



The Delay Economy

How Slow Systems Quietly Decide
Who Gets Paid, Who Gets Care, and
Who Absorbs the Risk

A Market Report by Reid Zeising, CEO & Founder, Gain

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A Note From Reid

Personal injury in America runs on a hidden assumption: that time is neutral. That a case, a claim, or a bill will get resolved eventually, and that eventually is close enough to fair.

It is not neutral. Delay is not friction that happens to the system. In large parts of the system, delay is the system. Every extra week a claim sits unresolved shifts leverage toward whoever can afford to wait, and away from whoever cannot. Insurers can wait. Large hospital systems can often wait. The person recovering from surgery with no paycheck coming in, and the small medical practice carrying an unpaid receivable, usually cannot.

I have written about pieces of this pattern over the past several months: what happens when a claim gets denied and almost nobody appeals it, why cases stall in the space between healthcare, law, and finance, why caps on damages move cost rather than remove it, and why regulations that look reasonable on paper often collapse the moment they meet an actual workflow. This report pulls those threads, along with outside research on claims, pricing, and regulation, into a single argument.

The argument is this: across healthcare, insurance, and litigation, the incentives line up in the same direction more often than they should. Slower is frequently cheaper for the party with more resources, and faster is frequently a luxury the injured person cannot afford. That is not a conspiracy. It is a set of independently reasonable decisions, made by independently reasonable institutions, that add up to a system where time itself has become a form of leverage. What follows is not a complaint about any single insurer, hospital, or law. It is a look at the pattern that connects them, and what it will take to build something that actually moves at the speed an injured person's life requires.

Best,

Reid Zeising,
CEO & Founder, Gain



Delay Is Not an Accident. In Personal Injury, It Is Often a Strategy.

Every personal injury claim moves through the same basic sequence: an injury happens, treatment begins, a claim gets filed, and a resolution eventually arrives. The distance between the first step and the last is where the leverage lives.

An insurer facing a claim has an incentive that most injured people do not share: time works in the insurer's favor. A claim that sits unresolved for another month costs the carrier very little. For the person waiting on it, another month can mean a missed mortgage payment, a maxed-out credit card, or a decision to settle for less than the claim is worth simply to make the waiting stop.

The mechanics of that delay are rarely dramatic. Files move between adjusters, each of whom needs time to review what the last one already reviewed. Submitted documentation is requested again. Settlement authority sits with someone several levels removed from the person actually working the file, so anything above a routine dollar threshold needs a sign-off that takes its own path through the organization. None of these steps look unreasonable in isolation. Stacked together, they produce months of runway that cost the payer little and cost the claimant everything.

This is why nearly 95% of personal injury cases settle before they ever reach a jury.¹ Negotiating position, not the underlying facts of the case, ends up deciding more of the outcome than most people realize, and negotiating position is built substantially out of who can afford to wait longer.

Why the Healthcare System Punishes People After They Are Injured

The financial penalty for getting hurt does not start with the accident. It starts with what happens to a person's access to care in the weeks after.

A person with a serious but non-catastrophic injury faces a set of choices that a healthy person never has to make. Every one of those choices costs money before any settlement or judgment exists to pay for it, and every gap in that timeline becomes evidence the other side can use. A treatment gap does not just delay recovery. It gets read, later, as proof the injury was never that serious.

The result is a system that asks the injured person to front the cost of proving their own injury, on a schedule set by other people's convenience, while carrying the financial consequences alone until a case is resolved months or years later.

The Denial Is the Default, Not the Exception

Nowhere is the imbalance clearer than in how often claims get denied in the first place, and how rarely those denials get challenged.

One in five in-network claims submitted to insurers offering plans through HealthCare.gov was denied in 2024. Fewer than 1% of those denials were ever appealed.²

A denial rate that high, paired with an appeal rate that low, is not a story about how many claims are invalid. It is a story about how much friction there is between denial and a successful appeal, and how few people have the time, documentation, or persistence to get through it. Denial has effectively become the default position, and the burden of proof has quietly shifted onto the person least equipped to carry it.

Caps Do Not Remove Cost. They Relocate It.

A recurring policy response to rising claims costs is the damages cap: a legislative ceiling on what an injured person can recover, usually justified as a way to control insurance premiums or the cost of care.

The savings caps are supposed to produce are smaller and land somewhere different than advertised. The nonpartisan Congressional Budget Office has estimated that a full package of federal malpractice limits, including damages caps, would reduce total U.S. healthcare spending by roughly 0.5%.^{3,4} Other research cited by KFF Health News puts the underlying cost of medical liability, the cost caps are meant to shrink, at only about 2 to 2.5% of total health spending in the first place.⁵ Capping a cost that small does not move the price of care in any way an injured family would notice.

What a cap does move is who absorbs the cost of a catastrophic injury once the award no longer covers it. A peer-reviewed study published in *Medical Care* found that about 2.55% of hospitalized injury patients who were not previously on Medicaid enroll in it specifically to cover their hospital bills, and that a disabled Medicaid recipient carried for 30 years accumulates more than \$345,000 in lifetime public medical payments.⁶ That is the cost a cap does not eliminate. It is simply reassigned from the party found responsible for the injury to Medicaid, Medicare, safety-net hospitals, and the family members who step in once a capped settlement runs out before the recovery does.⁷

Insured Rates Are Not the True Price of Care

A related distortion underlies most conversations about the cost of healthcare: the assumption that the rate a commercial insurer negotiates with a hospital reflects the actual cost, or fair market price, of the care delivered.

RAND's ongoing hospital price transparency research shows how unstable that benchmark really is. In 2022, employers and private insurers paid hospitals an average of 254% of what Medicare would have paid for the same services at the same facilities, and that ratio varied from under 170% of Medicare in Arkansas to over 300% in states including California, Florida, Georgia, and New York. RAND's researchers found that most of this variation is explained by a hospital's market power, not by the actual cost of the care or by how much Medicare or Medicaid business the hospital carries.⁸

An insured rate is a negotiated outcome between two large institutions, not a measurement of cost. Treating it as the universal benchmark for what care should cost misrepresents the economics for every patient who falls outside that specific negotiation, including most personal injury patients treated on a lien, and it hands one side of the caps and cost debate a number that was never designed to answer the question being asked of it.

Providers Are Absorbing the Gap

The cost of all this delay and denial does not stay abstract. It shows up directly on a provider's books, in the form of bills that never get collected at all.

Kodiak Solutions, which tracks patient financial transactions across more than 1,850 hospitals and 250,000 physicians nationwide, found that the collection rate from commercially insured patients fell from 54.8% in 2021 to 47.8% in 2022 and 2023, then to 34.4% in 2024.^{9,12} Over that same stretch, initial claim denial rates rose for four consecutive years, reaching 11.8% in 2024, while the dollar value of final inpatient claim denials climbed 51% between 2021 and 2023.¹¹ Insured patients accounted for 53% of the \$17.4 billion in bad debt hospitals and health systems wrote off in 2023.¹⁰

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These figures describe general commercially insured patient collections, not personal injury lien accounts specifically, but the direction is the same: providers are collecting a shrinking share of what they bill, insurers are denying a growing share of what they owe, and every dollar a provider does not collect is redistributed, in the form of higher prices for other patients, tighter margins that make providers more reluctant to accept lien-based care in the first place, and, in some cases, providers exiting personal injury treatment altogether. A collection problem for providers becomes an access problem for patients.

Where Policy Meets Practice, Policy Usually Loses

Much of this is really about a single gap: the distance between what a regulation, statute, or reform is designed to do and what actually happens once it reaches the people who have to implement it.

A rule written to protect injured consumers can be undermined by the operational reality of how claims get processed. A reform meant to speed up resolution can add a new documentation requirement that becomes its own source of delay. Compliance failures are rarely failures of understanding the rule. They are failures of the organizational discipline required to execute it consistently: diffuse accountability, workflows that do not get updated to reflect the new requirement, and inconsistent implementation from one team to the next.

This is why regulatory change so often breaks down in practice rather than on paper. Federal hospital price transparency rules, in effect since 2021, are a clean example: hospitals are required to post the prices they negotiate with insurers for their most common procedures. A compliance audit found that only 34.5% of the roughly 2,000 hospitals reviewed were fully compliant as of early 2024, and as of that same period, the Centers for Medicare & Medicaid Services had issued only 14 civil monetary penalty notices nationwide for noncompliance.¹³ The rule was reasonable on paper.

Enforcement, staffing, and organizational follow-through determined whether it actually changed anything for the person trying to compare prices.

The intent of a law and the daily experience of the person it was written to protect can diverge sharply, and that divergence, not a lack of good rules, is where most of the harm in this system actually happens.

Stuck Waiting for Justice

Scale matters here. This is not a story about a small number of unlucky claimants. The National Safety Council's Injury Facts reports that in 2024, 54.5 million people, about 1 in 5 Americans, sought medical attention for a preventable injury.¹⁴ Every one of those 54.5 million people entered some version of the same slow system: treatment first, documentation throughout, and a claims or legal process that, per the data, tends to move at a pace that favors whoever is paying rather than whoever is hurt.

Add all of this together and the picture is a claims and litigation environment where waiting is not a side effect. It is the mechanism through which cost gets shifted, leverage gets built, and outcomes get decided long before a settlement number is ever discussed.

Every stakeholder in this system, patients, providers, and attorneys alike, experiences the same underlying problem from a different angle. Patients feel it as uncertainty about when relief will arrive.

Providers feel it as an aging receivable they cannot fully predict or collect against. Attorneys feel it as a case that will not move until every other party's incentive to delay has been exhausted.

None of them, working alone, can fix a structural problem of this size and complexity.

Final Thoughts: Time Should Not Be a Weapon

None of this is a secret. Insurers know that delay lowers what they eventually pay. Legislators who pass damages caps know the cost of catastrophic injury does not disappear, only that it lands somewhere else. The gap between a well-intentioned regulation and its execution is not a mystery to the people who have to operationalize it.

What is missing is not awareness. It is a structure that removes the advantage delay currently provides. That means faster, more transparent claims handling. It means treating a denial as the beginning of a conversation rather than the end of one. It means building financial infrastructure, like access to care on lien and non-recourse funding, that keeps injured people from being forced to accept less simply because they cannot outlast the other side.

The next chapter of this industry will not be written by whoever files the most claims or fights the hardest in negotiation.

It will be written by whoever builds the infrastructure to close the distance between injury and resolution, and takes the leverage out of the wait.

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About Gain Servicing

Gain Servicing connects healthcare providers, attorneys, and patients on a single platform built to reduce the delay, friction, and financial pressure that define the personal injury claims process.

The Gain Platform gives providers and attorneys a shared view of case status, documentation, and financials, so that fewer decisions get made in the dark and fewer cases stall for lack of information.

Gain's Managed Services team supports healthcare providers accepting Letters of Protection, working settlement negotiations to reduce write-offs, and keeping every party informed as a case moves toward resolution.

Gain's Financial Solutions, including lien purchase programs, medical funding, and plaintiff cash advances, exist to remove the financial pressure that pushes injured people toward settlements that reflect their bank balance rather than the actual value of their claim.

To learn more or book a demo, visit gainservicing.com.





The challenge for organizational leaders is less a question of legal comprehension than of operational execution. Compliance failures commonly originate not in ignorance of the rule, but in the organizational response: diffuse accountability, delayed contract and workflow updates, and inconsistent implementation across teams

The corrective is not complexity — it is discipline. Systematic documentation, clear accountability structures, active leadership engagement, and the organizational capacity to execute repeatable responses to novel demands. Founders who internalize these principles and embed them into how their organizations actually operate are substantially better positioned to navigate the institutional landscape with confidence and control.

Thank You

"The companies that navigate this best aren't the ones that trust the process blindly. They're the ones that understand it — and plan accordingly."

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