simplifying healthcare administration

CAQH

Coordination of Benefits

Presentation for NCVHS
June 10, 2014

CAQH – Catalyst for Industry Collaboration

- CAQH, a nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration for health plans and providers, resulting in a better care experience for patients and caregivers.
- CAQH initiatives are national in scope and produce measurable results.
  - Help promote quality interactions between plans, providers and other stakeholders.
  - Reduce costs and frustrations associated with healthcare administration.
  - Facilitate administrative healthcare information exchange.
  - Encourage administrative and clinical data integration.
- **CAQH Vision:** CAQH is the leader in creating shared solutions to streamline the business of healthcare.
- **CAQH Mission:** To accelerate the transformation of business processes in healthcare through collaboration, innovation and a commitment to ensuring value across stakeholders.

COB Challenges Today

Health Plan and Provider Value Chain Components

Patient Access and Eligibility	Provider Billing / Claim Receipt	Routing	Claim Adjudication	EOB/Claim Payment	Appeals & Adjustments
• Providers request coverage info from patient. • Health plans request demographic, employer, and coverage info from member. • Excess costs result from missing or inaccurate info, resulting in manually intensive rework downstream.	• Providers produce bill applying relevant patient diagnosis and procedure codes. • Health plans receive claims and attachments from providers. • Excess costs result from lack of uniform use of billing codes, complicating COB reviews.	• Transmission of billing information between providers and relevant COB health plan(s). • Excess costs result from incorrect bill submission (i.e. wrong health plan), resulting in repeat bills.	• Health plans adjudicate claims in accordance with contractual rates. • Excess costs result from ad-hoc patient data requests, and confusion over primary health plan COB payment, resulting in significant manual turn around time.	• Provider receives payment and EOB. • Excess costs result from confusion over health plan payment (i.e., ambiguous EOB), resulting in lengthy and manual secondary COB bill submissions.	• Providers file appeals and perform follow-up underpayments. • Health plans retroactively file overpayment reviews. • Excess costs result from manual work associated with non-standardized appeal processes.

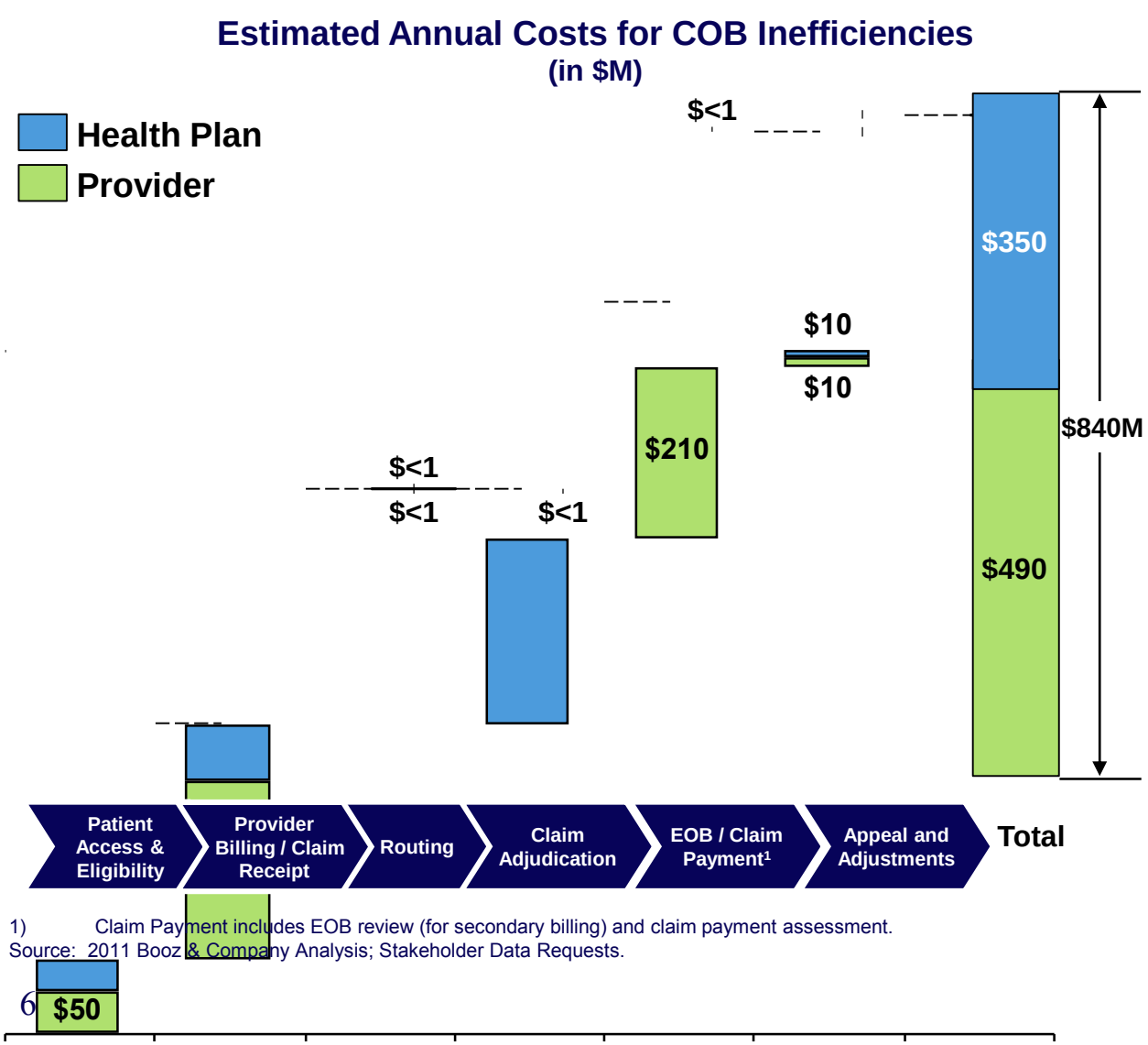
COB Pain Points – Provider

	Summary of Provider COB Pain Points	Example Impacts
Poor Patient Information	• Collecting coverage information at point of service is an administrative burden (i.e. different forms, formats, rules). • Patients provide unreliable coverage information. • Care givers may not capture COB relevant information.	• High front office costs. • Increased front office training. • Increased patient data inaccuracies. • Increased patient follow-up requests.
Fragmented Lifecycle Transparency	• Lack of visibility into a patient's cross health plan coverage and benefits. • Lack of visibility into a submitted COB bill's progress. • Low transparency into reimbursements, appeals, and adjustment processes.	• Poorer reconciliation of accounts. • Higher back office costs for claims follow up. • High incidents of payment recoveries. • High COB fatigue and write-offs.
Lack of Uniform Process for COB	• Existing rules, i.e. statutes of limitations, do not account for COB complexity. • Claims are rejected due to different provider interpretations of primary / secondary health plan hierarchy. • Multiple COB claim filing formats leads to manual massaging or technology complexity.	• Higher back office and technology costs. • Increased bill denials and resubmissions. • Increased TATs to collecting payments.
Manual Processing	• Providers spend a lot of time manually processing bills. • Providers experience increased processing time and significant delays in collection. • More staff are required to follow-up for denials and appeals.	• Higher back office costs for manual billing process. • Increased TATs to collecting payments.

COB Pain Points – Health Plan

	Summary of Health Plan COB Pain Points	Example Impacts
Poor Cross Health Plan Information	• Members are often unresponsive to inquiries or do not have accurate/complete information. • Health plans have difficulty identifying the secondary health plan based on the claim. • Lack of transparency into other health plan's responsibilities and payments.	• High back-office cost incurred for follow-up and outreach activities. • Increased overpayment and potential MLR impact. • Decreased provider and member satisfaction.
Lack of Uniform Process for COB	• Lack of standardized transactions between each other, leading to a high manual touch resolution. • Provider claims do not provide consistent information needed for accurate adjudication. • Identifying primary and secondary ownership varies between health plans.	• Increased back-office costs due to high manual processing. • Increased volume of appeals. • Increased volume of under/over payments.
Data Inaccuracy	• Inaccurate and missing data often pends claims leading to high manual processing. • Members frequently change health plans leading to inaccurate eligibility data and COB identification. • Inaccurate data provided by other health plan causes under or overpayments.	• High administrative load for manual claim processing. • Increased outbound follow-up volume. • Increased inbound provider call volume. • Increased appeals / adjustment processing effort.

Cost of Administrative Inefficiencies – $800M+



1) Claim Payment includes EOB review (for secondary billing) and claim payment assessment.
Source: 2011 Booz & Company Analysis; Stakeholder Data Requests.

Highlights

- Figures based on interviews, internal data analysis and industry research.
- 3-5% of claims involve COB, based on stakeholder input.
- Providers are burdened with ~60% of the extra costs, of which $430M are billing related (primary and secondary billing processes).
- FTE costs represent $500M (60%) of extra costs.
- IT and vendor spend represent the remaining $340M (40%) of extra costs.

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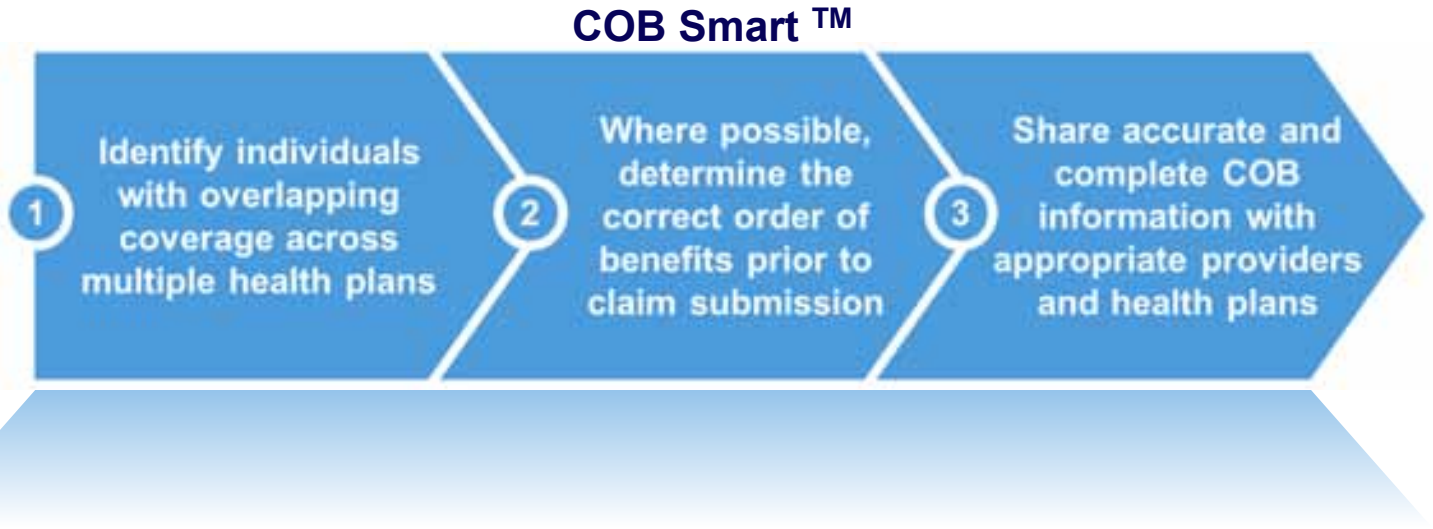
CAQH Industry-Wide COB Registry



- Launched in late 2013.
- National rollout to be completed in June 2014.
- 12 participating health plans, including Aetna, Cigna, United, and WellPoint. Discussions underway with several health plans underway.
- Currently covering 120M unique individuals with various forms of medical benefits (e.g., commercial, Medicaid, Medicare, etc.); inclusion of specialty benefits to be addressed in subsequent phase.

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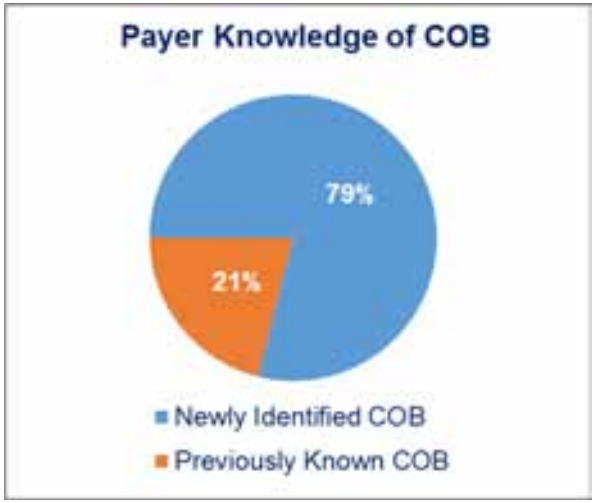
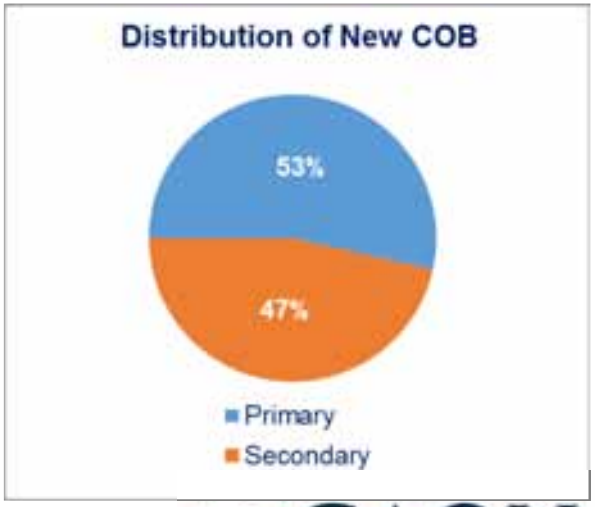
Preliminary Findings: Increased Knowledge of COB

- Based on preliminary results from COB Smart participants, health plans appear to have a significant number of members who are incorrectly classified as not having COB (prior to leveraging a national COB registry).
- Traditional information collection methods (e.g., patient registration forms, member canvassing, data mining) yield incomplete results.
- Lack of timely COB information prevents providers and health plans from submitting and processing COB claims correctly the first time, creating the need for retrospective, recovery-based approaches.
- Instances of new COB identified through a national COB registry do not necessarily imply additional primary payment responsibility for the health plan.

Results from a CAQH COB Registry Participant





Target Provider Experience

Accurate, timely and complete COB information is available to providers before the claim is submitted

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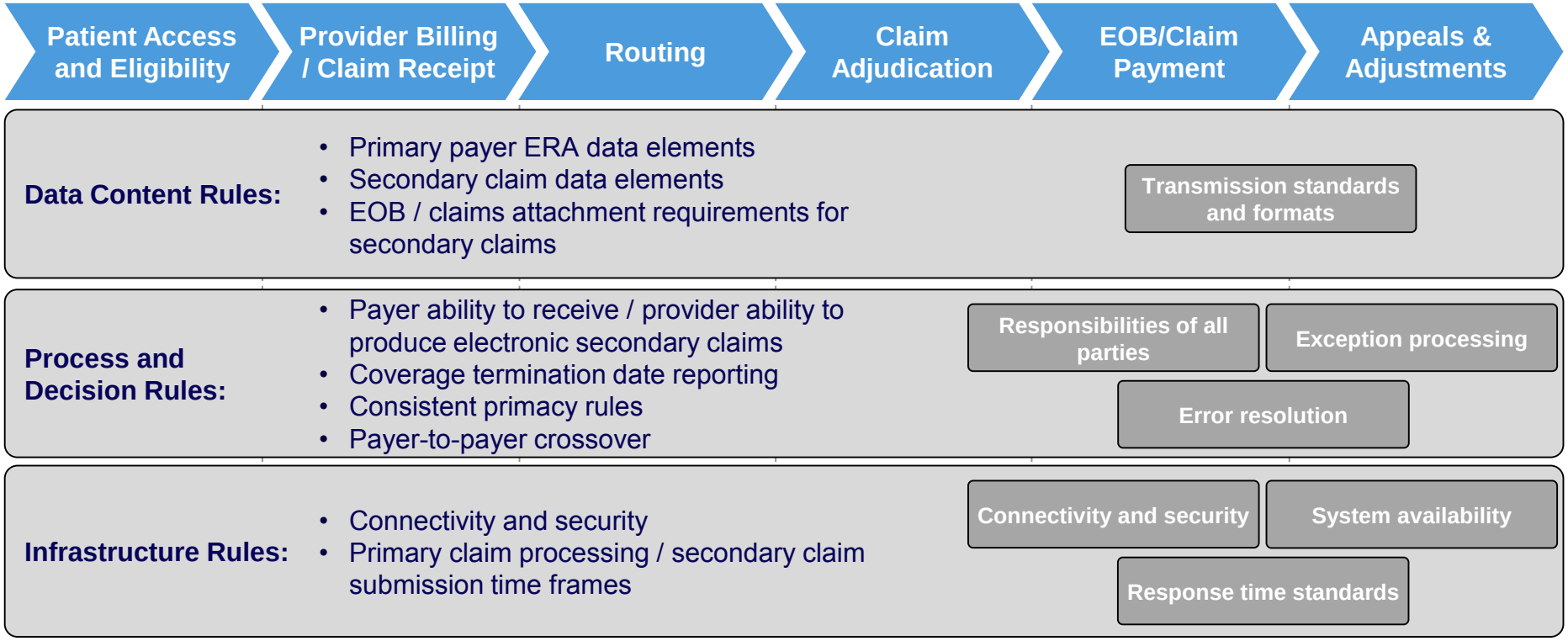
Need for Operating Rules

Potential Operating Rules across COB Value Chain



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