AMA Places Health Insurance Claim Accuracy at About 80%

BY SUSAN BIRK

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION'S HOUSE OF DELEGATES

CHICAGO — Twenty percent of health insurance claims are processed inaccurately, according to the American Medical Association's third annual National Health Insurer Report Card, which rates the nation's largest commercial insurers on timeliness and accuracy of claims processing.

Eliminating discrepancies in expected payment amounts would save doctors and insurers $15.5 billion annually, according to the report, which is based on a random sample of 2 million claims for 3.5 million services filed electronically February-March 2010 by 200 practices in 43 states.

Each year, claims processing costs as much as $210 billion and takes up 10%-14% of physicians' gross revenue and the equivalent for each physician of 5 work weeks, Dr. Nancy H. Nielsen, then immediate past president of the AMA, said in an educational session. "Physicians are drowning in this."

To remedy the problem, the AMA urges the creation of a single, transparent insurance industry standard "so that everybody knows in a seamless way how those claims are to be submitted and processed," Dr. Nielsen said, adding that such a standard would reduce errors and free physicians to focus more on patients and less on administrative red tape.

The report card "has actually turned out to be not just a 'gotcha' against the insurers, but an actual 'win win' between national payers and the AMA" because the insurers appear to be using the feedback to improve, she said.

Insurers made gains in some areas, including accuracy in the reporting of contract fees to physicians. They correctly reported contract fees 78%-94% of the time in 2010 versus 62%-87% of the time in 2008.

The report card has not become a 'gotcha' against the insurers, but rather a 'win win' for national payers and the AMA because insurers seem to be using the feedback to improve.

They also increased the transparency and accessibility of their fee schedules, according to Mark Rieger, chief executive officer of National Healthcare Exchange Services Inc. of Sacramento, which conducted the research.

Physicians' electronic access to complete fee schedules plays a major role in processing accuracy, he said.

"There's still a need for better transparency. But we're optimistic that if payers continue to demonstrate some of the improvements that they've shown" additional efficiencies can be gained, Dr. Rieger added.

Coventry Health Care Inc. had the highest overall accuracy (88%), while Anthem Blue Cross Blue Shield had the lowest (74%). Other insurers addressed by the report were Aetna, CIGNA, Health Care Services Corporation, Humana, and UnitedHealth Group.

Mr. Rieger said that every 1% increase in the match rate for claims would generate a conservatively estimated $777.6 million for physicians and payers. A 100% match rate would yield an annual savings of $15.5 billion.

The AMA asked physicians to do their part to improve the claims process by working to submit claims correctly the first time and implementing practice efficiencies such as an effective electronic practice management system, Tammy Banks, director of practice management and payment advocacy for the AMA, said.

Administrative portals for claims processing "are a great short-term solution—they're getting us where we need to be," but they are not a long-term replacement for a direct relationship with payers through an effective electronic practice management system, Ms. Banks said. ■

Law Ensures Patients' Rights to Challenge Insurance Decisions

BY MARY ELLEN SCHNEIDER

Federal regulations mandated by the Affordable Care Act will give patients new rights to appeal claims denials made by their health plans.

The rules, which were announced on July 22, will allow consumers in new health plans to appeal decisions through their insurer's internal process and to an outside, independent entity. Although most health plans already provide for an internal appeals process, not all offer an external review of plan decisions, said the U.S. Department of Health and Human Services. The types of appeals processes often depend on individual state laws.

HHS officials estimate that in 2011 there will be about 31 million people in new employer plans, and another 10 million people in new individual market plans will be able to take advantage of these new appeals opportunities. By 2013, that number is expected to grow to 88 million people. The rules do not apply to grandfathered health plans.

Under the new rules, health plans that begin on or after Sept. 23, 2010, must have an internal appeals process that allows consumers to appeal whenever the plan denies a claim for a covered service or rescinds coverage. The internal appeals process must also offer consumers detailed information about the grounds for their denial and information on how to file an appeal.

The new rules aim to make internal appeals more objective by ensuring that the person considering the appeal does not have a conflict of interest. For example, the health plan is not allowed to offer financial incentives to employees based on the number of claims that are denied. Health plans will also have to provide an expedited appeals process, which would allow urgent cases to be reviewed within 24 hours.

The regulations also standardize rules for external appeals. Currently, 44 states require health plans to have some type of external appeal but those processes vary greatly, according to HHS. Under the federal rules, health plans must provide clear information about external appeals and expedited access to the process. The decisions made through external appeals are binding under the new federal rules. ■

HHS Proposes Tighter Privacy Terms In Effort to Boost Electronic Records

BY MARY ELLEN SCHNEIDER

Patients could gain greater access to their health information and have more power to limit disclosures of certain personal information to health plans under a new proposal from the Health and Human Services department.

The new requirements are aimed at beefing up privacy and security, as the Obama administration pushes to get more physicians using electronic health records over the next few years.

"The benefits of health IT can only be fully realized if patients and providers are confident that electronic health information is kept private and secure at all times," Georgina Verdugo, director of the HHS Office for Civil Rights, said in a statement.

The proposal alters the Health Insurance Portability and Accountability Act (HIPAA) rules by setting new limits on the use of disclosure of protected health information for marketing and fundraising and by requiring business associates of HIPAA-covered entities to follow most of the same rules that covered entities follow. It would also bar the sale of protected health information without explicit authorization from the patient.

In addition, it implements elements of the 2009 Health Information Technology for Economic and Clinical Health Act, which requires physicians and other covered entities to grant patient requests to restrict certain information from their health plans. Individuals can provide comments on the rule until Sept. 11.

The HHS has also launched a new Web site (www.hhs.gov/healthprivacy/index.html) that provides consumers with information on their privacy rights under existing regulations. ■

The proposed requirements are available at www.ofr.gov/OFRUpload/OFRData/2010-16718_PI.pdf.

New Reforms Will Save Billions For Medicare, Extend Its Solvency

BY MARY ELLEN SCHNEIDER

Provisions of the new Affordable Care Act, coupled with other payment changes, will save Medicare nearly $8 billion over 2 years and extend the solvency of the Medicare Trust Funds by 12 years, says a report from the Centers for Medicare and Medicaid Services.

The immediate savings come from cuts to Medicare Advantage payments, competitive bidding for durable medical equipment, changes to how Medicare pays for advanced imaging services, productivity improvements in the hospital, and efforts to reduce waste, fraud, and abuse. These changes are expected to save $7.8 billion for the Medicare program by the end of next year. The report, issued Aug. 2, analyzes cost-cutting provisions that CMS has already implemented or will be implementing soon.

The new law will protect Medicare beneficiaries by maintaining current benefits and adding new ones such as free preventive care and the eventually closing the Medicare Part D prescription drug doughnut hole, Health and Human Services Secretary Kathleen Sebelius said at a press conference to release the report.

CMS officials estimate that Medicare savings will exceed $418 billion by 2019. Some of those savings will come from reducing hospital readmissions and hospital-acquired infections, bundling payments for end-stage renal disease care, promoting Accountable Care Organizations, and improving quality reporting by physicians. It also expects the Independent Payment Advisory Board, which will recommend payment changes aimed at slowing growth in Medicare spending, to contribute to those savings.

Ms. Sebelius said she expects private insurers to follow the federal government's lead in implementing some of these payment changes as they prove effective in the Medicare program. ■