PITON Global

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HEALTHCARE BPO · PHILIPPINES

# Healing the cost of care: the executive economics of healthcare BPO in the Philippines.

An analysis of administrative-spend structure, HIPAA-grade offshore delivery, revenue-cycle and member-services benchmarks, and vendor-selection discipline in healthcare's most proven outsourcing destination.


AUTHORS

**John Maczynski** — Chief Executive Officer
**Ralf Ellspermann** — Chief Strategy Officer



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**ABOUT THIS SERIES**

Each volume of the PITON-Global Executive White Paper Series takes a single outsourcing discipline or industry vertical and lays open its workings — the cost structures, the operating benchmarks, the shape of the provider field, and the governance that separates programs that compound value from programs that quietly leak it. The series documents the analytical foundations behind the advisory practice at piton-global.com.

THE PITON-GLOBAL LEADERSHIP TEAM

# About the authors

## John Maczynski

Chief Executive Officer

John built his reputation inside the operations he now helps clients buy: for more than three decades he commissioned, scaled, and repaired outsourced service programs for major US corporations, a career that taught him where offshore engagements break and what it costs to fix them late. Today he leads every PITON-Global mandate personally, translating a client's requirements into the provider search, the RFP, the negotiation, and the launch that follows.

j.maczynski@piton-global.com
+1 402-598-8740

## Ralf Ellspermann

Chief Strategy Officer

Ralf's vantage point is singular: he has watched the Philippine outsourcing industry grow from a niche experiment into a $40-billion global center of gravity — from inside it, in Manila, across more than two decades of running and advising delivery organizations for banking, insurance, healthcare, travel, and e-commerce clients. The market maps, cost models, and provider-intelligence files that anchor this series are built and maintained under his direction.

r.ellspermann@piton-global.com
Manila, Philippines

PITON Global

ABOUT PITON-GLOBAL

PITON-Global is a Manila-based, multi-awarded outsourcing advisory that has served one side of the table — the buyer's — since 2001. The firm maintains a living map of the Philippine provider landscape, qualifies the narrow slice of it genuinely suited to each client's program, and remains embedded as an independent advisor from requirements through go-live. It earns nothing from any provider's placement decision, which is precisely what makes its shortlists worth acting on. Organizations including HealthPartners, Tripadvisor, TSYS, Garmin, Yetipay, Workrise, and Norman Disney & Young have sourced their Philippine teams through the firm.

SECTION 01

# Executive summary

American healthcare does not have a care problem so much as an administration problem. Roughly a quarter of US health spending goes to administrative activity — eligibility checks, prior authorizations, claims adjudication, billing, coding, denials, member phone calls — and nearly every organization in the value chain, payer or provider, performs that work with expensive domestic labor it struggles to hire and cannot retain. Margins are compressing from both ends: reimbursement pressure above, labor inflation below.

The Philippines has quietly become the most consequential offshore answer to that problem. It combines a workforce unlike any competing destination — hundreds of thousands of licensed nurses, allied-health graduates, and medical-coding professionals working in English on US accounts — with two decades of institutional experience running HIPAA-governed processes for American payers, providers, and health-tech firms. For a US healthcare executive, the question is no longer whether the model works; it is which of the hundreds of providers claiming healthcare competence can actually evidence it.

This paper gives that executive the working materials: the administrative-cost logic, the compliance architecture that must be non-negotiable, the cost and performance benchmarks of vetted healthcare BPOs, the selection method that finds them, and a reconstructed 60-seat payer-services engagement that returned 5.8× its first-year cost. Five findings organize the analysis:

1 **Healthcare is the least forgiving BPO vertical — by design.** PHI exposure, OCR enforcement, and payer audit rights mean a sourcing error is a compliance event, not just a service failure. The vetting bar sits accordingly higher than in any other service line.

2 **The clinical bench is the Philippines' real moat.** Wage arbitrage exists in many countries; a deep pool of US-registered and Philippine-registered nurses, HIM graduates, and certified coders who can staff utilization management, clinical documentation, and complex claims work does not.

3 **Revenue-cycle metrics are where the money hides.** A 62% seat-cost saving is the visible win; moving first-pass claim rate from 88% to 96% and AR days from 52 to 38 is routinely worth more — it is working capital and denied revenue coming home.

4 **The healthcare-competent field is far smaller than it claims to be.** Hundreds of Philippine BPOs list "healthcare" among their verticals; PITON-Global's diligence work typically confirms genuine payer- or

provider-side depth, with the certifications to match, in fewer than forty — and right-sizes that field to six to ten for any given program.

5 **Governance must be built for auditors, not just dashboards.** The programs that endure treat the BAA, access controls, and evidence trails as operating disciplines reviewed weekly — so that an OCR inquiry or payer audit is a document-retrieval exercise, not an emergency.

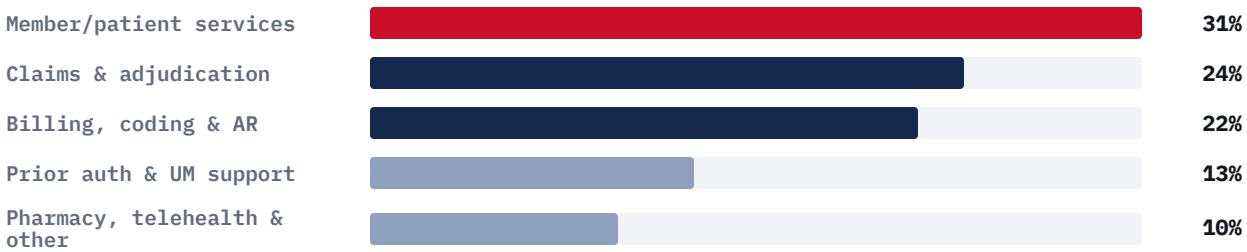
The intended reader leads operations, finance, or compliance at a payer, provider group, RCM firm, or health-tech company weighing a first Philippine program or expanding one. Sections 2–4 establish the market, compliance, and economic evidence; sections 5–7 supply the method.

SECTION 02

# The administrative-spend problem — and why healthcare found the Philippines

Every US healthcare organization runs a shadow enterprise of administration behind its clinical work. For payers it is enrollment, eligibility, prior authorization, adjudication, appeals, and member services; for providers and RCM firms it is scheduling, registration, coding, charge capture, billing, AR follow-up, and denials. The unit economics are unforgiving: this work is high-volume, quality-sensitive, and staffed onshore by roles with 30–45% annual turnover in a labor market that has repriced sharply since 2021.

FIG. 1 — WHERE HEALTHCARE BPO WORK SITS (SHARE OF OUTSOURCED HEALTHCARE ADMIN VOLUME, PITON-GLOBAL ENGAGEMENT BASE)




Source: PITON-Global healthcare engagement analysis, 2024–26. Shares of outsourced volume across payer, provider, and RCM clients.

The Philippine answer to this demand is structurally different from its competitors'. The country graduates tens of thousands of nursing and allied-health professionals annually — far more than its domestic health system absorbs — creating a standing bench of clinically literate, English-fluent professionals for whom healthcare BPO is a career, not a stopgap. Layered on top is twenty years of process inheritance: the

workflows, payer rule sets, and compliance muscle built serving US health plans since the mid-2000s. Manila and Cebu carry most of the delivery base, with Davao, Clark, and Iloilo growing as cost-advantaged secondary hubs.

AI is reshaping the work here as elsewhere — but in healthcare it is augmenting rather than replacing. Autonomous coding suggestions, prior-auth document assembly, and call summarization compress handle time, while the judgment calls — a coding edge case, a denial worth appealing, an anxious member navigating a diagnosis — stay with people. The result mirrors the voice market: the residual work is harder and more valuable, and the premium on provider quality keeps rising.

SECTION 03

## Compliance is the price of entry: HIPAA, HITRUST, and the offshore PHI perimeter

HIPAA does not stop at the water's edge. An offshore BPO handling US protected health information is a business associate in full: it signs a BAA, inherits the Security Rule, and exposes its client to breach-notification duty and OCR scrutiny exactly as a domestic vendor would. The practical consequence for buyers is that compliance cannot be one evaluation criterion among many — it is the gate through which any provider must pass before price, capability, or chemistry are even discussed.

**TABLE 1 — THE PHI PERIMETER: WHAT A VETTED HEALTHCARE BPO MUST EVIDENCE**

| LAYER | EVIDENCE PITON-GLOBAL REQUIRES IN DILIGENCE |
|---|---|
| **Contractual** | Executed BAA with breach-notification clocks; downstream subcontractor BAAs; audit and inspection rights exercised, not just granted |
| **Certification** | HITRUST CSF or SOC 2 Type II covering the healthcare delivery unit itself (not just the corporate entity); PCI-DSS where payments touch the workflow; ISO 27001 as supporting posture |
| **Technical** | Role-based minimum-necessary access; endpoint lockdown (no local storage, no personal devices in PHI zones); encrypted transit and rest; immutable access logging; DLP on every egress path |
| **Physical** | Segregated clean floors for PHI programs, badge-zoned access, clean-desk enforcement, camera coverage with retention — and a credible work-from-home architecture where hybrid delivery is proposed |
| **Human** | Annual HIPAA training with testing; sanction policy applied and documented; background screening; incident-response drills with post-mortems the client may read |

Composite of PITON-Global healthcare diligence checklists, 2024–26. Absence of any layer is disqualifying, regardless of price.

Two buyer-side cautions complete the picture. First, certificates describe scope: a HITRUST letter earned by a provider's fintech division says nothing about the floor where your members' PHI will be handled — diligence must walk the actual delivery unit. Second, compliance theater is real: glossy security decks correlate weakly with clean audit trails. The discriminating questions are operational — *show us last quarter's access-review evidence; walk us through your most recent incident and its post-mortem* — and top-tier Philippine healthcare BPOs answer them without flinching. It is one of the fastest ways to tell the genuine article from the brochure.

SECTION 04

# Cost and performance: what healthcare seats cost, and what the top tier delivers

Healthcare admin roles span a wide skill gradient — from member-services representatives to certified coders and licensed utilization-review nurses — and the economics should be read per role, fully loaded, per productive hour. Table 2 shows the comparison PITON-Global builds for clients across the three most commonly outsourced bands.

**TABLE 2 — FULLY-LOADED COST PER PRODUCTIVE HOUR BY ROLE BAND (US$, 2026)**


Basis: PITON-Global healthcare engagement pricing 2025–26. Fully loaded = wages, benefits, facilities, technology and security stack, management/QA overhead, attrition and backfill; net of shrinkage.

The performance side is where vetted providers separate from the field — and where healthcare differs from generic service work: several of these metrics convert directly into recovered revenue and working capital rather than soft satisfaction points.

**TABLE 3 — HEALTHCARE OPERATING BENCHMARKS, VETTED VS. BASELINE (2025–26)**

| METRIC | VETTED TOP TIER | BASELINE | EXECUTIVE READING |
|---|---|---|---|
| **First-pass claim rate** | **96%** | ~88% | Every point is cash landing sooner |
| **Initial denial rate** | **5.9%** | ~11% | Denial prevention beats denial appeals |
| **AR days (provider-side)** | **38** | ~52 | 14 days of revenue out of limbo |
| **Coding accuracy (audited)** | **97%+** | ~93% | Compliance risk and revenue integrity |
| **Member services SL (80/20) / CSAT** | **87% / 92** | ~74% / 84 | CAHPS and Stars exposure |
| **Annual attrition, healthcare programs** | **22–30%** | 40–55% | Tenure carries payer-rule fluency |

Source: PITON-Global healthcare engagement data 2025–26; baseline = client pre-engagement and industry-average onshore/commodity-offshore performance.

As in every service line PITON-Global benchmarks, the top tier's advantage is built from repeatable disciplines: coder-level audit loops with monthly calibration against client rubrics, payer-specific denial pattern libraries maintained as living documents, career lattices that keep experienced processors and nurses in seat past two years, and QA density roughly double the market norm. None of it is exotic; all of it is invisible on a rate card.

SECTION 05

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

Healthcare sharpens every step of PITON-Global's standard framework: the compliance gate arrives earlier, cuts deeper, and is never traded against price. Applied to a payer- or provider-side search, the funnel runs as follows.

**FIG. 2 — THE 7-STEP FRAMEWORK AS A HEALTHCARE-PROGRAM FUNNEL**

| | STEP | WHAT IT ELIMINATES IN A HEALTHCARE SEARCH | FIELD REMAINING |
|---|---|---|---|
| 1 | **Requirements definition** | Ambiguity that invites generic bids; fixes work types, volumes, systems (EHR/claims platforms), PHI scope, licensure needs, quality targets | 1,000+ |
| 2 | **Market mapping** | Providers with no genuine healthcare delivery unit — the "healthcare" logo-wall claims that do not survive a floor visit | ~90 |
| 3 | **Capability screening** | No payer/provider track record in the client's segment, no coder certification bench (AAPC/AHIMA), no comparable-platform experience | ~35 |
| 4 | **Compliance & security audit** | Anyone who cannot evidence the full PHI perimeter of Section 3 — BAA readiness, HITRUST/SOC 2 on the delivery unit, access-review and incident trails | ~15 |
| 5 | **Operational diligence** | Thin QA and audit loops, no denial-pattern intelligence, attrition cohorts that erase payer-rule fluency, references that soften under questioning | 6–10 |
| 6 | **Competitive RFP & negotiation** | Opaque pricing and trainee-heavy rosters; finalists compete on transparent per-productive-hour terms with quality-linked credits | 2–3 |
| 7 | **Transition & launch governance** | Launch drift and compliance decay: PITON-Global stays embedded buyer-side from BAA execution to certified steady state, then hands over | 1 |

Field-remaining counts represent a mid-market healthcare search (30–100 seats), PITON-Global engagements 2024–26.

The framework's two constitutional principles hold with special force here. **Vendor neutrality:** PITON-Global sells no seats and owes no provider volume, so a shortlist position cannot be bought — an assurance that matters most where the cost of a wrong vendor includes regulatory exposure. **Right-sizing:** a 40-seat prior-auth program inside a 30,000-seat global BPO is nobody's priority; the framework deliberately surfaces healthcare-specialist mid-sizers for whom the program is a flagship, with the certifications of the majors and the attention of a boutique. The output is unchanged: a shortlist of six to ten best-qualified providers within 48–72 hours, competing through a fully transparent, fair, comprehensive, and highly competitive RFP.

SECTION 06 · ANONYMIZED CASE STUDY

# From backlog to benchmark: a 60-seat payer-services program, reconstructed

The engagement designated HC-041 in PITON-Global's records is a regional US health plan serving roughly 420,000 members, whose member-services and claims-support operation was failing on two fronts at once: a 22-day adjudication backlog accumulated after a platform migration, and member-services performance (74% service level, CSAT 83) drifting toward CAHPS and Stars consequences. Onshore expansion quotes priced the fix at more than the department's existing budget. Identifying details are anonymized under NDA; the mechanics below are representative of engagements at this scale.

### SELECTION (WEEKS 0–9)

Requirements fixed a 60-seat blended scope — 34 member-services, 26 claims and AR support — on the plan's core admin platform, with full PHI handling, HITRUST-certified delivery, and bilingual (English/Spanish) coverage for 15% of volume. Mapping surfaced 87 self-declared healthcare providers; the compliance gate alone eliminated two-thirds. Operational diligence delivered a shortlist of 7 Manila and Cebu healthcare specialists; a three-round RFP concluded at $12.40 per productive hour with denial-rate and SL-linked service credits, 13% below the median bid.

### TRANSITION (WEEKS 10–28)

BAA and security validation preceded any data access. A dedicated backlog pod of 12 experienced processors attacked the adjudication queue while the main ramp proceeded in three gated waves, each released only after clearing accuracy and QA thresholds on the plan's own rubric. The backlog cleared in 11 weeks. PITON-Global chaired weekly buyer-side governance through month 7, when steady state was certified and the handover executed against documented criteria.

**TABLE 4 — HC-041 FIRST-YEAR VALUE BUILD-UP (US$)**

| VALUE COMPONENT | YEAR 1 | BASIS |
|---|---|---|
| Labor & overhead arbitrage | **$2.35M** | 113k productive hrs × ($33.10 − $12.40) |
| Backlog clearance — interest & penalty avoidance | **$0.42M** | 22-day adjudication backlog cleared; prompt-pay interest and penalty exposure retired |
| Rework avoided (claims accuracy 94.1%→97.6%) | **$0.37M** | ~31k reworked claims avoided × $12 fully-loaded touch cost |
| Member-services lift (SL 74%→87%, CSAT 83→91) | **$0.29M** | Repeat-call deflection and retention effect, conservatively factored |
| **Gross value created** | **$3.43M** | |
| Less: engagement & transition costs | **($0.59M)** | Transition, security validation, parallel-run, governance overlay; advisory fee $0 (provider-paid model) |
| **Net value ÷ cost = first-year ROI** | **5.8×** | $3.43M ÷ $0.59M |

Figures rounded; revenue and avoidance effects use conservative factors. Method detailed in Methodology & notes.

Note the composition: about 69% of first-year value came from the labor line, and the remaining 31% existed only because selection insisted on a provider capable of 97%+ audited accuracy and an 87% service level. The plan's original instinct — hire the cheapest HIPAA-certified bidder — would have banked the arbitrage and re-purchased the backlog within eighteen months. Selection discipline is what converted a cost decision into a durable operating upgrade.

SECTION 07

# The executive playbook: a compliance-first 180 days

Healthcare transitions succeed in the sequencing: compliance architecture first, volume second, optimization third. The playbook below is what PITON-Global installs on the buyer's side of the table in every healthcare engagement — with the client calling every shot and the advisor ensuring nothing goes unexamined.

**DAYS 0–30**

**Build the perimeter before the program**

Execute the BAA with real breach clocks and audit rights. Validate the delivery floor against the Section 3 perimeter — in person. Provision minimum-necessary access with named accounts and immutable logging before a single record moves. Contract per productive hour with quality-linked credits on accuracy, denial rate, and service level.

**DAYS 30–90**

**Ramp against accuracy gates**

Certify every wave against the client's own audit rubric — coding accuracy, adjudication quality, call QA — before it takes live volume. Run weekly buyer-chaired governance with compliance standing first on the agenda. Instrument denials and rework from day one; they are the earliest honest signal of process health.

**DAYS 90–180**

**Move from throughput to yield**

With quality stable for 60 days, shift governance toward value: denial root-cause elimination, payer-rule libraries, AI-assisted coding and summarization where volume concentrates, cross-training that deepens the tenure bench. Certify steady state and hand over governance on dated, documented criteria — never by fade-out.

**THE FIVE FAILURE MODES WE ARE HIRED TO PREVENT**

Accepting a corporate-level certificate for a floor-level risk · sourcing on rate card and inheriting a trainee roster for PHI work · moving data before the access architecture is proven · letting the provider audit itself · treating denials as an appeals workload instead of a prevention signal. Each is avoidable before signature, and each has a well-documented cost after it.

Healthcare outsourcing to the Philippines in 2026 is a mature, compliance-hardened discipline with a genuinely deep talent moat — and a provider field whose claims outrun its capabilities by an order of magnitude. The executives who capture its economics are the ones who treat selection as the control point: define the requirement precisely, gate the field on evidence rather than assertion, and keep an independent advisor at the table until the program is provably stable. The market rewards that discipline with numbers — 62% cost reduction, 96% first-pass yield, 5.8× first-year ROI — that no onshore initiative can match.

METHODOLOGY & NOTES

# How the numbers were built

**Operating benchmarks** (first-pass claim rate, denial rate, AR days, coding accuracy, service level, CSAT, attrition) come from PITON-Global healthcare engagements active in 2025–26, measured on provider production and QA systems and validated in client governance. Baselines blend client pre-engagement performance with published onshore and commodity-offshore averages; they characterize the starting position of a typical buyer, not any individual organization.

**Cost figures** are fully-loaded costs per productive hour by role band — wages, benefits and statutory charges, facilities, technology and security stack, management and QA overhead, and attrition-driven recruiting and ramp — net of shrinkage. US baselines reflect Tier-2 metro healthcare admin labor; Manila figures reflect 2025–26 PITON-Global engagement pricing. Exchange rates are held constant within the modeled year.

**The case study** (HC-041) is anonymized under NDA; segment descriptors are generalized and figures rounded. Value components use conservative factors: backlog value counts only retired interest and penalty exposure, not goodwill; member-services lift counts measured repeat-call deflection and a discounted retention effect. ROI = net first-year value ÷ all engagement-related costs borne by the client. PITON-Global's advisory fee is provider-paid and appears as $0 in the client cost base; the neutrality safeguards behind that model are documented at piton-global.com.

**Market context** combines IBPAP industry reporting, public health-spending research, and PITON-Global's proprietary provider mapping (1,000+ operations, healthcare capabilities re-verified June 2026). Figures identified as estimates are PITON-Global analysis and should be cited as such.

## Which healthcare BPOs belong on your shortlist?

Forty-five minutes with John will tell you. Free to buyers, strictly vendor-neutral — a compliance-gated shortlist within two to three business days.

j.maczynski@piton-global.com
+1 402-598-8740