Bloomberg BNA

Pension & Benefits Daily ™

Reproduced with permission from Pension & Benefits Daily, 12 PBD 114, 06/14/2012. Copyright © 2012 by The Bureau of National Affairs, Inc. (800-372-1033) http://www.bna.com

Why State All-Payer Claims Databases Matter to Employers

BY PATRICK MILLER

In less than a decade, all-payer claims databases (APCDs) have proven their value to state policymakers, researchers, consumers, and employers. This paper focuses on the value to employers and employer coalitions, both of which have been using claims data for many years to address cost, quality of care, employee wellness, and access. In addition to internal databases and carrier-supplied reports, APCDs are another tool available to employers and coalitions.

APCD Council Definition of an APCD

An APCD is a database, created by state legislative mandate, that typically includes data derived from *medical, pharmacy, and dental claims, combined with eligibility and provider* files from private and public payers, including insurance carriers (medical, dental, third-party administrators, pharmacy benefit managers, and public payers (Medicaid, Medicare).

APCDs are often managed by a state insurance department, health department, Medicaid agency, or state health data organization. In some states, there is joint management across agencies. In Colorado, a nonprofit entity was designated to be the entity responsible for the APCD operations.

Patrick B. Miller (patrick.miller@unh.edu) is the co-founder of the APCD Council and a research associate professor at the University of New Hampshire's New Hampshire Institute for Health Policy and Practice. The APCD Council (www.apcdcouncil.org) is a learning network co-managed by UNH and the National Association of Health Data Organizations.

States typically develop their legislation to collect data on all residents, for both fully insured and self-funded lines of business. The data is generally collected on a monthly basis from commercial payers and state Medicaid agencies. Several states have also added Medicare claims, and there is work under way with the federal Centers for Medicare and Medicaid Services to make Medicare data more easily accessible to states.

Data release of collected information is controlled by each state through release rules or legislation, and to date, all states have chosen to release data in a de-identified fashion. Some states must encrypt patient identifiers, whereas others have the ability to collect full patient identifiers, which allows for linkage to other platforms such as health information or insurance exchanges. It is expected that states will develop combined policies in the future that address the issues associated with data linkage and release.

Most states also have thresholds so that if a carrier has fewer than a certain number of lives, they do not need to report.

What They Said

'Indicator Information Is a Public Good'

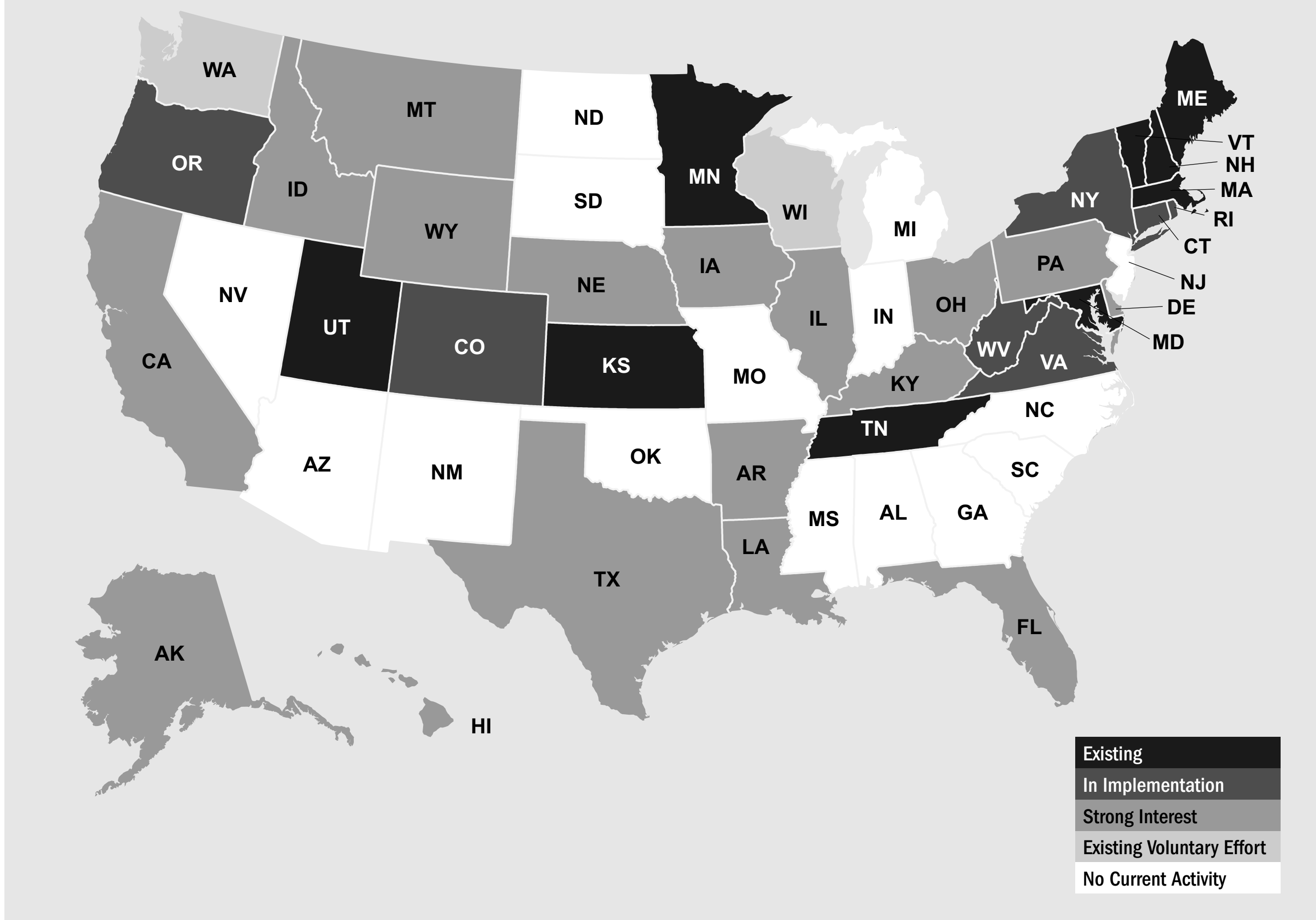
"Health care performance indicator information is a public good, whereby all patients, purchasers, and providers should have access to a common set of performance information. It is imperative that there be platforms developed to ensure standardized accountability in the marketplace with common performance metrics that will help all stakeholders and reduce information inefficiencies. Given the widespread variation in the practice of medicine, there is a defined need for aggregating claims information at both the physician and practice levels."

—Ted von Glahn, senior director, Pacific Business Group on Health

National Status of APCDs

While some states have had versions of APCDs for more than 20 years, the majority of the systems have been created since 2003. These are primarily state-mandated systems (exceptions are Washington and Wisconsin) under way in more than a dozen states shown in Figure 1. The states with active systems in-

COPYRIGHT © 2012 BY THE BUREAU OF NATIONAL AFFAIRS, INC. ISSN



Source: 2009-2012 APCD Council, a collaboration between the University of New Hampshire and the National Association of Health Data Organizations.
All Rights Reserved A BNA Graphic/den358g1

clude Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Tennessee, Utah, and Vermont. States currently implementing systems include Colorado, Connecticut, New York, Oregon, Rhode Island, Virginia, and West Virginia. Iowa and Texas have had study bills within the past two years, and Hawaii attempted legislation in 2010 and is likely to propose it again in the future. Legislation and study committees are currently being considered in several other states, and work groups have formed in others—these are indicated as the ''strong interest'' states on the map.

Historical Employer Use of Claims Data

Employers and employer coalitions (used interchangeably unless specified in this paper) have been using claims data for decades to drive decisionmaking. These include large individual (often self-funded) corporations as well as employer coalitions, such as the California Public Employees' Retirement System (CalPERS), the Pacific Business Group on Health, Health Action Council Ohio, the New Hampshire Purchasers Group on Health, and the Maine Health Management Coalition.

Historically, larger, self-funded employers in the early 1990s required their TPAs and carriers to deliver reports and data feeds to the employer or their broker for analysis. As carrier analytics became more sophisticated, they began to develop web portals for their customers for easier access to the information. Some offered benchmarking tools with geographic and other comparison information.

Today, these web portals vary in level of sophistication and typically focus on areas of quality, access, utilization, and cost. Many employers still also outsource their claims data analysis to a broker or one of many analytics firms that will provide risk adjustment, risk stratification, benchmarking, episode grouping, and other services. Many of the reporting tools developed for commercial carriers have been re-purposed for use by employers. APCDs provide a new data source to either augment or replace existing sources.

Benefits of All-Payer Claims Databases To Employers

When APCDs were first developed, they were primarily viewed as tools to be used by state agencies (public health, insurance, Medicaid) and health services researchers. Quickly, they became more robust with the development of consumer-facing information and the

 COPYRIGHT © 2012 BY THE BUREAU OF NATIONAL AFFAIRS, INC.

Figure 2
NH Health Cost

Detailed estimates for Hernia Repair (outpatient)

Procedure: Hernia Repair (outpatient)
Insurance Plan: Anthem - NH, Health Maintenance Organization (HMO)
Within: 50 miles of 03824
Deductible and Coinsurance Amount: $500.00 / 10%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity
LAKES REGION GENERAL HOSPITAL	$768	$2419	$3187	MEDIUM	MEDIUM
SPEARE MEMORIAL HOSPITAL	$832	$2988	$3820	HIGH	VERY HIGH
CATHOLIC MEDICAL CENTER	$894	$3547	$4441	HIGH	VERY LOW
SOUTHERN NH MEDICAL CENTER	$911	$3701	$4612	LOW	VERY LOW
FRANKLIN REGIONAL HOSPITAL	$934	$3915	$4849	MEDIUM	VERY LOW
ELLIOT HOSPITAL	$939	$3956	$4895	MEDIUM	LOW

Source: www.nhhealthcost.org A BNA Graphic/den358g2

What They Said

CalPERS Finds Claims Database 'Invaluable'

"CalPERS has been using a claims database for several years, and we've found it invaluable as a means to inform our benefit change and rate negotiation strategies. While each of our plan partners has the ability to perform robust data analysis on their segment of our members, evaluating our entire membership across carriers has provided us with invaluable insights about our overall population. We are deeply committed to the health of our members, and our decision support system is an integral part of our ability to fulfill that commitment."

—Ann Boynton, deputy executive officer, benefit programs policy and planning, CalPERS

adoption by employers in the Northeast. Claims data are available for an individual employer, comparatively across employers within coalitions, and normatively compared to state or regional data. Studies have now been done looking across states as well.

Figure 2 shows a snapshot of a consumer website called NH Health Cost, whereby the user selects his or her carrier, the procedure needed, and then is shown what the actual paid amounts are depending on which provider is seen. In the example shown for a hernia repair, there is a $1,700 difference in price between providers shown. The methodology is based upon episodes so as to not release true provider-payer contractual amounts. It is useful especially for employees with higher cost-sharing (deductibles and coinsurance) or those with high-deductible plans. One employer has now customized this site for its own population and carrier as a way to educate its employees on cost.

APCDs can be used to examine information about utilization, quality, preventive services, and pricing. The data can be run for an employer, a geographic region, a state, a provider, or across state lines. The following list contains a sample of reports generated for employers using APCDs:

- demographic analyses;
- medical volume, cost by age and gender;
- service location, cost;
- service type, volume, medical cost;
- major diagnostic categories, volume, cost;
- major diagnostic categories for inpatient stays, volume, facility cost;
- major diagnostic categories, volume, cost among high-cost claimants;

Figure 3
New Hampshire Hospital Ratings
Sorted by Highest Rated

Source: www.nhpghscorecard.org A BNA Graphic/den358g3

What They Said

Organization Uses Information for Benchmarking

"The NH Purchasers Group on Health has benefited from access to claims information for the benchmarking of our population against other NHPGH members, the entire commercial population in the state APCD, as well as against similar employers in our neighboring state of Maine. What we have accomplished by this benchmarking is a greater understanding of where to focus our attention for improving our health and wellness programs, as well as understanding where we stand in terms of cost, utilization, and quality metrics."

—Sandra Marquis, University System of New Hampshire Benefits

■ top diagnoses by cost;

■ top diagnoses by utilization;

■ top diagnoses by encounters;

■ high-cost claimant analysis;

■ top providers by cost by acute-care hospital, outpatient-only facility, and other nonfacility;

■ top providers by cost within region by acute-care hospital, outpatient-only facility and other nonfacility;

■ top laboratory, radiology, and surgical procedures by cost;

■ preventive care prevalence;

■ pharmacy volume, cost by age and gender;

■ drug type, volume, cost;

■ top pharmacy costs by drug classes and individual drugs; and

■ top pharmacy classes by cost among high-cost claimants.

Figure 3 is a snapshot from a hospital employer report card used in New Hampshire (modeled off of one developed first in Maine). The "$" in the last column is

COPYRIGHT © 2012 BY THE BUREAU OF NATIONAL AFFAIRS, INC.

Figure 4

New Hampshire vs. Out-of-State Spending by Carrier

2009 Commercial Membership

Health Insurance Carrier	Location of Care Provided	Average Membership	Patients	Patients as a Percent of Membership	Percent of Allowed Dollars	Payments per Patient	Average Risk Score
Anthem–NH	MA	161,556	23,561	15%	10%	$2,472	1.30
	NH		166,260	103%	85%	$3,047	0.91
	Other		38,663	24%	5%	$838	1.21
Totals/Overall Average						$2,614	1.00
HPHC	MA	95,662	19,552	20%	12%	$2,053	1.32
	NH		96,064	100%	84%	$2,949	0.90
	Other		15,096	16%	5%	$1,011	1.24
Totals/Overall Average						$2,591	1.00
CIGNA	MA	45,560	13,667	30%	12%	$1,525	1.23
	NH		46,630	102%	77%	$2,919	0.87
	Other		25,334	56%	11%	$743	1.12
Totals/Overall Average						$2,053	1.00

Source: NH Insurance Department, www.nh.gov/insurance/lah/documents/nhid_oos_study080210.pdf A BNA Graphic/den385g4

driven from an annual report created by the New Hampshire Insurance Department that shows price variation across all of the hospitals in the state. This report shows an approximately 70 percent pricing differential (paid, not charges). It is also used to drive a small-group, tiered-provider insurance product mandated by legislation to be offered in the marketplace.

Population Health and Transparency

Both employers and their employees recognize that there is value to a healthy workforce: reduced utilization, increased employee productivity, and a slowing medical cost trend are all goals of having a healthy population. Many of the APCD uses to date have been from state public health and Medicaid programs. Data provided has focused on:

- disease prevalence,
- wellness measures,
- cost and utilization measures,
- dental access, and
- access to quality hospital services.

Transparency comes in many forms. Websites for consumers, wellness measures, and cost and utilization measures are all examples. Additionally, Figure 4 shows information provided by the New Hampshire Insurance Department. The report is intended to highlight in-state versus out-of-state spending by carrier, but it also provides a risk score for the populations measured. For all three carriers listed, the patients receiving care in Massachusetts versus New Hampshire have a higher risk score, yet the payments per patient are lower in all cases. It is theorized that this is due to better carrier discounts in Massachusetts. A report like this can be used by an employer to compare itself with other employers, statewide norms, or across geographies.

What They Said

Every State 'Needs to Implement an APCD'

"HAC's employer members, such as Progressive Corp., Sherwin-Williams, and Nationwide, are self-insured and have an increasing need to pay for value, as measured by outcomes, not for procedures or process. Our members do not currently have this information available from a single employer, single health plan, or even a large coalition. To have sufficiently reliable data to measure what matters, such as emergency room visits, drug adherence, and readmissions, Ohio (and every state) needs to implement an APCD."

—Barbara Belovich, executive director, Health Action Council Ohio

Future Opportunities and Final Thoughts

- Both the health information technology and health data analytics spheres are moving at a rapid pace. From large capital infusions of funds provided for under the American Recovery and Reinvestment Act of 2009 to physicians, hospitals, and other providers to support investment in electronic health records (EHR), ePrescribing, and health information exchanges to the use of advanced analytic tools that enable employers to stratify risk, identify cost-effective and high-quality providers, and implement health and wellness activities, there is much that is coalescing on behalf of employers and their employee populations.

- There is also growing awareness that many of the stand-alone data sets, including APCDs, hold greater promise if the data can be linked and integrated. The future for health care data sets is not merely having access to disparate data sources (claims data, health information exchanges, patient registries, etc.) but having the ability through state and federal policies to provide sophisticated data analytics via data set linkages.

■ Given that APCDs gather not just commercial claims but also claims data for Medicaid and Medicare recipients, there is an opportunity for employers to gain a better understanding of the cost-shifting that takes place within the marketplace. Much of the analysis done in states to date has examined price variation within the commercial marketplace and Medicaid, but not across all residents.

■ Finally, APCDs are only as useful as state policies allow. Because these databases are promulgated via state legislation and rulemaking, there are some limitations. Not all states allow for the collection of unencrypted patient identifiers, which results in difficulty doing the linkages mentioned above. Additionally, the eligibility records do not currently contain premium (or premium-equivalent) information, nor do they contain benefit information. These data are sometimes collected by states via supplemental reporting requirements, yet are not linked directly to the APCD. Such information would allow employers to gain a better sense of how their benefits compare with those of other employers, and how premiums (or equivalents) compare. Additionally, there are fiscal transactions between payers and providers that are not recorded in claims (pay-for-performance bonuses, enhanced payments for medical homes, capitation settlements, etc.). It is envisioned that a supplemental fiscal file ultimately will be part of state APCDs in order to capture a truer understanding of pricing transparency.

For each of the above items, there is a role for employers to play in supporting their advancement.

There are multiple reasons why APCDs have been developed. Historically, there has been high interest from legislatures, health departments, insurance departments, and other governmental agencies in creating a source of data for overall health care transparency. In one state, a provider organization has been the driving factor. There is an opportunity for employers to be driving the development of APCDs.

Regardless of where the initial support comes from, it is key that employers be at the table from the earliest conversations through implementation due to the fact that they are not only a consumer of data but ultimately may be one of the strongest advocates. In several pieces of legislation regarding APCDs passed in recent years, employers have been specifically noted in the legislation as core members of the APCD governance structure. This is not only good news for employers, but it also makes good sense.

COPYRIGHT © 2012 BY THE BUREAU OF NATIONAL AFFAIRS, INC.
ISSN