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Helping Health Care Payers Improve Claim-Payment Accuracy

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The American Medical Association's fourth annual National Health Insurer Report Card found that commercial health insurers average a 19.3 percent error rate in processing claims, up 2 percent from the previous year. This increase means there were 3.6 million more erroneous payments and $1.5 billion worth of additional, unnecessary administrative costs in the health care system. The AMA estimates that eliminating all errors would save more than $17 billion overall.

Since the previous report, all examined health insurers but one failed to improve their accuracy rating; United Health Care was the only commercial insurer to demonstrate an improvement. Claim-payment accuracy is a major concern for large commercial insurers, self-insured employers, independent physician associations (IPAs), and any organization that strives to accurately adjudicate health care claims. The big question, of course, is why these efficiency and accuracy levels are so troubling and potentially such a drag on the overall health care system.

The answer likely involves three factors: people, processes, and technology.

In terms of people, many health care payers are deploying inexperienced claim examiners that will often err at a significantly high rate. Unfortunately, their training often falls short of what is necessary to ensure accurate and efficient payments, and many will continue making the same costly, repetitive payment errors once they become "experienced."

In terms of processes, a random audit is too often performed instead of a root-cause analysis. That's why a large number of errors aren't communicated to claims personnel in a comprehensive manner. The net outcome is that there's very little, if any, corrective action, so the same errors are repeated over and over again.

In terms of technology, payers continue to negotiate increasingly

complex contracts and offer complicated benefit plans to members. Often, the contract terms and benefit provisions can't be fully automated in the claim-payment system. This creates a heavy reliance on manual processes, which inevitably leads to payment inaccuracies. Furthermore, these problems are exacerbated when critical claim-system support files are configured and monitored by personnel with limited system or health care experience.

To address this problem, organizations will need to invest in staff and reengineer the processes that contribute to frequent payment errors. A six-point approach can help:

1. Upgrade training and audit programs. The training should focus on common mistakes, manual processes, and other key payment-error contributors.

2. Perform a root-cause analysis of common claim-payment errors. Communicate the results and collaborate with IT, contracting, and other departments to identify the best approach to reduce occurrences of each error type.

3. Encourage collaboration between audit and training teams. These departments should share information to help avoid common errors and train new claim examiners (and retrain existing examiners when necessary).

4. Review key claim-payment support files. Use experienced resources in claims, contracting, and IT to audit the configuration of claim-payment support files. This will help address the system-related root causes contributing to common payment errors.

5. Monitor common error occurrences daily. Once your organization completes training and implements redesigned processes, it's important to monitor the effectiveness of your efforts. Develop custom reports, filters, and other tools to provide daily monitoring of the most common and costly errors.

6. Embrace health care reform. It's unclear exactly how the new law will be implemented, but your organization—like every other payer in the industry—will be judged on the accuracy and quality of outcomes and results; therefore, it's critical to make improvements in the coming years.

Whether your organization is a large commercial insurer, self-insured employer, IPA, or other type of health care claim payer, it's impossible to completely eliminate claim-payment errors. But the work of reducing errors should prove hugely beneficial: It will decrease claim expenses, boost revenue, enrich profits, and enhance the industry's reputation during one of the most complex transformations in modern health care history.

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