibility denials cut by two-thirds — for buyers who re-check the accuracy instead of counting verifications processed, and compete the finalists through a fully transparent, fair, comprehensive, and highly competitive RFP. Anyone can run a check. We make sure you buy the team that gets the coverage right before the visit.

METHODOLOGY & NOTES

How the numbers were built

Eligibility-accuracy and denial figures (Fig. 1, Table 2) derive from engagement instrumentation in PITON-Global patient-access engagements, 2025–26. Eligibility accuracy is measured by re-verifying a sample of encounters against the payer; before-visit rate, auth-capture rate, eligibility-denial rate, and point-of-service collections are

measured against the client's pre-engagement baseline. The weak-provider column is a composite of pre-engagement vendor reporting reviewed in diligence, shown for contrast.

Cost-per-accurate-verification figures (Table 1) are fully loaded — wages, benefits and statutory charges, facilities, technology and eligibility-tooling, management and QA overhead including auditors and auth specialists, attrition-driven recruiting — divided by verifications completed accurately, with inaccurate or incomplete checks excluded from the denominator; US comparators reflect fully-loaded in-house cost on the same basis. An accurate verification is coverage confirmed correctly and completely before the visit.

The case study (IV-043) is anonymized under NDA; volumes and dates are generalized, figures rounded. Accuracy, denial, and collection effects are audit-verified; the recovered-revenue line reflects restored net collections, and the patient-collections line is a conservative point-of-service estimate. ROI = net first-year value ÷ all engagement-related client costs. PITON-Global's advisory fee is provider-paid and appears at $0 in the client cost base; neutrality safeguards are documented at piton-global.com.

Market context draws on IBPAP reporting and PITON-Global's proprietary provider mapping (1,000+ operations; eligibility accuracy and denial performance re-verified May 2026). Estimates and projections are PITON-Global analysis and should be cited as such. The full series is available at piton-global.com.

Would your provider's check price survive an eligibility re-check?

Thirty minutes with John will tell you. Free to buyers, strictly vendor-neutral — an accuracy-verified shortlist within two to three business days.

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