



Health Insurance Association of America

**Results
from an
HIAA Survey
on Claims
Payment Processes**

March 2003

INTRODUCTION

The issue of claims processing, especially turnaround times for claim payment, has attracted increasing attention among health plans and providers. The Health Insurance Association of America (HIAA) has surveyed its member companies on their claims systems and processes in the past, most recently reporting in December 2000. Because of the continued importance of prompt payment as a legislative issue in various states, and the specific issue of receipt and processing of “clean” claims, recent, more detailed information was sought for these measures.

In 2002, HIAA again surveyed member companies to collect data on their claim payment processes. The survey was designed to collect information on claims submissions by type and time period, and processing times.

RESULTS IN BRIEF

- Over the period of a decade, there has been a steady increase in the percent-age of claims received electronically by health plans. That percentage stands at 44 for 2002.
- Nine out of 10 claims are processed within 21 days of receipt.
- More than one-quarter of claims (28 percent) are received more than 30 days after the date of service. Almost 16 percent of claims are received more than 60 days after health care services have been provided to the patient.
- Lack of information and the need to coordinate benefits between multiple insurance coverages were the primary reasons for pending claims.
- Almost half of all claim denials (48 percent) are due to the submission of duplicate claims.

M E T H O D O L O G Y |

The survey questionnaire was developed with a primary focus on the time period between the provision of medical services and the receipt of a claim by a health plan, and the time necessary to process a claim once it is received. For this survey time periods were measured in calendar days. Completed processing was defined as a claim that was paid, denied, pended, or closed. To facilitate a response, a sample of claims from a one-week period (May 13–19) during early 2002 was analyzed. The questionnaire was tested among a group of appropriate member company representatives for content and time for completion.

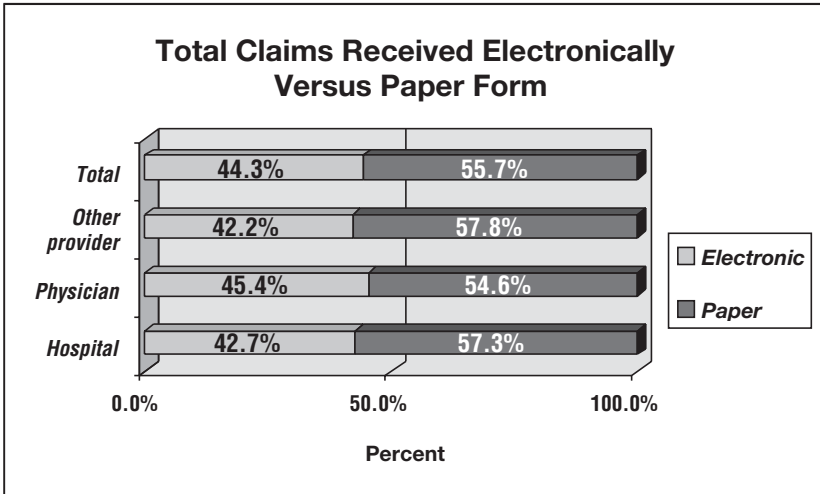
Surveys were mailed in mid 2002 to representatives of various HIAA committees with interest in the issue of prompt payment. HIAA members responded representing companies of various sizes and product lines. Responding companies represent health plans covering more than 26 million persons. The survey sample included almost 900,000 claims.

RESULTS

Electronic Claims Submission

The percentage of claims that companies receive electronically has steadily increased over time. When measured by various HIAA surveys, this percentage has increased dramatically from 2 percent in 1990 to 24 percent in 1995 to 40 percent in 1999. This most recent survey indicates that over 44 percent of all claims were received electronically. The percentage of claims received electronically did not vary greatly between different categories of providers.

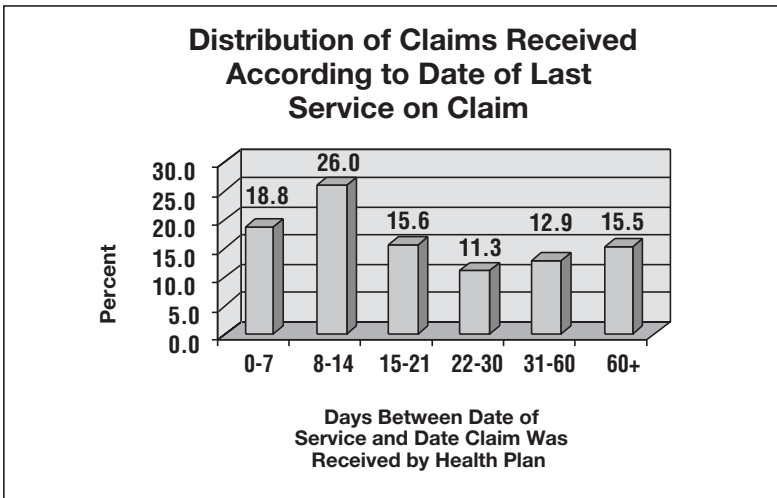
Chart 1



Time Taken for Claims Submission

Insurers and health plans can only begin their processing of submitted claims once they are received. Electronic transmission of claims can cut down on the time between the date of service and the date of claim receipt. However, since most claims are still received via print media, our survey asked for information on time intervals for all claims. Almost 30 percent of all claims were received more than 30 days after the date on which services were provided. Sixteen percent of claims were for services performed more than 60 days prior to receipt.

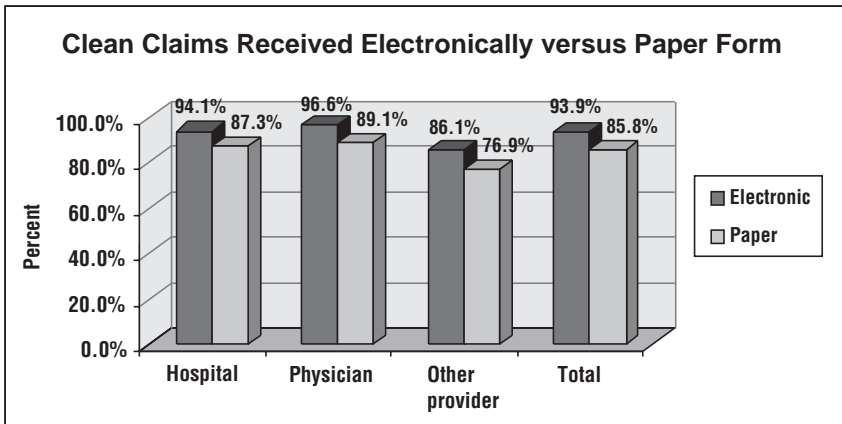
Chart 2



Proportion of "Clean" Claims

The vast majority of claims received, whether electronically or on paper, are "clean" and do not present problems with missing information or format errors. Claims received electronically have some advantage over paper claims across all provider categories surveyed. On average about 94 percent of claims received electronically are clean versus 86 percent of paper claims. Physicians do slightly better on their percentage of clean claims than do hospitals (97 percent versus 94 percent for electronic claims and 89 percent versus 87 percent for paper), and both do better than other health care providers.

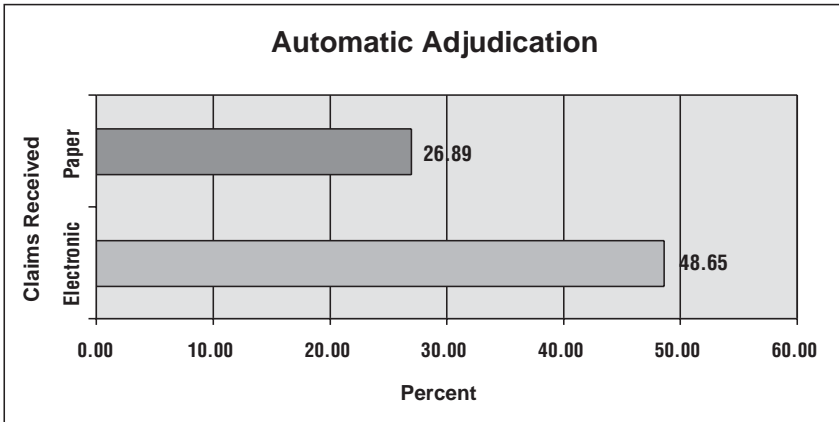
Chart 3



Automatic Adjudication of Claims

Electronically submitted claims have a large advantage over paper in the automatic adjudication of claims (claims processed without human involvement once they are entered into the processing system). There is almost a two-to-one margin in the percentage of electronic versus paper claims that are so adjudicated (49 percent versus 27 percent respectively). Automatic adjudication of claims allows for quicker processing times and less costly processing than manual intervention resulting in savings to the health plan, providers, and ultimately consumers.

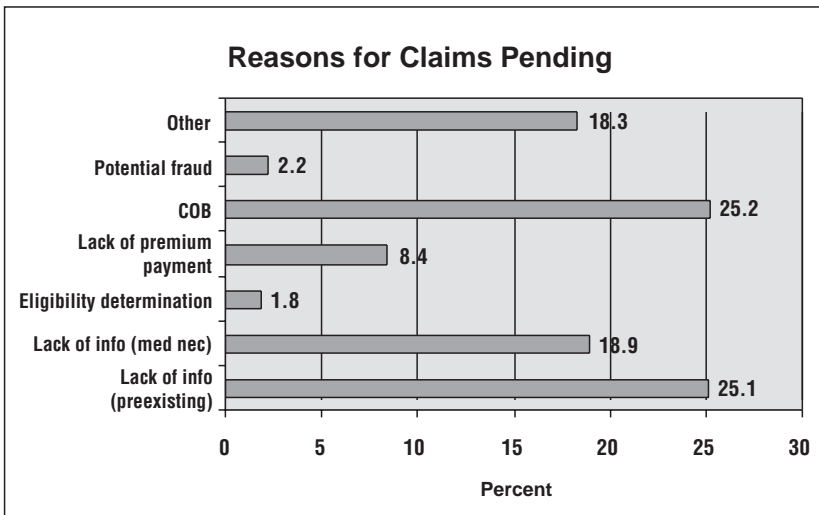
Chart 4



Reasons for Delays in Claims Processing

While most claims received are clean, there are a sizable percentage of claims that require additional information, leading to longer processing times. When asked about the reasons for delays in claims processing, companies indicated several reasons for these delays. The reasons most often indicated were either coordination of benefits (COB) provisions specified in the policy or lack of information on potential preexisting condition investigations (indicated for 25 percent of pended claims in each case). Other reasons frequently mentioned for delays in processing were lack of information to determine medical necessity (19 percent) and questions about premium payment (8 percent). It should be noted that some of these areas might overlap. For example, some claims that may be pended as potential fraud may be due to a suspicion of a fraudulently completed application for insurance where pre-existing conditions may have been intentionally omitted.

Chart 5

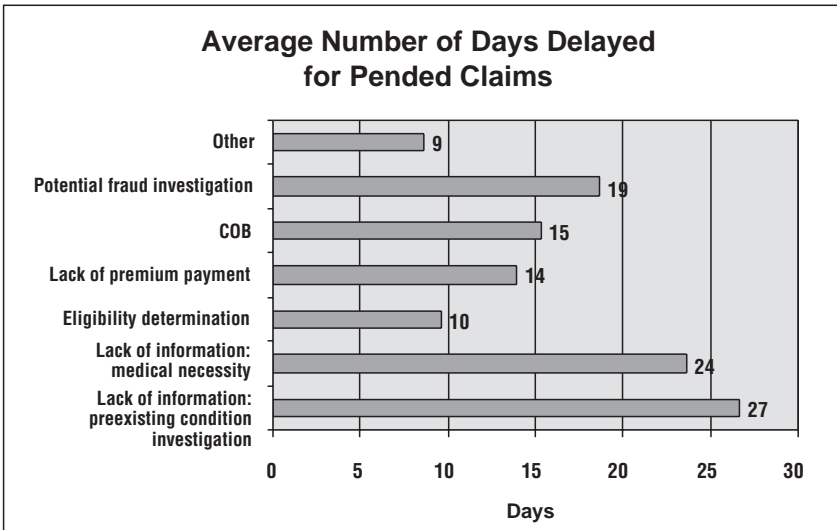


Note: Coordination of benefits takes into account the total benefits available to a person who has overlapping coverage under more than one policy. An example of how this can occur is if both a husband and wife are employed and each has employer coverage that covers dependents. COB ensures that the total benefit payments received do not exceed total expenses.

Time for Claims Investigation

The amount of time it takes to investigate a claim that does not pass claim edits varies according to the reason for pending. The number of days it takes to process these claims can vary on average by almost three-fold. Claims that caused the longest delay on average were those that involved some preexisting condition determination. On average these claims took 27 days to resolve. Almost as long to resolve were claims involving lack of necessary information to determine medical necessity (24 days). Some of the work in resolving these claims may involve requesting further information from the member and physicians and/or consultation with medical directors and expert consultants. Investigations of potential fraud averaged 19 days, while eligibility determinations took, on average, 10 days.

Chart 6



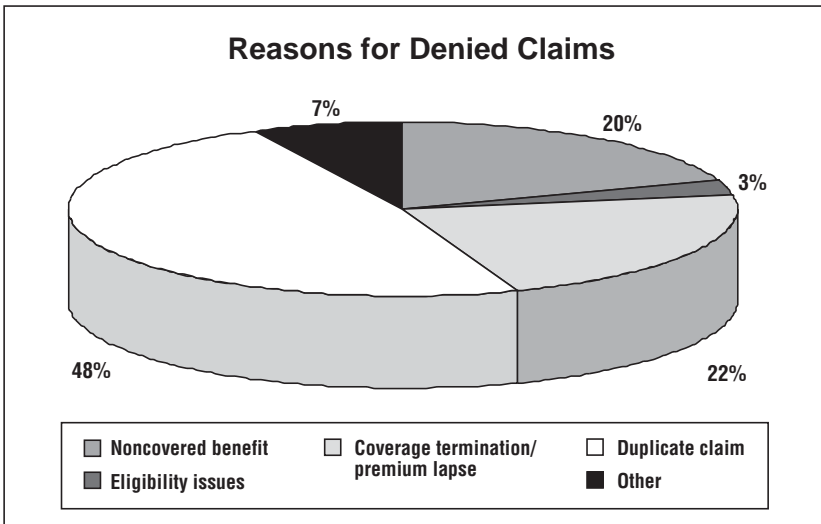
Reasons for Claims Denial

In addition to pended claims, claims processing may also result in the denial or rejection of claims. These claims may very well have come in as clean claims; however, some reason has been determined for the nonpayment of the claim. On average, 14 percent of claims received were denied for payment.

Almost half of all claim denials (48 percent) were due to the submission of a duplicate claim. Some plans indicated that though a claim may have been initially submitted electronically, there often is a paper claim received that unnecessarily follows up to confirm the submission.

A claim for a noncovered benefit, or for an individual who is no longer covered or whose policy has lapsed, each represented about 20 percent of rejected claims.

Chart 7

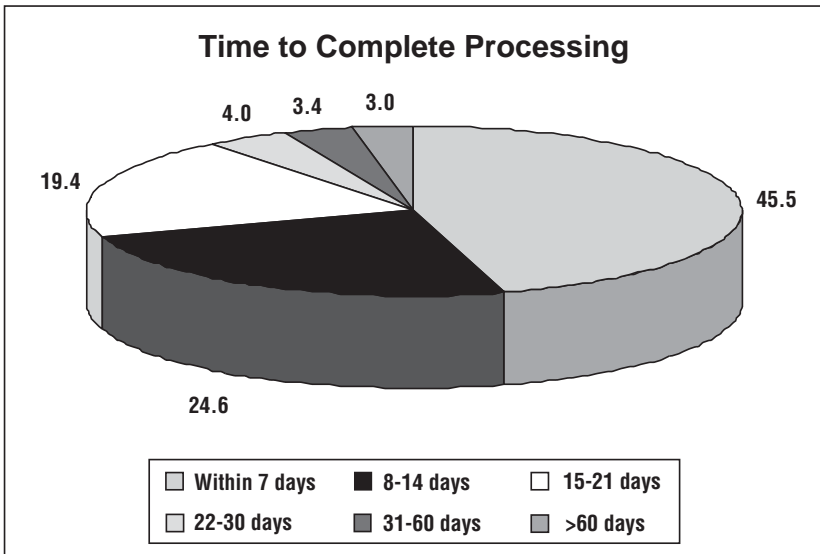


Claims Processing Time

Payers and providers have made tremendous strides in making claims processing more efficient, given the increase over time in the percent of claims transmitted electronically and the efficiencies made possible through payers' automated claims processing systems. These advances have resulted in the vast majority of claims being processed in a relatively short time frame.

This most recent survey indicates that health plans process (pay, deny, close, or pend for further information) almost half (46 percent) of all claims within the first seven days after receipt and over 70 percent of all claims within the first two weeks of receipt. An additional 24 percent are processed in the next two weeks. Still, given the problems encountered in potential investigations for fraud, preexisting conditions, COB, etc., about 6 percent of claims require more than 30 days to complete processing.

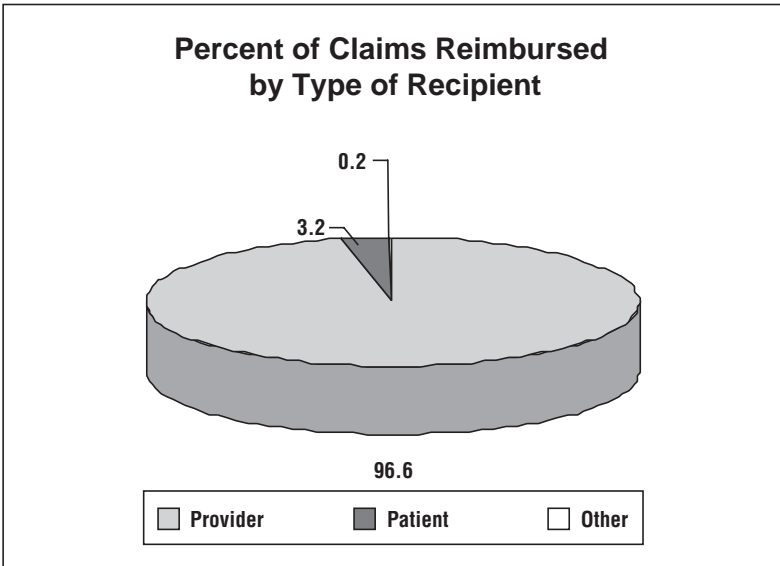
Chart 8



Insurance Payment Recipients

To provide additional evidence of the progress made in processing and reimbursing claims, and of providers' willingness to submit claims and accept payment directly from health plans, the survey asked to whom payment was made. Almost 97 percent of claims were reimbursed directly to the provider, and only a little more than 3 percent were paid to the patient.

Chart 9



S U M M A R Y

This recent survey indicates that while steps have been taken to improve the efficiency of claims' submissions and processing, problems still persist. While most claims are processed within a relatively short period of time after their receipt (only 6 percent of claims take more than 30 days), almost 30 percent of claims are received more than 30 days after the date on which services were provided to the patient, with 16 percent received after more than 60 days. The length of time taken by a hospital or a physician's office to submit a claim obviously has an important bearing on how long it will take to receive payment for the services in question. Additionally, lack of information on the claim is still the number one reason for pending claims, and the filing of duplicate claims by hospitals and physicians' offices is the predominant reason for claims denial. The promptness and thoroughness of claims submission, and the frequency of duplicate claims, are all matters largely within the control of health care providers.

On the positive side, much progress has been made. The industry is approaching the point where half of all claims are transmitted electronically, and for these claims almost half flow through claims systems with no manual intervention. To the credit of both providers and health plans, the vast majority of claims are received "clean," require no additional information to process, and are completed within the short time frame of only several weeks if not days. These markers result in savings to all parties—health plans, providers, and ultimately consumers. This benefit will only increase as these trends continue.



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