

## An Updated Survey of Health Care Claims Receipt and Processing Times, May 2006

Electronic submission of health insurance claims more than tripled in the last decade, reducing administrative costs and allowing 98 percent of claims to be processed within 30 days of receipt.

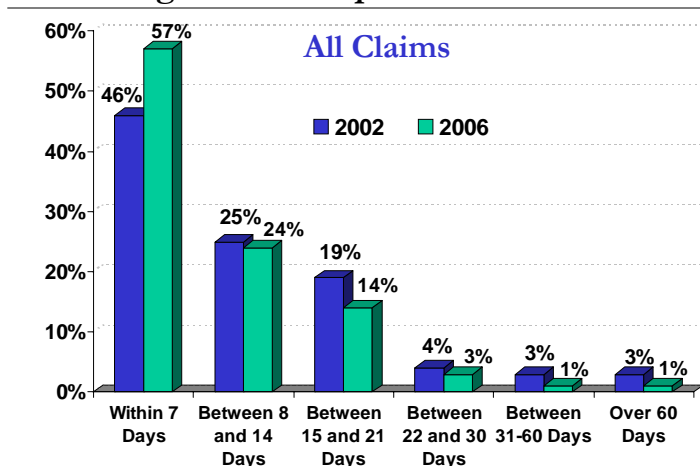
### Summary

Consumers, health care providers and insurers have a common interest in the prompt and accurate payment of medical claims. In the winter of 2005-2006, America's Health Insurance Plans (AHIP) conducted a survey of its members to examine the issue of claims processing and turnaround times for claim payments. The study is a follow-up to a survey done in 2002. A comparison of findings from the 2002 and 2006 studies shows that claims processing times have improved significantly in the past four years.

Here are some highlights of the latest survey:

- The percentage of claims received electronically was 75 percent in 2006, up from 44 percent in 2002.
- There is often a significant time lag before health insurance plans receive claims from health care providers. In 2006, 29 percent of claims were received from health care providers more than 30 days after the date of patient service, and 15 percent of claims were received from providers more than 60 days after the service was provided.

**Figure 1. Average Time to Complete Processing After Receipt of "Clean" Claim**



- According to the 2006 survey, health insurance plans processed 98 percent of "clean" claims within 30 days, up from 94 percent in 2002 (see Figure 1). Processing time is the number of days from when a claim is received until the claim is paid, denied, or "pending" for further information. ("Clean" claims are those for which no additional information is needed.) Fourteen percent of claims in the survey were "pending" or delayed, usually because of

incomplete or incorrect information. On average, pending claims take an additional 9 days to process, while more information is being gathered from the provider.

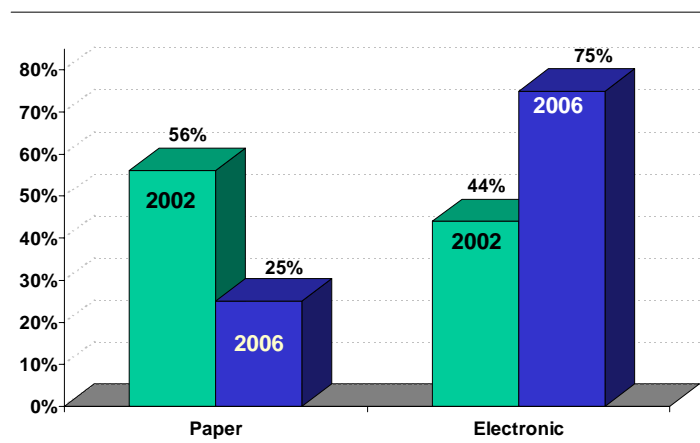
- Approximately two-thirds (68 percent) of all claims are now adjudicated automatically; that is, processed without manual intervention. Among electronic claims, 71 percent were adjudicated automatically in 2006, up from 49 percent in 2002. Forty-four percent of paper claims were adjudicated automatically in 2006, up from 27 percent in 2002
- Electronic claims are less costly to process than paper claims. The average cost of processing a clean electronic claim was 85 cents, nearly half the \$1.58 cost of processing a clean paper claim. Pending claims requiring manual or other review cost \$2.05 on average per claim to process.

The 2006 survey was based on aggregated data from nearly 25 million claims, processed by a total of 26 large and small health plans throughout the United States. The questionnaire and methodology were designed so that results would be comparable to prior surveys.<sup>1</sup>

## Electronic vs. Paper Claims

Most claims are now submitted and processed electronically. From 2002 to 2006, the percent of claims filed electronically has risen substantially, from 44 percent to 75 percent (see Figure 2). At the same time, the percentage of claims submitted on paper dropped from 56 percent in 2002 to 25 percent in 2006. Surveys conducted in the 1990s found much lower percentages of claims filed electronically: 40 percent in 1999; 24 percent in 1995; and 2 percent in 1990.

**Figure 2. Types of Claims Submitted**



<sup>1</sup> For prior survey results, see "Results from an HIAA Survey on Claims Payment Processes," Health Insurance Association of America (March 2003).

[http://www.ahipresearch.org/PDFs/21\\_ClaimsPaymentProcessesSurveyChartbook.pdf](http://www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurveyChartbook.pdf)

## Receiving and Paying Claims

With the rise of electronic claims systems, health care providers are submitting a greater share of claims within a week of the service date. In 2006, 30 percent of all claims were submitted within 7 days, compared to 19 percent in 2002 (see Figure 3).

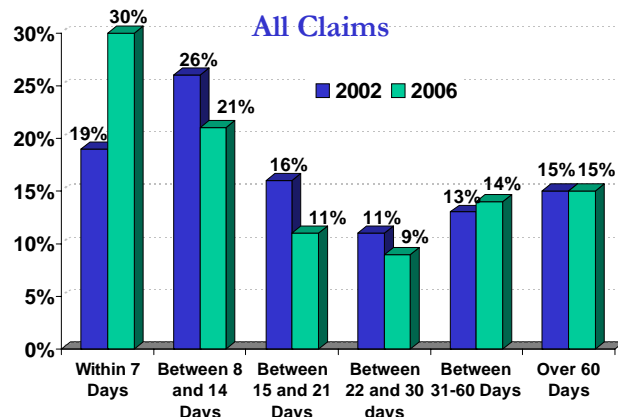
However, a large number of claims continue to be received after long lag times. In 2006, 29 percent of claims were received more than a month after the date of patient service. This percentage remained largely unchanged from 2002 when 28 percent of claims were received after 30 days. Moreover, 15 percent of claims were received more than 60 days after the service date. Paper claims were slower to arrive than electronic claims, with 31 percent received more than 60 days after the date of service.

Ninety-seven percent of claims are paid directly to the health provider; the remaining three percent are reimbursed to the patient.

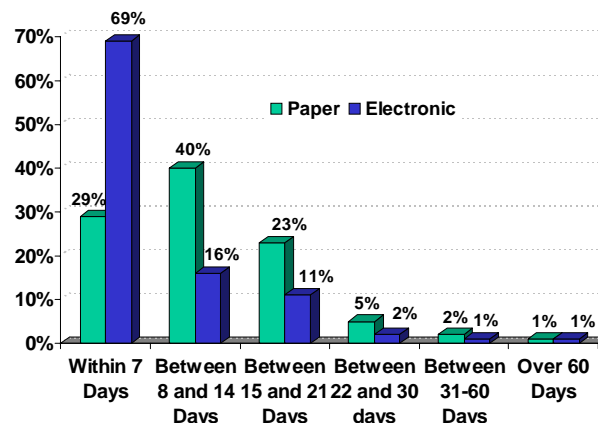
## Average Claims Processing Time

Most claims are processed within 30 days of receipt. In 2006, 98 percent of all claims, paper or electronic, were processed within a month, up from almost 94 percent in 2002. Eighty-one percent of all claims were processed within two weeks of submission, compared with 71 percent in 2002. Fifty-seven percent of claims were processed within one week, an increase over the 46 percent rate in 2002.

**Figure 3. Lag Time for Receiving Claims from Health Care Providers**



**Figure 4. Average Time to Complete Processing After Claim Receipt**

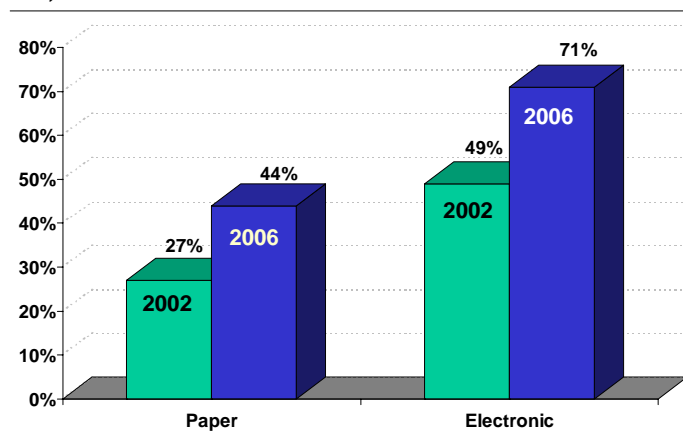


In general, electronic claims are processed faster than paper claims. Sixty-nine percent of electronic claims are processed within 7 days; by contrast, only 29 percent of paper claims are processed within one week of receipt (see Figure 4). After two weeks, however, the disparity shrinks: about 85 percent of electronic claims are processed within 14 days, versus 69 percent of paper claims.

## Automatically Adjudicated Claims

The percentage of claims that are automatically adjudicated -- that is, processed without manual intervention -- increased significantly for both paper and electronic claims from 2002 to 2006. Overall, 68 percent of claims were adjudicated automatically in 2006. Among electronic claims, 71 percent were adjudicated automatically in 2006, up from 49 percent in 2002. Forty-four percent of paper claims were adjudicated automatically in 2006, up from 27 percent in 2002 (see Figure 5).

**Figure 5. Percent of Claims Automatically Adjudicated, 2002 to 2006**



## Pended or Delayed Claims

If more information is needed to complete processing a claim, a claim may be "pended." For pended claims, the payment process is suspended until the information is received or verified, and the resulting "clean" claim is returned to the payment processing system. Overall, 14 percent of total claims were pended in 2006. On average, pended claims require an additional 9 days to process, while more information is being sought.

Nearly half of all claims (48 percent) were pended due to the submission of duplicate claims (35 percent), lack of complete information or other information needed to justify the claim (12 percent), or invalid codes (1 percent). Twenty-four percent of pended claims were due to coverage issues, including no coverage based on date of service (8 percent), non-covered or non-network benefit or service (7 percent), coordination of benefits (5 percent), or coverage determination (4 percent). Other or miscellaneous reasons were the cause of the remaining 28 percent of pended claims.

The following breakdown shows the reasons for which claims were pended and the average number of days they were delayed in processing (see Table 1 on page 5).

<b>Table 1. Reasons for Pended/Delayed Claims</b>	<b>Percentage of Pended/Delayed Claims</b>	<b>Average Number of Days Pended/Delayed</b>
Duplicate Claims Submitted	35%	9
Lack of Necessary Information	12%	11
No Coverage Based on Date of Service	8%	11
Non-covered/Non-network Benefit or Service	7%	5
Coordination of Benefits (COB)	5%	14
Coverage Determination	4%	8
Utilization Review	3%	10
Authorization	3%	20
Pre-existing Condition Review	1%	16
Invalid Codes Submitted	1%	25
Other*	21%	4
<b>Total</b>	<b>100%</b>	<b>9</b>

\*Other reasons cited included: Medicare as primary payer, incorrect provider ID, no provider, ineligible provider, possible third-party liability (TPL), provider watch, member alert, multi-surgery manual pricing, and high dollar claims.

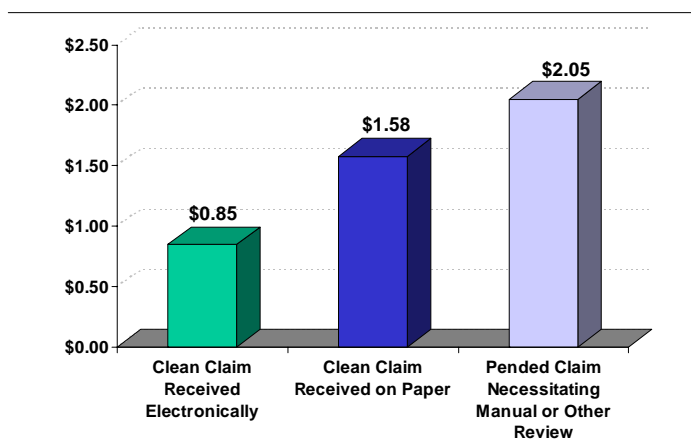
## Cost of Processing Claims

Electronic claims are less costly to process than paper claims. Pended claims that necessitate manual or other review cost an average of \$2.05 per claim (see Figure 6).

## Acknowledgements

This census and report were compiled and written by Hannah Yoo and Karen Harner, Policy Analysts at AHIP's Center for Policy and Research. For further information, please contact Jeff Lemieux, Senior Vice President at AHIP's Center for Policy and Research, at 202.778.3200 or visit [www.ahipresearch.org](http://www.ahipresearch.org).

**Figure 6. Average Cost to Process a Claim**



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