



AMA Launches Campaign To Cut Waste From Chaotic Insurance Claims Process, Unveils New Health Insurer Report Card

Delayed and inaccurate insurance payments add cost, inefficiency to health care system

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CHICAGO — To help reduce the substantial administrative burden of ensuring accurate insurance payments for physician services, the American Medical Association (AMA) today launched the Heal the Claims Process campaign to help cure the ailing system of processing medical claims with health insurers, and unveiled the first AMA National Health Insurer Report Card on claims processing.

"The goal of the AMA campaign is to hold health insurance companies accountable for making claims processing more cost-effective and transparent, and to educate and empower physicians so they are no longer at the mercy of a chaotic payment system that take countless hours away from patient care," said AMA Board Member William A. Dolan, MD.

The inefficient and unpredictable system of processing medical claims adds unnecessary cost to the health care system, estimated as much as \$210 billion annually, without creating value. Physicians divert substantial resources, as much as 14 percent of their total revenue, to ensure accurate insurance payments for their services.

"Eliminating the inefficiencies of the billing and collection process would produce significant savings that could be better used to enhance patient care and help reduce overall health care costs," said Dr. Dolan. "To diagnose the areas of greatest concern within the claims processing system, the AMA has developed its first online rating of health insurers."

The AMA's new National Health Insurer Report Card provides physicians and the public with an objective and reliable source of information on the timeliness, transparency and accuracy of claims processing by health insurance companies. Based on a random-sample pulled from more than 5 million electronically billed services, the report card provides an in-depth look at the claims processing performance of Medicare and seven national commercial health insurers: Aetna, Anthem Blue Cross Blue Shield, CIGNA, Coventry Health Care, Health Net, Humana and United Healthcare.

Key findings include:

Denials

There is wide variation in how often health insurers pay nothing in response to a physician claim (from less than 3 percent to over 7 percent), and in how they explain the reason for the denial. There was no consistency in the application of codes used to explain the denials, making it extremely expensive for physician practices to determine how to respond.

Contracted payment rate adherence

Health insurers reported to physicians the correct contracted payment rate only 62 to 87 percent of the time. Additional analysis will be necessary to determine how often these errors were tied to inaccurate payment. When health insurers report an amount that does not adhere to the contracted rate, it adds additional, unnecessary costs to the physician practice to evaluate the inconsistency.

Transparency of fees and payment policies

More than half of the health insurers do not provide physicians with the transparency necessary for an efficient claims processing system.

Compliance with generally accepted pricing rules

There is extremely wide variation among payers as to how often they apply computer generated edits to reduce payments (from a low of less than .5 percent to a high of over 9 percent). Payers also varied on how often they use proprietary rather than public edits to reduce payments (ranging from zero to as high as nearly 72 percent). The use of undisclosed proprietary edits inhibits the flow of transparent information to physicians, adding additional administrative costs to reconcile claims.

Payment timeliness

Prompt pay laws appear to have been effective in ensuring a relatively quick response to physician's electronic claim. Further analysis will be necessary to determine the extent to which this response is accompanied by accurate payment if the claim.

The report card will be available for the first time today on the [AMA Web site](#).

"Physicians want to focus on caring for their patients, not fighting health insurance red tape that may delay, deny or shortchanged payments for their services," said Dr. Dolan. "The report card provides a useful snapshot of how each of the nation's biggest health insurers can improve the process they use to pay their bills."

The report card demonstrates the inconsistency and confusion that results from each health insurer using different rules for processing and paying medical claims. This variability requires physicians to maintain a costly claims management system for each health insurer.

The report card also suggests that both physicians and health insurers can help reduce unnecessary administrative costs if electronic transactions and full transparency are widely adopted. The costs of re-submitting claims can also be reduced if health insurers make better use of voluntary fields and reason and remark codes in electronic transactions to communicate crucial information to physicians about their claims.

The Heal the Claims Process campaign will empower physicians to create a systematic approach to claims management so they spend less time and resources on payment hassles with health insurers. To help physicians submit timely and accurate claims, the AMA has created the Practice Management Center, an easy-to-use online resource offering physicians and their staff members tools for preparing claims, following their progress and appealing them when necessary.

The Practice Management Center's library of education materials and practical tools are available online.

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For additional information, please contact:

Robert Mills,
AMA Media Relations
(312) 239-4991 or (312) 464-5970