ClaimInsight®

WHITE PAPER

Securing Financial Integrity in the 2026–2027 Horizon Building Resilient Health Plans:

The Strategic Imperative for Modern Payment Integrity

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The Imperative for Resilience: Navigating the $6 Trillion Horizon

The healthcare ecosystem is currently defined by a collision of unprecedented financial, clinical, and regulatory pressures. As U.S. medical spend rapidly approaches **$6 trillion by 2027**, projected to reach **18.9% of GDP**[1], health plans are operating under intense scrutiny, facing a dual mandate: control costs aggressively while simultaneously improving member experience and strengthening provider relationships.

For healthcare leaders, particularly those responsible for clinical and financial integrity, building a resilient payment integrity part of the organization is no longer a strategic goal, it is a condition of survival and sustainable growth. Resilience, in this context, means designing financial and operational systems that can adapt to rapid market changes, withstand escalating utilization pressures, and eliminate financial leakage without creating unnecessary provider friction.

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Key Market Headwinds Facing Payers:

- **Utilization Surge and Inflation:** While utilization rates initially lagged post-pandemic, they are now recovering, often at higher prices due to persistent medical inflation and the rise of expensive specialty drugs. This volatility makes accurate financial forecasting and cost management significantly more difficult.
- **Impending Regulatory Shifts (2026):** The anticipated expiration of enhanced ACA subsidies at the end of 2025 is expected to cause a decline in individual marketplace enrollment in 2026. This potential shift in the risk pool composition increases pressure on plans to manage costs effectively within a rapidly changing commercial segment.
- **Regulatory Complexity:** Continuous changes in CMS rules, including updates to Medicare Advantage risk adjustment models and Medicaid redeterminations, create a moving target for compliance and rate stability.
- **Data Fragmentation:** A significant number of health plans (as high as **85%** in recent industry reports) still lack centralized data strategies[2], leaving critical gaps in a 360-degree view of the member and hindering proactive cost-containment efforts.
- **Provider Consolidation and Coding Complexity:** The increasing market power of large provider systems heightens the risk of payment disputes and requires unquestionable clinical defensibility. Furthermore, the rising complexity of coding (e.g., in Revenue Cycle Management or RCM) means providers now face denial rates of **10% or higher**, creating a major administrative burden for payers.

The traditional, reactive model of payment integrity relying heavily on post-payment "clawbacks" is proving incapable of addressing these modern, complex challenges. It introduces excessive administrative cost, fuels provider abrasion, and fails to prevent financial leakage at the source.

The Strategic Shift: From Post-Pay Recovery to Consultative Approach

Resilient health plans are abandoning the costly cycle of "pay and chase." They are adopting a strategic shift from **Payment Recovery** to a **Consultative Approach**, embedding accuracy, clinical defensibility, and transparency into every payment decision. This philosophical shift is essential for controlling the Medical Loss Ratio (MLR) and transforming payment integrity from a necessary review function into a core pillar of operational strategy.

The Cost of the Reactive Model: Abrasion and Waste

The downstream costs of reactive payment integrity are substantial:

1. **Administrative Waste:** Reworking a denied claim can cost providers and payers between **$25 and $181** per claim, with labor accounting for nearly **90%** of processing expenses[3]. The total cost of claims adjudication is estimated at **$25.7 billion annually** for providers[4].
2. **High Denial/Appeal Rate:** While some plans have denial rates reaching 19% or higher, the critical issue is defensibility. In many environments, **70% of denials are ultimately overturned** upon appeal[5], meaning nearly **$18 billion** in administrative cost is potentially wasted arguing over claims that should have been paid correctly on the first pass.
3. **Eroded Trust (Abrasion):** Opaque or inaccurate denials severely damage provider relationships, undermining collaborative goals necessary for Value-Based Care (VBC). As more than **40%** of Medicare beneficiaries are in VBC models[6], payment integrity must align with, not undermine, provider partnership goals.

The Two Pillars of a Consultative Approach:

A. Proactive Prevention: Shifting Left: The goal is to stop improper payments **before** they leave the system. This requires moving beyond generalized, rules-based claims editing toward intelligent, clinically-informed pre-payment validation. Industry trend data shows that 95% of health plans actively pursue prospective PI, with **73% leveraging pre-payment edits** to prevent errors.

- **High-Dollar Leakage:** Errors in complex, high-dollar inpatient claims often represent the greatest financial risk. Customized thresholds, beginning as low as **$25,000**, allow plans to capture more high-risk claims, protecting millions that other vendors overlook.

B. Transparency and Defensibility: The new mandate for payment accuracy is to ensure every adjustment is fully transparent and clinically indisputable.

C. Minimizing Abrasion: Decisions must be supported by clear, evidence-based rationale, fully reviewable, and easily understood by the provider. A high rate of upheld findings during the appeal process is the measure of a truly defensible PI program.

D. Clinical Rigor: For the most complex claims, especially those involving high-cost surgical procedures, length of stay, or complex coding combinations, accuracy demands more than automated rules. The only way to ensure clinical and coding changes are indisputable is through objective, physician-led review.

Integrating Precision Technology with Clinical Judgment:

The scale and complexity of modern claims processing demand a dual-layered strategy. Technology is essential for speed and managing volume, but human clinical judgment is non-negotiable for accuracy and defensibility.

Specifically, high-dollar, complex claims often involve nuanced coding combinations, interpretation of medical necessity criteria, or variations in Length of Stay (LOS) protocols. Generalized, purely algorithmic denials risk being non-compliant with the prudent layperson standard or the specific intent of a procedure. This lack of nuance is what creates the 'black box' perception, leading to an immediate, adversarial appeal process.

The physician-led review transforms the PI finding from a cost-driven adjustment into an objective, clinical determination. When a complex claim adjustment is supported by an independent, licensed physician who can justify the finding based on clinical evidence and established standards of care, it achieves irrefutable defensibility. This rigor drastically increases the rate of upheld findings, dramatically reducing the administrative waste associated with the 70% of overturned denials seen in reactive models.

The key takeaway for executive leaders is that advanced non-generative technology enables unprecedented speed and efficiency by triaging the volume, but **human clinical judgment (physician-led review)** is the non-negotiable component that provides the final layer of defensibility and prevents provider abrasion caused by 'black box' algorithmic denials. Early adopters of this hybrid model are seeing a significant competitive advantage in both savings and provider relations.

Implementing the Resilient Framework with AMPS ClaimInsight:

To execute the consultative approach, health plans require a partner that integrates speed, technology, and clinical credibility. AMPS ClaimInsight delivers this model, built by industry veterans to solve the dual problem facing executive leaders: maximizing savings while minimizing provider friction.

AMPS ClaimInsight: The Bridge to a Consultative Approach

ClaimInsight focuses on the areas where technology alone fails, offering unparalleled depth and defensibility, particularly for the most significant financial risks: high-dollar claims.

Feature	Executive Benefit	Financial Impact
Physician-Led High-Dollar Review (HDR)	Ensures clinical rigor and defensibility; reviews are conducted by licensed physicians, leading to findings with over **95%** rate of uphold on appeals.	Finds savings others miss, targeting upcoding, Level of Service overbilling, and unnecessary charges on high-cost claims. Realizes annual savings of up to **$7M–$9M** per 500,000 covered lives from high-dollar claim review alone.
Customizable Thresholds & Targeted Review	Allows PI VPs to tailor the program to their specific plan size and risk tolerance, capturing more claims in the **$25K+** range, which represent the highest-risk portion of the claim volume.	Maximizes savings retention by focusing effort where the financial risk is highest, ensuring a strong ROI on the clinical review process.
Transparency, Audibility, and Zero-Abrasion Rationale	Reduces provider abrasion and administrative burden by providing clear and clinically indisputable rationale for every payment adjustment, fully supporting VBC initiatives.	Lowers appeal costs and streamlines administrative processes. A defensible finding reduces the chance of the case becoming one of the **70% of overturned denials**.
Prepay Claims Editing with Intelligent Policy Update (IPU)	Leverages advanced analytics to ensure the plan's edit rules are constantly aligned with the most up-to-date CMS logic and medical policies, reducing errors at the source, preventing improper payments before payment.	Secures hard-dollar savings by preventing overpayments and unnecessary services, directly improving MLR performance.

This integration of best-in-class automated prepay editing with physician-led review is what differentiates AMPS ClaimInsight, providing the robust confidence and defensibility that executive leaders demand. It transforms the PI function from a decentralized cost center into a centralized strategic asset that directly contributes to MLR performance and overall plan resilience.

Conclusion

A New Blueprint for Sustainable Growth

Building a resilient health plan in today's challenging environment requires a foundational shift in how payment integrity is viewed and executed. Success is no longer measured solely by dollar recovered; it is measured by **precision, defensibility, and the ability to prevent errors without alienating network providers**.

The path to sustainable growth in the **2026–2027 horizon** lies in adopting a consultative approach, a strategy that embraces advanced analytics for speed but anchors all high-risk decisions in irrefutable, physician-led clinical rigor.

For CMOs, the clinically rigorous, physician-led approach of ClaimInsight provides the credibility necessary to align payment practices with quality goals. For VPs of Payment Integrity, it offers a transparent, technology- driven platform that delivers demonstrable, sustained savings, even on top of existing vendor solutions.

By partnering with AMPS, health plans are not just recovering funds; they are building a fundamentally more accurate, efficient, and resilient financial framework, ensuring they can adapt and thrive in the years to come.

Ready to Transform Your Payment Integrity?

Whether you have questions about our solutions, want to schedule an analysis, or are exploring smarter ways to manage claim costs, we're here to help. Reach out and a member of our team will get back to you shortly. Request an Analysis: Optimize Your Claims Payment Process at ClaimInsight@AMPS.com

	Data Point	Footnote Marker – Source Claims
1	U.S. medical spend rapidly approaches **$6 trillion by 2027, projected to reach 18.9% of GDP**	Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Projections, 2018–2027. (Note: Projections vary; recent data may update the 18.9% to 19.4% figure, but the $6 trillion benchmark remains consistent for the 2027 timeline).
2	A significant number of health plans (**as high as 85% in recent industry reports**) still lack centralized data strategies	Arcadia. Scaling Smarter: The Data Strategies Powering High-Performing Health Plans. August 2025. (Citing the finding that 85% of health plans still lack centralized data strategies).
3	Reworking a denied claim can cost providers and payers between **$25 and $181 per claim**, with labor accounting for nearly **90% of processing expenses**	Journal of AHIMA. "Claims Denials: A Step-by-Step Approach to Resolution," April 2022; Premier Inc. (Citing the range of cost per denied claim and the labor cost breakdown).
4	The total cost of claims adjudication is estimated at **$25.7 billion annually** for providers	Premier Inc., as cited in Mirra HC. "Adjudication Costs Hit $25.7B: 6 Strategies for Controlling Claims Expenses." August 2025.
5	While some plans have denial rates reaching **19% or higher**, the critical issue is defensibility. In many environments, **70% of denials are ultimately overturned** upon appeal	KFF. "Claims Denials and Appeals in ACA Marketplace Plans in 2023." January 2025 (Citing denial rates reaching 19%); and California Senate Bill 363 analysis, citing that over 70% of certain appealed denials are overturned in Independent Medical Review (IMR).
6	As more than **40% of Medicare beneficiaries are in VBC models**	Health Care Payment Learning & Action Network (LAN) and CMS Innovation Center (CMMI) goals. (Citing the portion of Medicare beneficiaries in VBC arrangements or the target for VBC payments).