



CLAIMS COST MODEL CLEARINGHOUSE FOR THE BLUE SYSTEM

CONSORTIUM



HEALTH PLANS

consistent

A C C U R A T E

OBJECTIVE



Increasingly, health care consultants—and the employers they serve—have been raising the bar for information about provider network financial performance, asking carriers for data that meet a higher standard for accuracy and dependability. A sample fee schedule bears little relationship to what happens when actual claims are processed; self-reported data in a repricing exercise cannot present a reliable picture of health plan discounts. To address these issues, along with the need to provide consistent claims discount information across the Blue System, Consortium Health Plans took the initiative to find a solution.

Meeting the market demand for reliable information on provider network financial performance

With sales, marketing, claims, operations, and underwriting representatives from Blue Plans across the nation, a task force under the direction of Consortium Health Plans recommended a new approach to gathering, calculating, and reporting claims data, and developed the foundation and structure for a new cost model. Consortium Health Plans then engaged the services of Milliman USA, a leading actuarial firm with more than a decade of cost modeling experience.

Together, they created ClaimsQuest®, a revolutionary data warehouse and cost modeling system that quickly and accurately delivers provider network financial performance information based on actual claims paid—without projections, trend increases, actuarial manipulations, or other adjustments. Using a time-tested cost modeling methodology for this unprecedented system, Milliman collects and evaluates raw claims data and calculates experience-based charges and discounts.

Setting a new pricing standard with ClaimsQuest

Now one of the world's largest commercial claims data warehouses—with 1.5 billion claims records representing more than \$270 billion in claims expense—ClaimsQuest enables participating Blue Cross Blue Shield (BCBS) Plans to provide consistent information on provider network financial performance. As a third-party actuarial firm, Milliman not only brings methodology and data processing expertise but also delivers an important level of objectivity to the resulting cost model reports. Through ClaimsQuest, the BCBS System achieves a new level of responsive service to the national account marketplace and sets a new industry standard. The result is a methodology with more rigor, and information with greater validity.



Supporting better decision-making with better claims

Before ClaimsQuest, multi-state employers frequently had to settle for self-reported data of inconsistent quality. To support critical decision-making, pricing data must provide the basis for a true carrier-to-carrier comparison. To be reliable, it must be based not on a health plan's sample fee schedule but on actual claims paid. ClaimsQuest meets those criteria and enables employers to compare the economic value of health plan networks.

Historical methods—discounts by major service category, per diem, diagnosis related grouping (DRG) case rate, and hospital contract review—do not lead to consistent pricing or numbers that can be relied on to make assumptions about future costs. ClaimsQuest uses historical book-of-business claims data to create a unit-cost database. Raw claims detail can be compiled into various formats: cost model, inpatient major diagnostic category (MDC), inpatient DRG, and CPT-4 code listing.

Bringing actuarial expertise to network reimbursement evaluation and claims repricing

The ClaimsQuest cost model approach comes from a proven actuarial methodology. Similar cost modeling tools have long been used internally by carriers and by the actuarial firms themselves to understand and monitor health care costs. Milliman pioneered the concept of cost modeling to help health care providers better understand overall episode of care expenditures. Consortium Health Plans now takes this proven industry tool and applies it to claims cost analysis for the benefit of the large purchasers of health benefits.

Reflecting patterns of service to gauge actual utilization

All decisions surrounding the ClaimsQuest Cost Model methodology have been made to build a cost model that gets as close as possible to historical medical service utilization. ClaimsQuest:

- Only uses actual claims paid.
- Captures health care costs by member residence.
- Uses the average of what was paid across a geographic area.
- Defines service type uniformly and consistently applies the unit of service—whether it is a day, a visit, or a procedure.
- Reprices claims line by line

ClaimsQuest does not reprice a claim to a particular provider; it's based on a weighted average in a geographic area, which leads to better, more representative data. The repricing is very specific on the procedure and the geographic location, but not specific to a given hospital or physician.

By using the employee’s residential zip instead of the provider zip in the claims cost model, ClaimsQuest more effectively measures the costs associated with employees in specific geographic areas, no matter where they travel to receive care. The employee zip more accurately reflects true patterns of care and offers employers the most relevant information for their decision-making needs. This ability to closely capture the employee health care cost experience becomes particularly important considering the movement toward consumer-directed health care.



Following a disciplined approach.

Twice a year, all participating BCBS Plans submit their book-of-business claims data according to detailed specifications that ensure uniformity. An extensive integrity review takes place when the data arrive for processing. Once validated, the claims coding is reviewed for various types of claims, including reversals and adjustments. Any data issues and claims coding questions are addressed with the local Plans. The raw claims data are converted to standard cost categories and compiled into ClaimsQuest formats for PPO and POS networks, with the initial cost model results and zip code rollups reviewed by local BCBS Plan staff. The results are then finalized and made available for use by the BCBS Plans.

Claims are mapped to cost model categories using defined and consistent criteria, relying primarily on HCFA revenue codes for facility claims and CPT-4 codes for professional claims. When ClaimsQuest certified data go to the marketplace, consultants and employers alike know that it carries a stamp of consistency and credibility based on a rigorous third-party methodology and eight-step data collection and validation process.

ClaimsQuest incorporates a strict data collection and validation process, resulting in reliable information, certified by an objective third party.

8 Step Collection & Validation Process



Providing a Powerful New Tool for Consultants

ClaimsQuest enables efficient responses to consultants' discount RFIs and individual employer RFPs. Consultants can call upon a Blue Plan representative at any time during the RFP process—before, during, or after—whether it is for client reporting, information to advise a client on relative carrier performance, or repricing a claims tape. While ClaimsQuest was developed to bring unprecedented speed and reliability to the proposal process, the Blue Plans can also use it to respond to complex ad hoc questions quickly and effectively. In addition, BCBS Plans can use ClaimsQuest data internally to evaluate their provider network financial performance and discounts on an ongoing basis and, in doing so, continue to provide the marketplace with the best network value.

Delivering pricing insight through a variety of reports

BCBS Plan representatives have access to four different types of reports that demonstrate the economic value of the BCBS provider networks. They pull from this information to populate consultant templates and answer specific questions. The Cost Model Report is the foundation report, with three additional reports: CPT-4 Code Listing, DRG Module, and MDC Module. Customized claims repricing services are also available, along with responses to ad hoc queries.

Inpatient MDC summaries for each metropolitan statistical area (MSA) map inpatient claims to one of 25 unique categories based on primary diagnosis code on the claim record. These summaries show utilization, average length of stay, case rates, and per diems (both billed and allowed) for each MDC. The DRG module is derived from the MDC values. For all DRGs included in an MDC category, amounts are calculated based on Milliman's utilization assumptions and HCFA DRG cost weights. Cost detail information can be examined at increasing degrees of granularity from the national, state, MSA, and three-digit zip level. With every report comes an evaluation of data credibility—high, moderate, minimal—based on the total number of claims.

As a result, the compiled data reflect actual distribution of utilization among BCBS contracted providers. The information is experience-based and reflects what happens to claims in the real world, reflecting provider stop loss provisions, manual claim adjustments, prompt pay discounts, and other provider arrangements. Repricing exercises are therefore reliable surrogates of what really would have happened if BCBS had been the carrier during the time period.

◀ **Four levels of data: Reports generally present state-by-state information, but data can be rolled up to provide national totals or drilled down to the MSA and 3-digit zip levels.**

NATIONAL

STATE

MSA

ZIP

ClaimsQuest Delivers Accurate Repricing Comparisons

Category	Billed	Incumbent Carrier Allowed	BCBS Allowed	Savings*	Incumbent Carrier Discount	BCBS Discount
Inpatient Hospital	\$ 7,831,689	\$ 5,515,761	\$ 4,030,317	\$ 1,485,444	29.6%	48.5%
Outpatient Hospital	7,254,783	5,688,195	4,320,267	1,367,928	21.6%	40.4%
Physician	8,972,422	7,148,774	5,473,598	1,675,176	20.3%	39.0%
Ancillary	629,067	587,789	460,623	127,167	6.6%	26.8%
Total	\$ 24,687,961	\$ 18,940,519	\$ 14,284,804	\$ 4,655,715	23.3%	42.1%

*Before any benefits are applied.

This comprehensive report shows charges and discounts for PPO/POS networks across 47 service categories. With this valuable decision-support tool, consultants and employers can get an accurate view of Blue Cross Blue Shield pricing and instantly compare discounts between a BCBS Plan and an incumbent carrier.



ClaimsQuest® Cost Model Format Blue Cross and Blue Shield of XXX PPO

Benefit Category

Hospital

Hospital Inpatient
Medical/Surgical
Psychiatric and Alcohol & Drug Abuse
Skilled Nursing Facility
Maternity

Hospital Outpatient
Emergency Room
Surgery

Radiology
Pathology
Cardiovascular
OT/ST

Therapy
Cardiac Rehab
Dialysis
Psych Facility
Pharmacy
Maternity Non-Deliveries

Surgery - Non-Maternity
Primary Surgeon
Assistant Surgeon
Anesthesia

Normal Deliveries
Cesarean Deliveries
Non-Deliveries

Utilization	Units	Average Billed Charge	Average Allowed Charge	% Discount Off Billed
88,109	Days	\$ 2,882.07	\$ 1,035.49	64.1%
6,720	Days	1,109.03	422.84	61.9%
-	Days	416.86	287.69	31.0%
13,301	Days	2,713.70	1,432.37	47.2%
108,130	Days	\$ 2,751.17	\$ 1,046.23	62.0%
41,896	Cases	\$ 510.15	\$ 263.87	48.3%
23,255	Cases	2,506.19	876.72	65.0%
83,945	Services	389.59	242.20	37.8%
266,068	Services	53.28	29.65	44.3%
16,684	Services	365.42	164.52	55.0%
59,730	Services	80.22	46.06	42.6%
23,257	Services	340.20	194.44	42.8%
2,276	Services	125.50	79.60	36.6%
1,366	Services	3,711.70	1,253.15	66.2%
4,749	Services	201.64	95.13	52.8%
21,370	Services	458.47	247.02	46.1%
435	Services	260.19	191.09	26.6%
545,031	Services	\$ 296.42	\$ 141.99	52.1%
23,199	Procedures	\$ 2,778.77	\$ 928.09	66.6%
1,756	Procedures	1,533.96	437.17	71.5%
12,903	Procedures	1,241.71	73.15	94.2%
37,858	Procedures	\$ 2,197.44	\$ 73.15	96.7%

HIGHLY CREDIBLE

More than 5,000

MODERATELY CREDIBLE

2,000 - 5,000

MINIMALLY CREDIBLE

Under 2,000

ClaimsQuest Data Credibility Based on Inpatient Days

Data thresholds also exist to assign credibility levels based on the number of cases and procedures, the other two units of service.

Benefiting from Total Value Purchasing

In the absence of reliable network charge and discount information, employers have relied heavily on the fixed monthly administration costs when comparing the prices of various health carriers. Administrative fees, however, only represent a small fraction of the employer's financial exposure, accounting for less than ten percent of the total cost. In an organization with annual health care expenditures of \$100 million, the cost of claims paid can account for as much as \$91 million, as compared to administrative costs of \$9 million.

Two closely related factors have significantly more impact on the employer's actual costs: the size of the provider network and the depth of the negotiated provider discounts. The larger the carrier's provider network, the better the employees' access to care and the easier it is for them to remain in network. In turn, the size of the network and the strength of local relationships leads to a better position for negotiating favorable discounts. With a higher selection of in-network physicians, the employer benefits from subscriber utilization at deeply discounted reimbursement rates.

ClaimsQuest brings into clear focus the two factors with significantly more impact on the employer's actual costs. A sample fee schedule cannot reliably predict the actual cost of claims paid, because it cannot take into consideration the value and the performance of the provider network. ClaimsQuest brings visibility to the concept of Total Value Purchasing and makes it possible for employers to have a more accurate picture of health benefit costs.

Total Value Purchasing Formula



TAKING THE GUESSWORK OUT OF CLAIMS COST ANALYSIS

With ClaimsQuest, Consortium Health Plans addresses a major marketplace need for dependable information about provider network financial performance. ClaimsQuest creates a picture of what the Blue networks can deliver based on past performance. ClaimsQuest delivers on every attribute for data.

- **COMPLETE** ClaimsQuest provides in-network and out-of-network data for all 50 states in three-digit zips and MSAs.
- **ACCURATE** ClaimsQuest calculates discounts based on historic claims data. Working with claims actually paid results in real-world information that allows employers to project claims costs with confidence. Because the figures used for provider network charges and discounts serve as the basis for other calculations in an RFP, ClaimsQuest provides a reliable foundation for the entire proposal.
- **ROBUST** The sheer size of the ClaimsQuest data warehouse means that it generates information with a high degree of statistical accuracy.
- **CONSISTENT** The ClaimsQuest methodology is the same for every Blue Cross Blue Shield Plan, and the same data criteria are applied across every state, every MSA, every zip code.
- **CLEAR** ClaimsQuest user-friendly reporting makes it quick and easy to provide consultants and employers with the straightforward information they need in any format they prefer, knowing that the data hold true from market to market.
- **FLEXIBLE** The ClaimsQuest model not only works effectively for every Plan in the Blue System, it also applies to other carriers. Applying the ClaimsQuest cost model to all carriers permits an “apples-to-apples” comparison.
- **FAST** The ClaimsQuest system is fully automated and capable of turning around consolidated responses to standard RFP requests quickly.
- **OBJECTIVE** The ClaimsQuest cost model approach uses time-honored and tested actuarial principles. Milliman provides third-party verification of every report generated.

■ **CONFIRMED**

Just how good is the ClaimsQuest cost model approach? In empirical testing of results for several large national organizations totaling more than \$500 million in claims, ClaimsQuest repricing proved itself to be an excellent predictor of actual performance. In three separate tests, actual claims costs were within a range of .1 to 1 percent of the repricing exercise.

Setting a new standard for the Blue network...and the

ClaimsQuest brings an unparalleled consistency and reliability to measuring the performance of the Blue Cross Blue Shield provider networks throughout the country. As an industry standard, ClaimsQuest can also provide an objective experience-based means for comparing discounts among carriers. Furthermore, ClaimsQuest offers an important backend delivery benefit by assisting BCBS clients in understanding health care costs associated with their workforce. Through the development and management of ClaimsQuest, Consortium Health Plans brings a new rigor to the process of claims cost analysis.

Milliman brings discipline and third-party objectivity to the process, through its involvement at every stage of ClaimsQuest development and implementation—from the creation of the cost model itself to the specification of data requirements, from the management of data collection and validation to the ultimate delivery of the BCBS Plan data in consistent ClaimsQuest formats.

ClaimsQuest has been market-tested for two years, revealing itself to be reliable and credible. Moreover, ClaimsQuest makes it possible for BCBS Plans to demonstrate the superior value of the Blue System through the real-world performance of its provider networks and the savings they represent for employers.

With ClaimsQuest, multi-state employers and the consultants and brokers who represent their interests, have the ability for the first time to evaluate network financial performance and compare carrier costs. ClaimsQuest represents a new starting point for understanding the cost of health care and a reliable framework for decision-making.

health care industry.

ROBUST

complete



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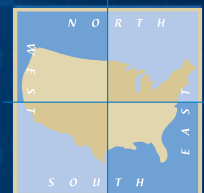
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