

2025

CAQH Index[®] Report

Recovery by the Numbers: Administrative
Resilience After a Systemwide Disruption

Methodology

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Introduction

Understanding how administrative tasks move through the healthcare system is essential to improving them. The CAQH Index measures this activity each year so the industry can see where progress is being made and where opportunity remains. By tracking the adoption of electronic transactions and comparing them to manual and partially electronic processes, the Index shows how much time and money the system can save when workflows are modern, reliable, and efficient.

The 2025 CAQH Index is our thirteenth annual report and reflects data from medical and dental plans and providers representing more than half of the insured population in the United States. To build a clear and accurate picture, we worked with organizations across the country through direct outreach, industry events, and collaboration with NORC at the University of Chicago. Participants included long-standing contributors and new partners engaged in CAQH initiatives.

This methodology outlines how the data was collected, how transaction volumes and spending were calculated, and how we assessed cost savings opportunities. Our goal is to make the process transparent and accessible so readers can understand both the strength of the findings and the shared effort behind them.



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Background

The CAQH Index tracks the industry adoption of electronic administrative transactions over time. It measures industry volume, spend, cost avoided, and the cost savings opportunity associated with switching from conducting partially electronic and manual transactions to using fully electronic transactions. The 2025 CAQH Index is the thirteenth annual report which collects data from medical and dental plans and providers covering more than half of the insured United States population, according to enrollment reports from the AIS Directory of Health Plans and NADP Dental Health Plan Profiles.^{1,2}

Recruitment

Medical and dental plans and providers were recruited to participate in the study through direct outreach, including email, telephone, industry conferences, webinars, the CAQH website, and social media. CAQH managed recruitment efforts for medical and dental plans and providers, including developing outreach lists and sending email invitations, while collaborating with NORC at the University of Chicago³ on recruitment, data collection, and analysis for medical and dental providers. Plans and providers included organizations that had previously participated in the CAQH Index, as well as additional contacts engaged through other CAQH initiatives.

In addition, NORC updated and expanded the legacy contact and hospital lists to recruit additional provider participants. CAQH also partnered with CAQH member organizations, the CAQH Index Advisory Council, the Workgroup for Electronic Data Interchange (WEDI), the American Dental Association (ADA), the American Hospital Association (AHA), and the American Medical Association (AMA) to increase survey participation.

All CAQH Index participants receive a benchmark report comparing their data to the aggregate industry results. Medical and dental providers along with hospitals were also offered honorariums to encourage participation in the survey.

Data Collection

The CAQH Index collected data through a voluntary online survey tool from June to September 2025. A fillable PDF and Excel version of the survey were also offered to participants. Plan and provider data are representative of the 2024 calendar year, January 1 to December 31, 2024. The medical and dental plan surveys collected data on nine administrative transactions. For providers, data was collected for 10 medical and eight dental transactions.

Supplemental Questions

The medical and dental plan survey also included supplemental questions regarding:

- Use of proprietary reports for Acknowledgements.
- Use of artificial intelligence (AI) for administrative and clinical tasks.
- Preparation for the Interoperability and Prior Authorization Final Rule⁴ — implementation of electronic prior authorization (ePA) (Medical plans only).
- Value of conflict-of-interest data.
- Payer/provider contracting process.

The medical provider survey collected data on eight administrative transactions and two pharmacy transactions, Prescription/Drug Prior Authorization (NCPDP SCRIPT) and Realtime Pharmacy Benefit Prescription Check (NCPDP RTPB). The dental provider survey included eight administrative transactions.

For medical and dental providers, this year's survey included supplemental questions regarding:

- Use of proprietary reports for Acknowledgments.
- Average number of Eligibility and Benefit Verification checks per patient per visit.
- Role within the practice (clinical or administrative).
- Use of the NCPDP drug formulary and benefit standard (Medical providers only).
- Use of artificial intelligence (AI) for administrative and clinical tasks.

- Preparation for the Interoperability and Prior Authorization Final Rule⁵ — implementation of electronic prior authorization (ePA) (Medical plans only).
- Payer/provider contracting process.

Additional insights on these topics will be released as part of Index Pro* in Q2 2026.

Imputations

To ensure that responses were accurate, logic checks were embedded in the online survey tool for plans and providers to check for data reliability and accuracy for all transactions. Logic checks included a request for additional information if estimates were outside specified bounds. For example, in the provider surveys, if electronic times were three minutes or more, participants were asked to provide an explanation of the process.

For the 2025 Index, the provider surveys saw increased incidence of low-quality and potentially fraudulent submissions. This problem was quickly detected and targeted adjustments were made to both the survey process and the dataset to preserve the accuracy and reliability of the results:

- The survey was limited to accept responses only from US-based IP addresses.
- Additional bot detection technology and security-scan monitoring were implemented.
- Cases were flagged as suspicious using a combination of clinic name, contact name, email address, phone number, location, IP address, completion time, and overall number of questions answered with non-missing information. Additionally, cases with unusually high or low transaction volumes relative to number of staff were reviewed. All reviews were conducted both by project staff and through use of Microsoft's Copilot LLM.
 - Fraudulent cases included:
 - Duplicate names, email addresses, or phone numbers with more than 2 records or other detected issues

- Near duplicate names, email addresses, or phone numbers (e.g., email addresses with a single changed digit)
- Irrelevant information in required fields, such as clinics which listed impossible physical addresses instead of contact names
- Notable hospitals or clinics without other identifying business information
- Unusually high or low transaction volumes relative to staff size
- Unusually high staff pay relative to transaction volume
 - All cases with unusual transaction or pay data were contacted for clarification on transactions, and several were determined to be genuine.
- Some additional cases with suspicious but not obviously fraudulent data were contacted to confirm clinic details. Any case which did not respond or was unable to provide matching clinical information was removed from the dataset.

Even with logic checks, some responses were insufficient or out of range. When this occurred, NORC followed up with respondents to obtain more information about the relevant transactions. If clinics did not respond or were unable to provide sufficient additional information, values were imputed using the following rules.

- For processing time values, if a respondent provided information that was greater than the median value plus the Interquartile Range multiplied by 2, the processing time was imputed using the median value plus the Interquartile Range multiplied by 2. In cases where partial time was the same as manual time, partial time was imputed.

* **Index Pro**, an interactive dashboard, includes trended metrics, detailed transaction findings, cost and time savings opportunities, and access to CAQH consulting services. Subscribers also have access to an interactive return-on-investment calculator and a Ask the Index feature that makes it easier to get answers and strategy. Visit caqh.org/index for more information.

- For salary values, if a respondent provided information that was greater than the median value plus the Interquartile Range multiplied by 3, the salary time was imputed with the median value plus the Interquartile Range multiplied by 3. In cases where the reported salary was less than the Median-Interquartile Range, the salary was imputed to the Median-Interquartile Range, or \$20,000, whichever was lower.
- For volumes, transaction volumes that were much higher than expected were imputed using the following rules: If there were fewer than 20 providers on staff, and the total monthly transaction volume was higher than 12*Median transaction volume, the transactions for all categories were assumed to be annual, rather than monthly, and recalculated accordingly.

Overview of Fully Electronic Administrative Transactions Studied, 2025 CAQH Index:

Transaction	Transaction Standard	Definition
Eligibility and Benefit Verification†	ASC X12N 270/271	An inquiry from a provider to a health plan or from one health plan to another to obtain eligibility, coverage or benefits associated with the plan and a response from the health plan to the provider. Does not include referrals (applicable only to providers).
Prior Authorization	ASC X12N 278	A request from a provider to a health plan to obtain authorization for healthcare services or a response from a health plan for an authorization. Does not include referrals.
Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter information for the purpose of reporting delivery of healthcare services.
Attachments	ASC X12N 275, HL7 CDA*	Additional information submitted with claims for payment, claim appeals or prior authorization, such as medical records to support a claim or to explain the need for a procedure or service.
Acknowledgements**	ASC X12N 277CA/999	A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearinghouse; or confirmation received by a provider that the information shared with a health plan has been rejected or accepted.
Coordination of Benefits	ASC X12N 837	Claims that are sent to secondary payers with explanation of payment information from the primary payer to determine remaining payment responsibilities.
Claim Status Inquiry†	ASC X12N 276/277	An inquiry from a provider to a health plan to determine the status of a health care claim or a response from the health plan
Claim Payment†	NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)	An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment.
Remittance Advice†	ASC X12N 835	The transmission of explanation of benefits or remittance advice from a health plan to a provider explaining a payment.

† Both HIPAA standards and CAQH CORE Operating Rules are federally mandated.

* ASC X12N 275 and HL7 CDA are both industry recognized standards for electronic attachments.

** The reporting of Acknowledgements has been retired after achieving consistent 100% electronic adoption; data is included in total volume for trend analyses.

Medical plans represented 217 million covered lives, or 63 percent of the United States enrolled population. Medical plans accounted for 4 billion claims received and 20 billion transactions annually. In comparison, dental plans represented

118 million covered lives and approximately 40 percent of the enrolled population. Dental plans represented a smaller portion of volume with 205 million claims received and a total of 915 million transactions.

Basic Characteristics of Data Contributors, 2019-2025 CAQH Index

	2019 Index	2020 Index	2021 Index	2022 Index	2023 Index	2024 Index	2025 Index
MEDICAL							
Plan Members (total in millions)	154	167	202	204	209	216	217
Proportion of Total Enrollment (%)	47	51	61	60	60	63	63
Number of Claims Received (total in billions)	2	2	2	3	3	3	4
Number of Transactions (total in billions)	8	10	12	14	15	17	20
DENTAL							
Plan Members (total in millions)	111	112	116	126	127	136	118
Proportion of Total Enrollment (%)	44	43	44	48	45	47	40
Number of Claims Received (total in millions)	185	186	156	201	199	223	205
Number of Transactions (total in millions)	726	740	703	828	851	967	915

Metrics

Results were aggregated to ensure data privacy. Benchmarks were calculated and reported only for transactions where three or more plans participated. The following metrics were reported for each transaction:

Adoption Rate — The degree to which medical and dental plans and providers complete transactions using fully electronic, partially electronic, or manual modes. Adoption rates are calculated using only medical and dental plan reported volumes.

Estimated Volume — The number of fully electronic, partially electronic, and manual administrative transactions reported by medical and dental plans and providers weighted to a national level.

Cost Per Transaction — The labor costs (e.g., salaries, wages, personnel benefits, and related overhead costs) associated with full electronic, partially electronic, and fully manual transaction as reported by medical and dental plans and providers. Costs include the labor time required to conduct the transaction, not the time and cost associated with gathering information for the transaction and follow-up. Costs do not include system costs (e.g., maintaining, building, or buying software or other equipment).

Administrative Spend (Estimated Spend) — The amount that medical and dental plans and providers spend conducting an administrative transaction in total and by modality.

Cost Avoided — The amount that medical and dental plans and providers have saved by not conducting transactions using partially electronic or fully manual modes.

Cost Savings Opportunity — The administrative cost savings that could be achieved by switching the remaining partially electronic and manual transactions to fully electronic transactions.

Time to Conduct — The time required for providers to conduct a fully electronic, partially electronic and fully manual transaction.

Time Savings Opportunity — The time that providers could save by switching partially electronic and manual transactions to fully electronic transactions.

Adoption Rate

The degree to which medical and dental plans and providers complete transactions using fully electronic, partially electronic, or manual modes. Adoption rates are calculated using only medical and dental plan reported volumes. Transaction adoption is classified into three modes:

Fully Electronic — Administrative transactions conducted using a HIPAA-mandated standard, unless otherwise specified.

Partially Electronic — Administrative transactions conducted using web portals and interactive voice response (IVR) systems.

Fully Manual (Manual) — Administrative transactions requiring end-to-end human interaction such as telephone, mail, fax, and email.

For the figures depicting the medical and dental plan adoption rates, adoption rates were calculated by mode as a proportion of the total volume reported by plans and represent the percent distribution of transactions conducted by mode.

Adoption Rate (per mode) = Volume Reported by Plans (per mode) / Total Volume Reported by Plans

The annual percentage point change is computed as the arithmetic difference between percentages.

Provider Weights

Medical and dental provider results are weighted to provide representative estimates of the medical and dental provider populations.

For medical providers, results are estimated based on the size and type of practice as well as specialty of the responding provider. The groups were defined using the American Medical Association (AMA) Benchmark Practice Survey⁶ and the AAMC Physician Specialty Data Report.⁷ The distribution of providers in the population was determined using active and self-attested MD/DO information contained within CAQH's Provider Data Portal.⁸ Size and type of practice included: Less than 5 physicians, 5-50+ physicians, and hospitals. Specialty groups included: Generalist, Specialist, Behavioralist, and Hospitalist.

For dental providers, results are estimated based on the provider's practice size and Dental Support Organization (DSO) affiliation status. The distribution of providers in the population was determined using the American Dental Association (ADA) Survey of Dental Practice.⁹ The distribution of dental providers was split into 3 groups: non-DSO affiliated solo practice, DSO affiliated solo or group practice, and non-DSO affiliated group practice.

The following table shows the percent of the medical provider population represented in each group:

Specialty	Size	Percent
Generalist	1-4	25.6%
Generalist	5-50+	18.9%
Specialist	1-4	19.2%
Specialist	5-50+	17.8%
Behavioralist	1-4	3.1%
Behavioralist	5-50+	2.3%
Hospitalist*	Hospital	13.1%

* Refers to a hospital-based respondent.

The following table shows the percent of the dental provider population represented in each group:

Type of Entity	Percent
Non-DSO Affiliated Solo Practice	28.0%
DSO Affiliated Solo or Group Practice	8.3%
Non-DSO Affiliated Group Practice	63.7%
Total	100%

Provider weights were calculated by dividing the percent of the sample in each group by the percent of the population in each group as defined by the CAQH's Provider Data Portal and the ADA. Since not all providers submit data for every transaction, provider weights were calculated individually for each transaction.

Provider Weight (per transaction) = Percentage of the Sample in Each Group Reporting the Transaction / Percentage of the Population in Each Group

Estimated Volume

Plan Estimated Volume

The total transaction volume is estimated based on the proportion of covered lives represented by participating medical plans using the AIS Directory of Health Plans or reported enrollment for medical plans, whichever value was higher. For dental plans the plan reported enrollment was used for estimation. To determine the percent of covered lives represented, the total enrollment from the AIS Directory of Health Plans¹⁰ was used for medical plans and the NADP Dental Health Plan Profiles¹¹ for dental plans. The reporting of Acknowledgments has been retired after achieving consistent 100% electronic adoption; data is included in total volume for trend analyses. The extrapolated national volume for each transaction is calculated by mode as follows for both medical and dental plans:

Extrapolated Plan Volume (per modality) = Volume Reported by Plans / Percent of Covered Lives Represented by CAQH Data Contributors

Provider Estimated Volume

Provider volume is calculated first by determining the percentage of each transaction that was conducted by mode (electronic, partial, or manual) for each provider.

Provider Mode Distribution (per transaction) = Provider Reported Volume for Mode (per transaction) * Provider Reported Volume for All Modes (per transaction)

The provider specific mode distribution was then averaged among providers and weighted by the size and specialty groups listed above.

Average Provider Mode Distribution (per transaction) = Average(Provider Weight (per transaction) * Provider Modality Percentage (per transaction))

To account for small provider cell sizes for some transactions by mode, the plan adoption rate per mode is averaged with the weighted average provider mode distribution. This generates a single estimated percentage by modality for each transaction.

Provider Distribution (per mode per transaction) = Average(Plan Adoption Rate (per mode per transaction), Average Provider Modality Percentage (per transaction))

Given that each transaction for a plan also occurs for a provider, the national estimated plan volume (by mode) is assumed to be same value as the national estimated provider volume (by mode). To determine the provider volume for each mode, the average provider distribution is multiplied by the national estimated provider volume.

Extrapolated Provider Volume (per modality) = Total Plan Estimated Volume for a Given Transaction * Average Modality Percentage

The industry estimated volume for each transaction is the sum of the plan estimated volume and the provider estimated volume for each mode.

Cost Per Transaction

Transaction costs are reported for fully electronic, partially electronic, and manual transactions for medical and dental plans and providers when available depending on sample size. For medical and dental plans, the cost per transaction by mode is a weighted average based on the data submitted by participants reporting a valid result using the proportion of their membership enrollment. The calculation requires both the reporting of a valid transaction volume and transaction cost by a survey participant to be included in the weighted average cost.

For medical and dental providers, weighted average costs per transaction by mode were calculated by NORC based on transaction type, average staff time to conduct a transaction, and cost per transaction for each mode. The cost calculation followed a multi-step process to calculate weighted costs per transaction for medical and dental providers:

- The time per transaction by mode and reported salary were averaged using the provider weights stated above, which account for both size and specialization of practice.

Time per Transaction (per mode) = Average(Provider Weight (per transaction)* Provider Reported Time per Transaction (per Mode, in minutes))

Average Salary = Average(Provider Weight (per transaction)* Provider Reported Salary)

- The average loaded salary per minute per mode for each provider was created by multiplying the average salary by a specific loading factor to account for benefit and overhead costs and then dividing that number by minutes in a work year (40 hours/week, 52 weeks/year, or 124,800 minutes).

Loaded Average Salary (per mode per provider, in minutes) = Average Salary * Loading Factor / Minutes in Work Year

- The individual provider loaded cost per transaction per mode was calculated by multiplying the average loaded salary per minute for each responding provider with the average time per transaction by mode among all providers.

Loaded cost (per provider per transaction per mode) = Loaded Average Salary per minute (per mode per provider) * Time per Transaction (per mode, in minutes)

- The average cost per transaction was calculated using the individual provider loaded cost per transaction per mode and the provider weights stated above.

Cost per Transaction (per modality) = Average (Loaded cost (per provider per transaction per mode) * Provider Reported Time per Transaction (per Mode))

Estimated Spend, Cost Avoided and Cost Savings Opportunity

Administrative Spend (Estimated Spend)

Administrative spend (estimated spend) is calculated by multiplying the estimated volume per mode by its respective weighted cost per transaction for medical and dental plans and providers within a transaction. The total spend per transaction is equal to the sum of spend for each mode per transaction.

Estimated Cost Avoided

The estimated cost avoided is the arithmetic difference between the spend if all transactions were conducted manually and the total estimated spend by transaction. The total manual spend per transaction was computed by multiplying the estimated national volume of all modes by the manual cost per transaction.

Estimated Cost Savings Opportunity

The cost savings opportunity for switching from manual to fully electronic transactions is calculated by multiplying the estimated national volume of manual transactions by the cost per transaction difference between fully electronic and manual transactions for each transaction. The cost savings opportunity for switching from partially electronic to fully electronic transactions is calculated by multiplying the estimated national volume of partially electronic transactions by the cost per transaction difference between the fully electronic and partially electronic transactions for each transaction.

Considerations

Some over-counting and under-counting of transaction volume may occur:

- Some transactions may be reported as fully electronic transactions even if they were initially sent as a manual transaction and then converted to a fully electronic transaction by a practice management system. No direct relationships between or among the volumes of transactions should be inferred.
- Some eligibility and benefit verification transactions may never result in a claim submission or claim payment since some practice management systems make periodic eligibility and benefit verification requests that are not connected to patient encounters.
- Some claim submission transactions may not be requests for payment since only a few plans can distinguish claim submissions that are requests for payment from encounter reports versus claim submissions that are only transmissions of medical service information, such as for value-based payments and capitation arrangements.

- Some transactions may not result in a claim payment transaction if there is no payment due from the health plan after adjudication, such as when a patient is meeting the annual deductible.
- Due to availability of data and the ability to report data in the required format, health plans and providers may be unable to report values for all modes. Blank cells may not indicate that a mode is not used to complete a transaction but rather that data is not available.

The results of this report are based on surveys and may be subject to response bias.

The CAQH Index uniquely tracks only direct costs:

- Costs reported include the labor time required to conduct the transaction, not the time and cost associated with gathering information for the transaction and follow-up. System costs are excluded from the cost and savings estimates.
- Sample variation may impact some transaction cost trends from year to year.
- Medical and dental provider costs to conduct a transaction reflect only a snapshot in time for the specific group of providers. Sampling factors such as salary increases or declines, learning curve for a new employee to process a transaction, and the mix of specialty type may impact the trending of data.

- The ability to report on all transactions exchanged is dependent on accurate reporting practices used by health plans and providers. Due to employment changes and increases in utilization after the pandemic emergency, some health plans and providers may have had new staff gathering and submitting data, increasing data variability.
- The cost calculation methodology calculates each step (salary, time, and unit cost) as separate results on average based on the provider distribution by size and specialty. This is designed to create a modular and replicable process for cost calculation that can be useful to the industry. However, this assumes that the time and unit cost are independent of each other at the provider level. If results were explicitly calculated at the provider group or respondent level, there may be some slight variation in the overall outcome.



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- Medical and dental plans and providers that submitted data and participated in follow-up interviews.
- NORC at the University of Chicago for data collection and analytics.
- CAQH Index Advisory Council for their ongoing guidance and support of the CAQH Index research.

2025 CAQH Index Advisory Council Roster

2025 CAQH Index Advisory Council Member	Organization
Amy King	Blue Cross Blue Shield of Michigan (BCBSM)
Amy Neves	Aetna
Brad Smith	Nacha
Cat Douglas	Florida Blue
Cathy Sheppard	X12
Erin O'Rourke	Advancing Health Insurance Providers' Strategic Priorities (AHIP)
Geanelle Herring	Centers for Medicare & Medicaid Services (CMS)
Heath Hanwick	Epic
Heather McComas	American Medical Association (AMA)
Jay Eisenstock	JE Consulting
Lorraine Doo	Centers for Medicare & Medicaid Services (CMS)
Mahesh Siddanati	Centene
Margaret Weiker	National Council for Prescription Drug Programs (NCPDP)
Paul Keyes	Cigna
Rebekah Fiehn	American Dental Association (ADA)
Robert Tennant	Workgroup for Electronic Data Interchange (WEDI)
Sofia Fayazdeen	UnitedHealthcare (UHC)
Stanley Nachimson	Nachimson Advisors
Suzanne Lestina	University of Chicago Medical Center (UChicago Medicine)
Tab Harris	Florida Blue
Terrence Cunningham	American Hospital Association (AHA)
Tom Mort	Vyne Dental
Viet Nguyen	Health Level Seven International (HL7 International)

Endnotes

Background

- ¹ AIS Health Data, a Division of Managed Markets Insight and Technology, LLC, AIS's Directory of Health plans: 2025.
- ² National Association of Dental Health Plans, Dental Benefits Report, 2023.

Recruitment

- ³ NORC at the University of Chicago is an independent research institution that delivers insights and data analysis for government, nonprofits, and businesses. For more information, visit: <https://www.norc.org/Pages/default.aspx>.

Data Collection

- ⁴ Interoperability and Prior Authorization Final Rule (CMS-0057-F), Federal Register: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program | [Federal Register](#).
- ⁵ Ibid.

Provider Weights

- ⁶ "Physician Practice Benchmark Survey". AMA (2025). | [ama.org](https://ama-assn.org).
- ⁷ "Physician Specialty Data Report". AAMC (2024). | aamc.org.
- ⁸ "Provider Data" | [CAQH](#).
- ⁹ "Distribution of dentists according to size of dental practice and affiliation with a dental support organization (DSO) (XLSX)" ADA. (May 2023). | ada.org.

Estimated Volume

- ¹⁰ AIS Health Data, a Division of Managed Markets Insight and Technology, LLC, AIS's Directory of Health plans: 2025.
- ¹¹ National Association of Dental Health Plans, Dental Benefits Report, 2023.

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