

AMA Efforts with Health Insurers Cut Medical Claims Errors by Half

Improvements save billions of dollars

CHICAGO – June 18, 2012 – Efforts by the American Medical Association (AMA) to lead a transformation in the chaotic health insurance billing and payment system cut the number of medical claims paid incorrectly by large health insurance companies in half, according to the findings released today for the AMA’s fifth annual [National Health Insurer Report Card](#).

Error rates for private health insurers on paid medical claims dropped from 19.3 percent in 2011 to 9.5 percent in 2012. This improvement resulted in \$8 billion in health system savings due to a reduction in unnecessary administrative work to reconcile errors. While dramatic improvements were made this year, the commercial health insurance industry still paid the wrong amount for nearly one in ten medical claims. The AMA estimates an additional \$7 billion could be saved if insurers consistently pay claims correctly.

“The AMA has been working constructively with insurers, and we are encouraged by their response to our concerns regarding errors, inefficiency and waste that take a heavy toll on patients and physicians,” said AMA Board Chair Robert M. Wah, M.D. “Paying medical claims accurately the first time is good business practice for insurance companies that saves precious health care dollars and frees physicians from needless administrative tasks that take time away from patient care.”

All the health insurers measured by the AMA improved their accuracy ratings since last year. For the second year in a row, UnitedHealthcare came out on top of seven large commercial health insurers with an accuracy rating of 98.3 percent. Anthem Blue Cross Blue Shield, which had last year’s worst accuracy rating of 61.0 percent, made the largest improvement with an accuracy rating of 88.6 percent. Humana rounded out this year’s list with an accuracy rating of 87.4 percent.

Savings generated by improved insurer accuracy were partially offset by administrative costs associated with a resurgence of intrusive managed care policies on clinical decisions. Medical services requiring prior authorization from a commercial health insurer were reported on 4.7 percent of all claims, a 23 percent increase since last year. The AMA estimates that burdensome prior authorization policies will add up to \$728 million in unnecessary administrative costs to the health system in 2012.

“The costly administrative burdens of the prior authorization process can complicate medical decisions and delay or interrupt patient care,” said Dr. Wah. “The AMA calls for replacing the largely manual process with an automated decision support system that will enhance patient care and reduce paperwork costs.”

The National Health Insurer Report Card provides an annual check-up for the nation’s largest health insurers and diagnoses the strengths and weaknesses of the systems they use to manage, process and pay medical claims. Other key findings from five years of data generated by the report card include:

Timeliness. Private insurers have improved response times to medical claims by 17 percent from 2008 to 2012. Among private health insurers, Health Care Service Corporation (HCSC) and

Humana had the fastest median response time of six days. Aetna was the slowest with a median response time of 14 days.

Transparency. Health insurers have increased the transparency of rules used to edit medical claims by 33 percent from 2008 to 2012. Reducing the use of undisclosed proprietary edits unlocks the flow of transparent information to physicians and reduces the administrative costs of reconciling medical claims.

Denials. Medical claim denials are on the rise, reversing a downward trend that occurred between 2008 and 2011. The overall denial rate for private health insurers went from 2.10 percent in 2011 to 3.48 percent in 2012, an increase of nearly 69 percent. Every private health insurer except Humana increased denials this year. Anthem Blue Cross Blue Shield had the highest denial rate at 5.07 percent, while Regence had the lowest denial rate of 1.38 percent.

The National Health Insurer Report Card is the cornerstone of the AMA's [Heal the Claims Process™ campaign](#). Launched in June 2008, the campaign's goal is to lead the charge against administrative waste by improving the health care billing and payment system.

“The AMA is a strong advocate for bringing transparency, simplicity and consistency to the medical claims system,” said Dr. Wah. “We are urging a streamlined approach that allows medical claims to be submitted and settled in real-time at the patient’s point of care. This will allow patients to know their total out-of-pocket costs prior to treatment and help give them more control over their health care dollars.”

To learn more about Heal the Claims Process™ campaign or how AMA tools and resources can help physicians better manage the process of preparing and submitting medical claims, please visit the AMA's Practice Management Center at www.ama-assn.org/go/pmc.

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Editor's Note: The findings from the 2012 National Health Insurer Report Card are based on a random sampling of approximately 1.1 million electronic claims for approximately 1.9 million medical services submitted in February and March of 2012 to Aetna, Anthem Blue Cross Blue Shield, Cigna, Health Care Service Corporation, Humana, Regence, UnitedHealthcare and Medicare. Claims were accumulated from more than 380 physician practices in 79 medical specialties providing care in 39 states.

A webinar is available on the AMA website highlighting the results of the 2012 National Health Insurer Report Card at: <http://goo.gl/l6ml8>

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