CAQH Solutions℠

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ISSUE BRIEF

How to Modernize Your COB Approach

And End the Pay and Chase Cycle

Many plans wait until after claims are paid to identify overlapping coverage and recover incorrect payments, a process commonly referred to as "pay and chase." But focusing on recovery creates a manual and time-consuming process for you and frustrates providers and your members.

A prospective COB program enables plans to increase efficiency, prevent incorrect payments and provide a better experience for providers and members. Here is what you need to get started.

Use high-quality data

Prioritize high-dollar claims

Automate

Eliminate COB letters

Use high-quality data

Increasing the success of your COB program by becoming more prospective requires having high-quality data to use to make payment decisions. There are six must-dos when it comes to selecting a primary source of data:

1. **Go directly to the source.** The highest quality data comes directly from other health plans.
2. **Get data before the claim is paid.** If the data comes before a claim is paid, the plan will already know whether they are the primary or secondary payer and can pay the claim correctly the first time, avoiding the extra cost of recovery or re-work.
3. **Consider the impact on your staff.** Managing and/or verifying the data should reduce the administrative burden on team members, not increase it.
4. **Look for frequent updates.** The more regularly that data is updated, the higher the likelihood that the member information is accurate.
5. **Make sure the data is affordable.** As COB is primarily done as a cost savings measure, purchasing expensive data can cut into recovered costs.
6. **Don't forget out-of-state data.** CAQH found that almost one third of coverage overlaps come from payers in a state other than the one where the member resides.

Prioritize high-dollar claims

We all have limited resources and time, so identifying and pursuing the claims that will provide the greatest return will ensure that your program maximizes cost savings—and does so quickly.

Take the case of a regional health plan in the South that had been working their data on a first-in / first-out basis using a recovery vendor. Using this method, they achieved roughly $230,000 in cost savings annually.

Then the plan set a dollar threshold. The in-house team worked all claims higher than the threshold. Only the claims that were lower were outsourced to a vendor. The next year, the plan achieved $11 million in savings, and $28 million the year after. And while they still paid for an outside vendor, they were able to minimize contingency fees by sending them only the lower-dollar claims.

$28M+

increase in annual savings by focusing recovery efforts on high-dollar claims

Automate

Automation is a critical component in reducing burden and costs associated with all healthcare administrative transactions. For the COB process, it also helps to avoid errors and overpayments. Once an overlap is identified, many plans engage in a highly manual process—often calling the other payer in the overlap—to ensure that the overlap is still active. Removing this manual step presents significant opportunities for savings.

For example, a regional plan with a rapidly growing Medicaid membership relied on phone calls to plans, recovery vendors and data from the state recovery vendors, data from the state, and phone calls to plans to find COB information. The quality of the data they received was poor and required extensive and expensive follow-up.

The plan audited data from their various data sources and determined which sources consistently sent high-quality data and which frequently required a second pass. Now, the plan can autoload data sent from the trustworthy sources (almost 85 percent of their data) directly into their system without performing any manual validation.

> By using standardized X12 270 inquiries, health plans can autoload overlap data into their claims systems with no further investigation.

CAQH recommends using standardized electronic transactions as the gold standard to validate coordination of benefits data. Since data can vary in quality, sending standardized X12 270 inquiries to both plans in an overlap is the easiest and best way to validate whether those overlaps are still active. If the 271 response confirms the overlap, plans can autoload this data into their claims systems with no further investigation, so it is available before claims come in.

Eliminate COB letters

Many plans rely on members to report coverage, but members are not the best source of COB information. They are typically unfamiliar with the process, and they may be unaware that they have other coverage or believe that disclosing this information will somehow be detrimental to them.

And COB letters are more expensive than you think. The cost of postage and processing fees necessary to get them out the door is just the beginning.

First, if a member receives this letter and is unfamiliar with the COB process, they will often call customer service to better understand what is being asked of them. Additionally, the response rate for these letters is very low, only 25 percent on average. Of those that do respond, many report incorrect information.

The total cost of the letters, follow-up and incorrect payments is more than $380 per member. These letters also significantly impact member experience.

One regional plan in the Northwest relied on letters to members to gather COB data. However, the low response and poor quality of the data it received created incorrect payments that were expensive to recover. The plan chose instead to collect COB data directly from other payers through the coordination of benefits solution from CAQH, which allowed them to eliminate their member letter program.

The change improved the member experience by taking members out of the COB process. In addition, the approach increased recoveries by 27 percent. The plan also avoided adding two staff members to its operations team that would have been necessary to keep up with its previous process, creating further savings.

$280

The total cost of a single COB letter, including follow-up and incorrect payments.

Pay claims correctly the first time

Identify primary and secondary coverage and determine primacy weekly, before claims are paid, to increase payment accuracy and reduce administrative costs associated with recovery.

CAQH COORDINATION OF BENEFITS

To learn more about how to build a proactive COB process, visit **caqh.org/COB**.