APCD COUNCIL

All-Payer Claims Databases: Current Status and Future Directions

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APCD All-Payer Claims Database COUNCIL

About the APCD Council

The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

Our Work

- Early Stage Technical Assistance to States
- Shared Learning
- Catalyzing States to Achieve Mutual Goals
- Advocacy for State and Federal policies

What is an All-Payer Claims Database (APCD)?

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Databases, created by state mandate, that typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:

- Insurance carriers (medical, dental, TPAs, PBMs)
- Public payers (Medicaid, Medicare)

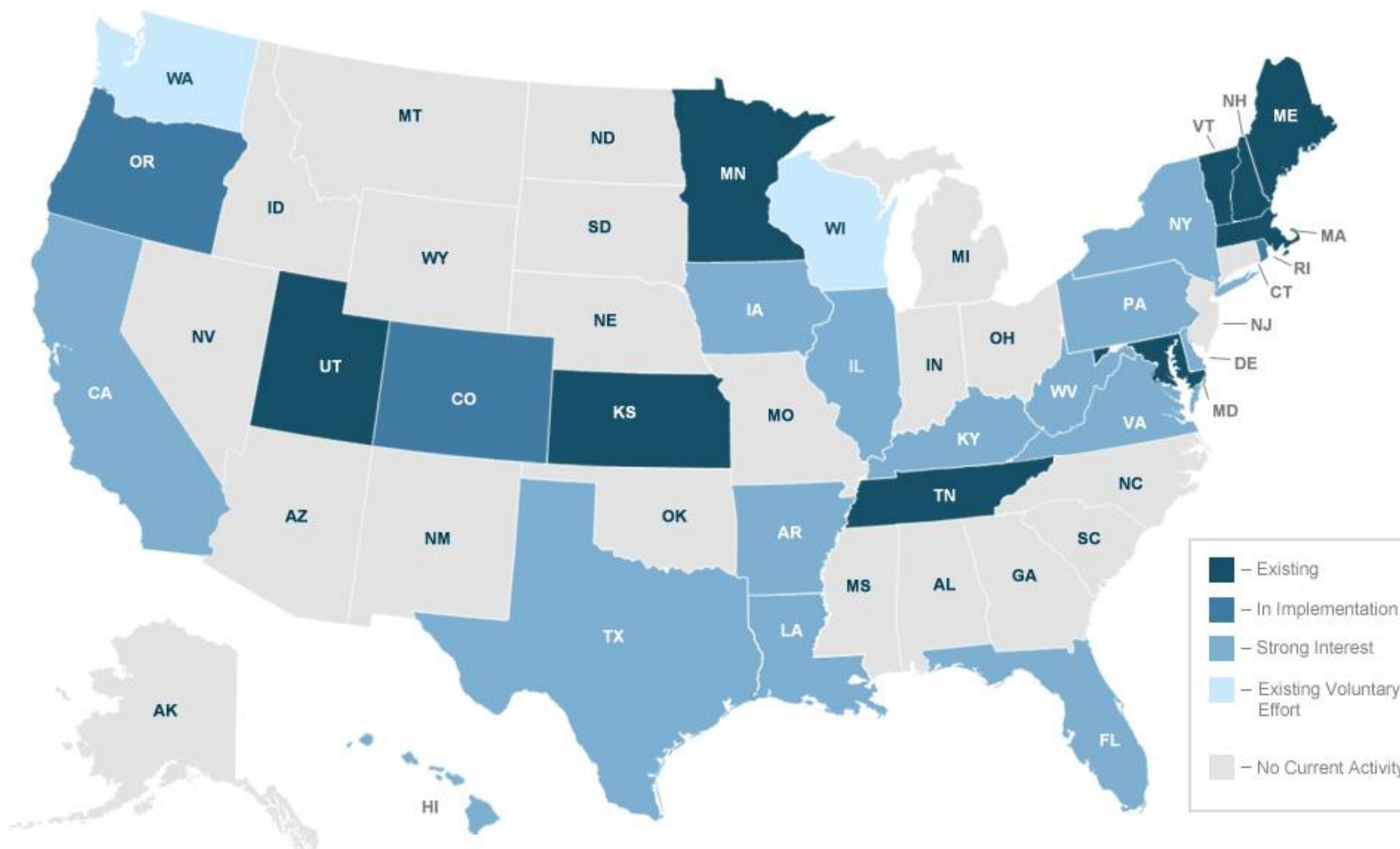
APCD Global "Business Case" for States

APCD All-Payer Claims Database COUNCIL℠

- APCDs provide an understanding for a broad set of the state's insured population.
- APCDs are filling critical information gaps for state agencies.
- APCDs build off of experience with and supplement other healthcare data systems.

March 2011 State Progress Map

APCD All-Payer Claims Database COUNCIL



December 2013 State Progress Map

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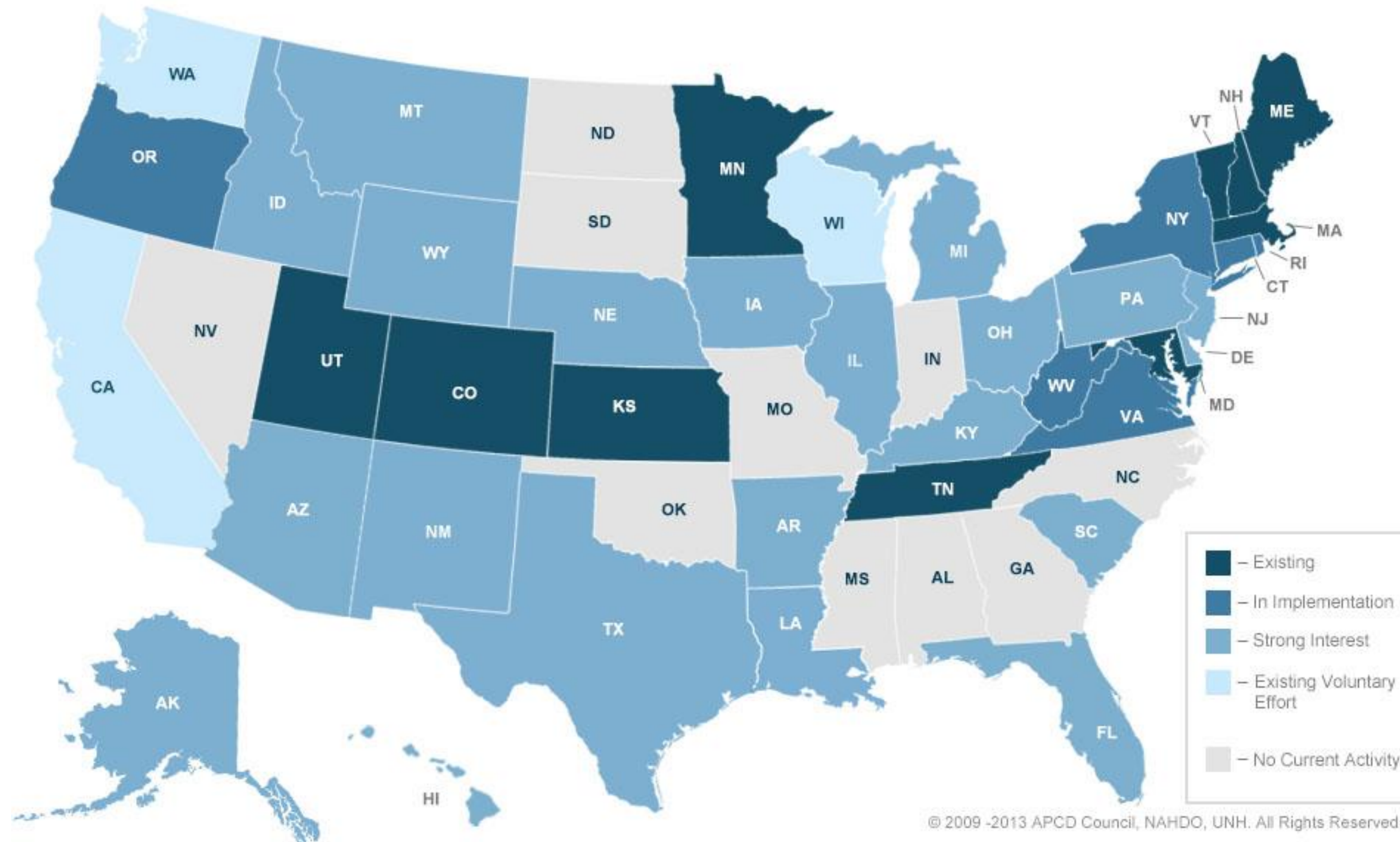

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May 2016 State Progress Map

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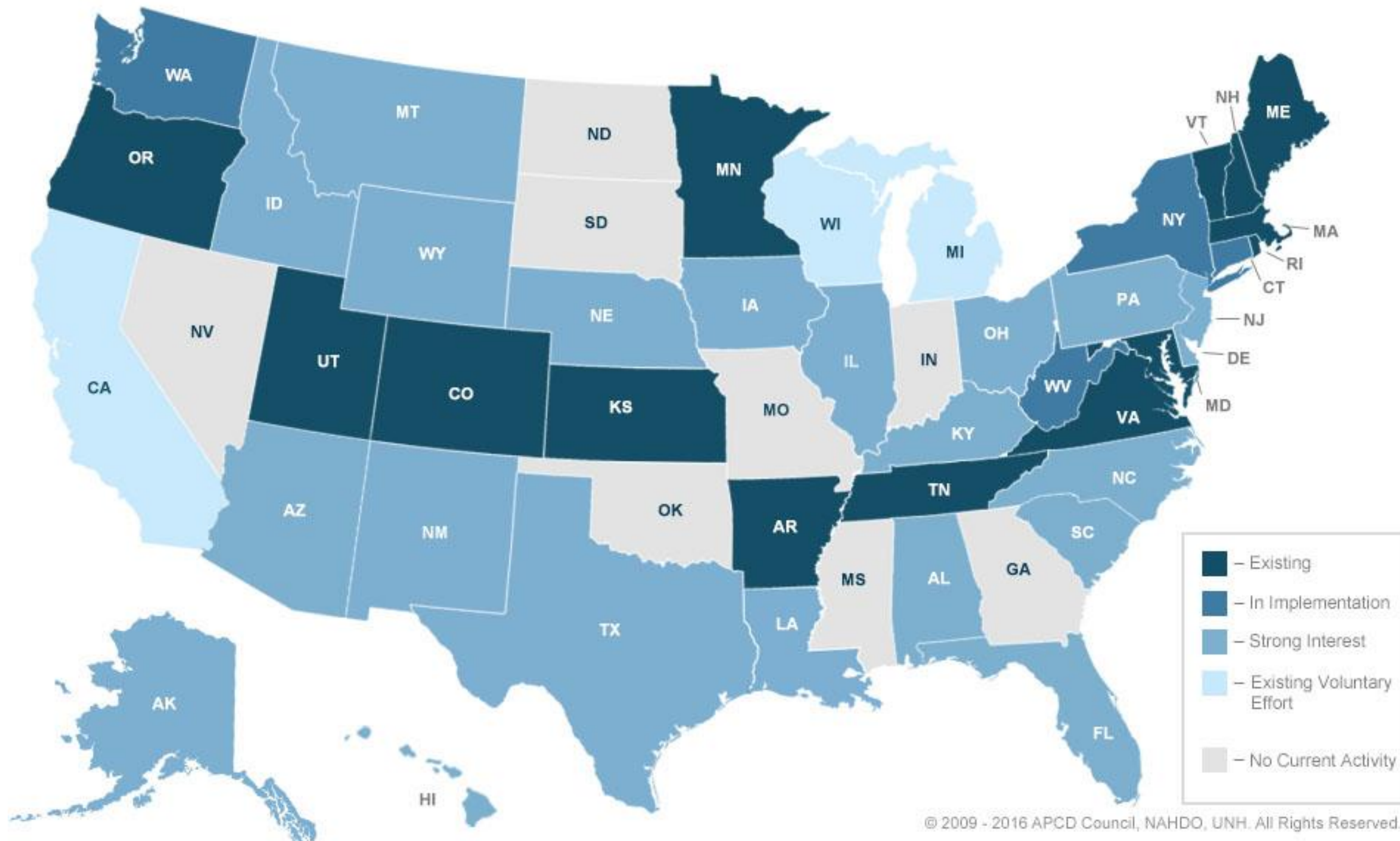

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March 2019 State Progress Map

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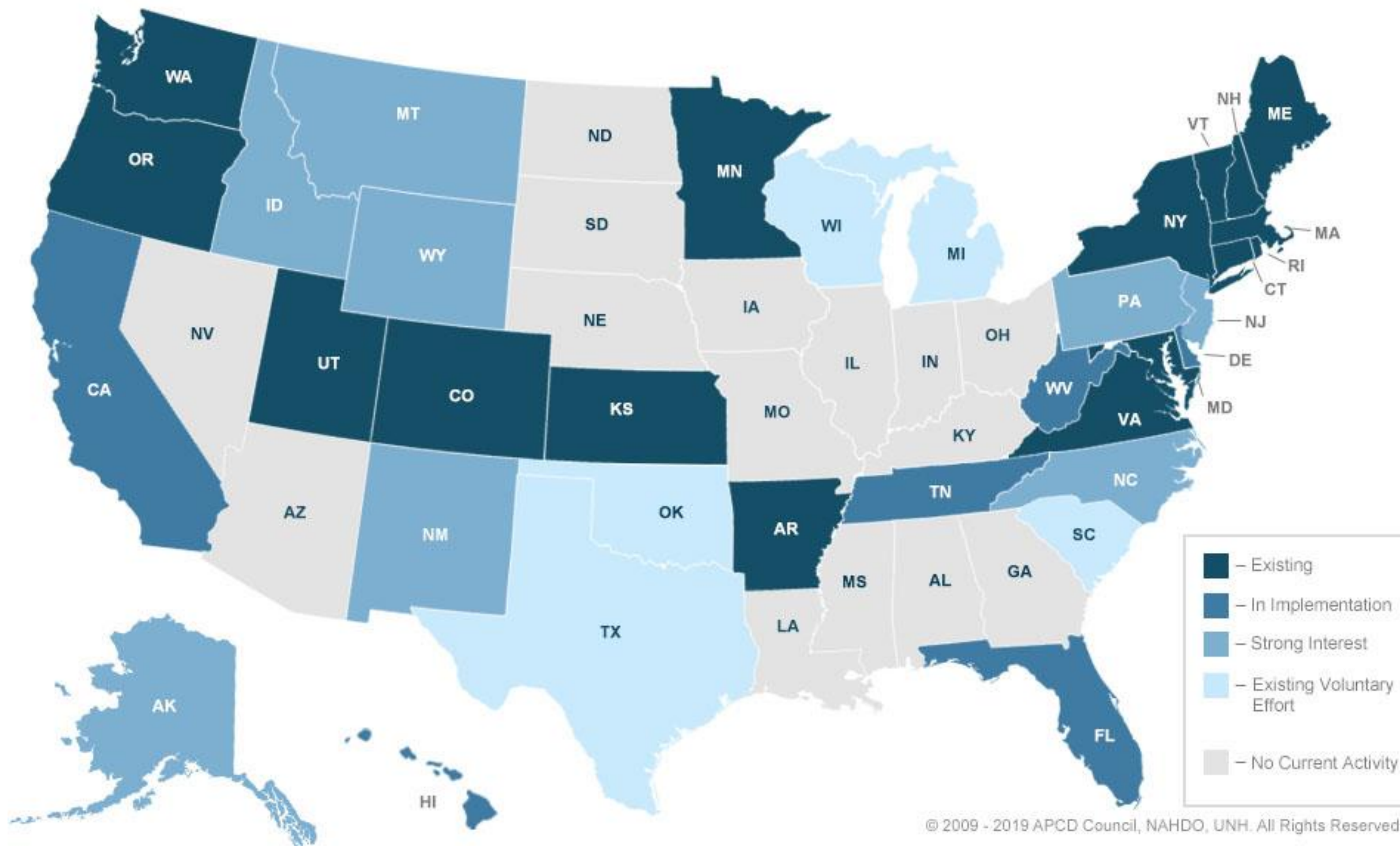

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Typically Included Information

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- Social Security Number (often encrypted)
- Patient demographics(date of birth, gender, residence, relationship to subscriber)
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator / other Rx
- Revenue codes
- Service dates
- Service provider (name, tax id, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan charges & payments
- Member liabilities (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type
- Other 835/837 fields

Typically Not Included Information

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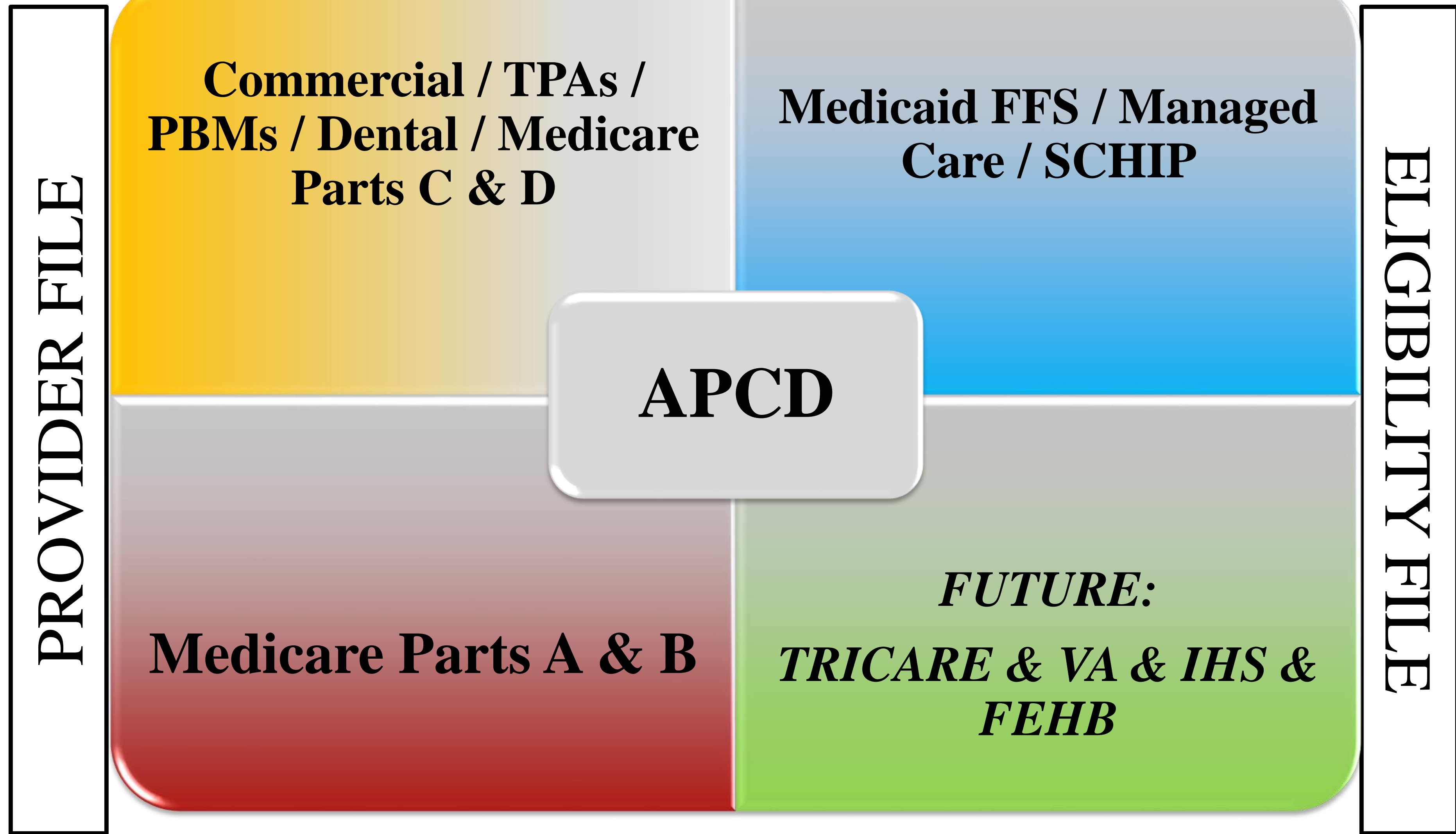
- Services provided to uninsured
- Denied claims
- Workers' compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- Premium information*
- Alternative payment models*

* States exploring/piloting collection

Typical APCD Data Sets

APCD COUNCIL All-Payer Claims Database



Framework for APCD Development

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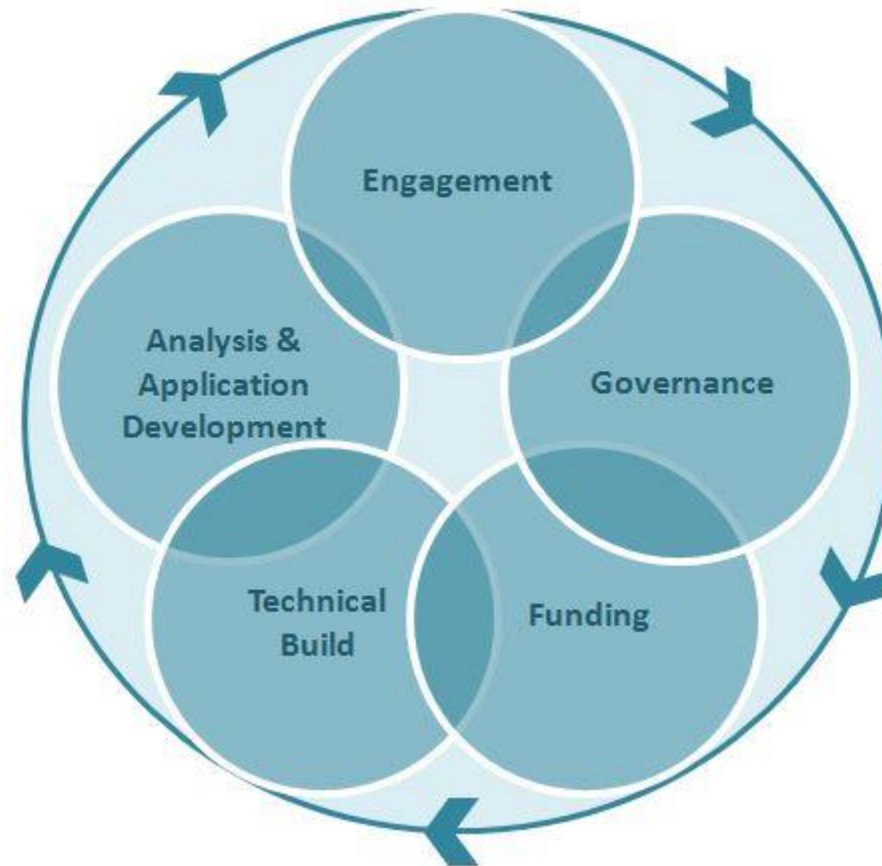

Lessons Learned by States

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- Develop Multi-Stakeholder Approach
    - Form Provider Relationships
    - Form Payer Relationships
- Be Transparent and Document
- Understand Uses and Limitations
- Seize Integration and Linkage Opportunities
- Develop Use Cases

Something for Everyone….

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- **Providers:**
  - Quality and utilization of provider and peer group care
  - identify and monitor quality improvement projects.
- **Payers:**
  - Comparative performance of provider networks to statewide benchmarks
  - Identify variation in utilization and cost efficiency.
- **Employers:**
  - Increased transparency in the cost and utilization of health care to stabilize the cost of health coverage for employers.
  - Larger population/sample size and benchmarks.
- **Policy Makers:**
  - Inform support public policy with information on how the health care system is operating and support data-driven improvements in access, quality and cost of healthcare.
- **Public Health Practitioners:**
  - Variation in utilization of health care services to target "hot spot" opportunities to improve population health
  - Cost burden of chronic diseases such as diabetes, cardiovascular disease and asthma.
  - Evaluate public health programs

State Use Case Examples

APCD COUNCIL All-Payer Claims Database SM

- Understanding overall and categorical costs for care (e.g., CO, NH, ME, VT, UT, MA, MD)
- Consumer tools (e.g., MA, NH, ME)
- Intrastate cost variation (e.g., CO, ME, NH, VT)
- Benchmarks for purchasers (e.g., NH)
- Medical home evaluation (e.g., VT, NH)
- Accountable care – regional cost profiles (e.g., NH)
- Risk assessment (e.g., MA)
- Population health and management (e.g., OR, MA, NH)
- Low value services and waste calculators (e.g., VA, MN)
- Opioid patterns of prescribing/use (e.g., AR, UT)

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APCD Showcase
ALL-PAYER CLAIMS DATABASE

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presented by the APCD Council

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APCD Showcase: States Leading by Example

Welcome to the APCD Showcase where examples from state all-payer claims databases (APCDs) have been organized in order to provide stakeholders with tangible examples of APCD reports and websites. The examples have been organized by intended audience, and are also searchable by additional criteria. We invite you to explore the site and learn more about the value that APCDs provide to states and their stakeholders.

Choose from the categories below or See all Case Studies >

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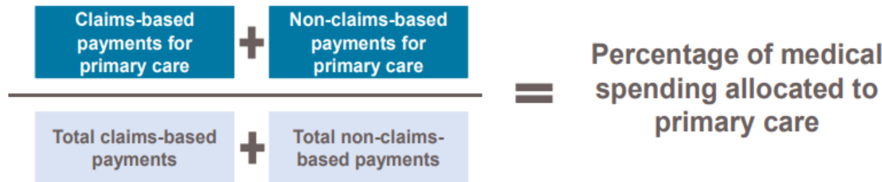
Estimate of Primary Care Spending: OR

APCD COUNCIL All-Payer Claims Database

Primary care spending: What's included?

To calculate the percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to prima providers is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated below). As the denominator, total include all payments for members including specialty care, mental health care, hospitalizations and more. However, total payments do not include drugs.



Claims-based payments

Payments to primary care providers and practices:

Primary care providers
- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic providers
- Physicians' assistants, and
- Nurse practitioners

Primary care practices
- Primary care clinics
- Federally qualified health centers (FQHCs), and
- Rural health centers

For primary care services:
- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery, and
- Other preventive medicine

Non-claims-based payments

Payments to primary care providers and practices:
- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home centered medical home recognition
- Payments to reward achievement of quality or cost goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers

Per-member per-month (PMPM) primary care spending

In 2016, the average PMPM primary care spending for commercial plans was $44. The carriers' spending ranged from $13 PMPM to $67 PMPM. Among most carriers, the proportion of total primary care that is non-claims-based is less than 1 percent

	PMPM primary care	PMPM non-primary care	Primary care as %	Of primary care, % non-claims-based
Kaiser Foundation Health Plan of the Northwest	$67	$326	17.1%	95.0%
Providence Health Plan	$36	$248	12.9%	3.9%
Moda Health Plan, Inc.	$36	$303	10.6%	0.6%
PacificSource Health Plans	$33	$249	11.8%	0.9%
UnitedHealthcare Insurance Company	$29	$204	12.6%	0.0%
Regence BlueCross BlueShield of Oregon	$29	$241	10.6%	0.9%
Health Net Health Plan of Oregon, Inc.	$25	$235	9.8%	5.5%
Atrio Health Plan	$24	$330	6.9%	0.0%
Trillium Community Health Plan, Inc.	$13	$81	13.9%	0.0%
All carriers	$44	$280	13.6%	44.1%

https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/SB-231-Report-2018-FINAL.PDF

Employer Report Series: MN

APCD COUNCIL All-Payer Claims Database

To offer feedback or share ideas for new reports, or to find out more about how self-insured employers can safely contribute de-identified health care data to the MN APCD, email the Minnesota Department of Health at health.apcd@state.mn.us.

Protecting individual privacy in the MN APCD is of paramount importance. All identifying patient and provider data is de-identified and encrypted before it leaves the data submitter site and is sent to the MN APCD.

For further information about the MN APCD:
Online: www.health.state.mn.us/healthreform/allpayer
Email: health.apcd@state.mn.us

85 East 7th Place, Suite 220, Saint Paul, MN 55101
(651) 201-3550
www.health.state.mn.us/healtheconomics

MINNESOTA HEALTH CARE:
High-Value Reports Designed for and by Employers

What are the most expensive health care procedures in Minnesota? Where are the best opportunities to negotiate lower prices or achieve more competitive contract agreements? Where should your employees go to get more value from each health care dollar?

A new series of reports that focuses on variation in health care prices for common treatments and procedures in Minnesota can help answer these and other questions.

The MN APCD is the most robust dataset in Minnesota, with more than 100 entities contributing data

"This is eye-opening information for the purchasers of health care. Employers have long suspected that there is a great deal of variation in both the quality and the cost of health care, but to be able to see the actual numbers provides them an opportunity to make better purchasing decisions. Employers can also help employees and their family members identify and access more affordable care."

Carolyn Pare MN Health Action Group

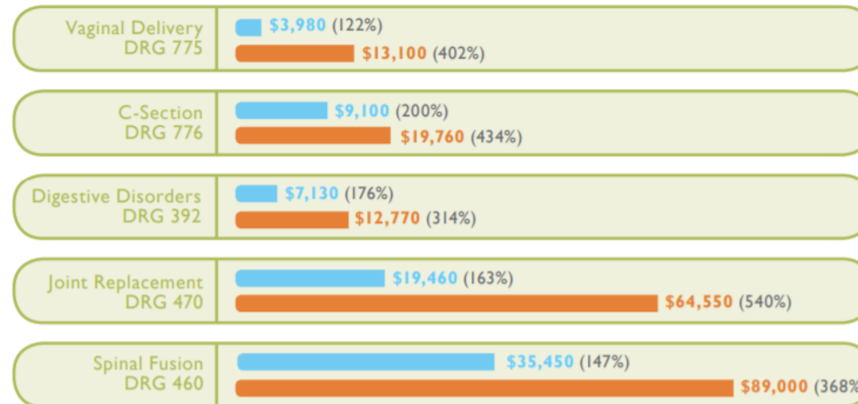
Reference-based Pricing Estimates: CO

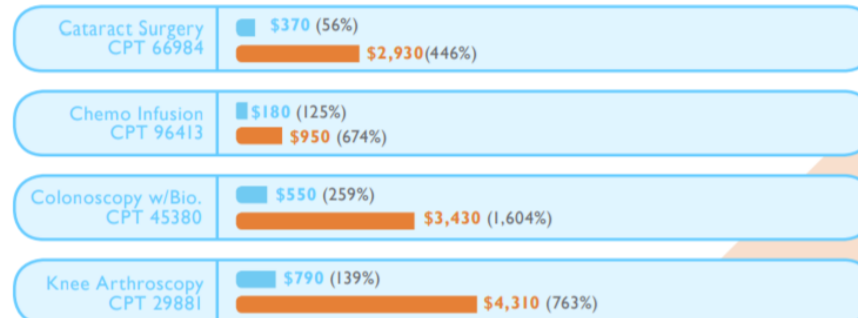
APCD COUNCIL All-Payer Claims Database

Reference-Based Inpatient and Outpatient Payment Analysis:

Reducing Payment Variation as a Potential Cost-Savings Mechanism

November 2018





https://www.civhc.org/wp-content/uploads/2018/11/Reference-Based-Price-Report-November-2018.pdf

Research on Opioid Prescribing and Chronic Use: MN

APCD COUNCIL All-Payer Claims Database

ISSUE BRIEF | APRIL, 2018

Patterns of Opioid Prescribing in Minnesota: 2012 and 2015

Introduction

Opioids are a class of drugs that include prescription opioid medications for pain relief —such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and fentanyl—as well as illicitly produced drugs like heroin and fentanyl-related substances (also called fentanyl analogs).[1] While prescription opioids play a role in the management of some types of severe acute, cancer-related and end-of-life pain, increased opioid use since 1990, including for chronic pain unrelated to cancer, has resulted in sharply rising opioid addiction and overdoses, as well as increased healthcare utilization and costs. Recent Centers for Disease Control and Prevention (CDC) guidelines point out the limitations of the evidence base in support of opioid therapy for pain, recommend non-opioid therapy for chronic pain, and emphasize the risks associated with opioid therapy.[2] In Minnesota, opioids—both prescription and illicit—were responsible for 336 overdose deaths in 2015, more than a six-fold increase since 2000.[3] In 2016, opioid use accounted for 395 overdose deaths in Minnesota—a one-year increase of nearly 18 percent.[4] Forty-nine percent of the opioid overdose deaths in Minnesota in 2016 were from prescription opioids.[5] In addition to overdose deaths, opioids play a causal role in other deaths, including automobile accidents.

As Minnesota, like other states, struggles with the economic, community and individual impacts of the opioid epidemic, this issue brief looks to bring new empirical evidence specific to Minnesota to discussions about the shape of the problem, contributing factors, and options for addressing them. This issue brief focuses on opioid prescription patterns among Minnesotans with private or public insurance coverage in 2012 and 2015. We explore

Key Findings:

- Overall rates of opioid prescribing declined in Minnesota from 2012 to 2015, but the morphine milligram equivalents (MME) per prescription increased.
- Medicare and Medicaid, where eligibility is determined by age, disability status, and/or income, covered approximately one-third of Minnesotans with general health coverage and accounted for two-thirds of opioid prescriptions filled in 2015.
- Nearly one in three Minnesotans with an opioid prescription in 2015 had multiple prescribers.
- In both 2012 and 2015, 6 in 10 opioid prescriptions were filled within 15 days of the patient's last medical visit; however, 1 in 10 opioid prescriptions were filled without a medical visit in the past 90 days, suggesting closer patient-prescriber communication or opioid oversight may be needed in some cases.
- Prescription opioid use varied across counties. In some counties, prescription opioid use in 2015 was over 3 times the statewide average of 523 MME per resident.

to reduce unnecessary use and overuse of prescription opioids. They may also help identify additional analytic questions and contribute to assessments of the impact of policy changes currently debated by the Minnesota Legislature.

The research in this issue brief relies on the Minnesota

Focuses on opioid prescription patterns among Minnesotans with private or public insurance coverage

Explores:

- Opioid prescription trends by payer
- Patients' diagnoses preceding a prescription opioid fill
- Number of prescribers
- Patients' geographic location

http://www.health.state.mn.us/divs/hpsc/hep/publications/opioidbrief20185.pdf

Research on Low Value Services: VA

APCD COUNCIL All-Payer Claims Database

2016 Statewide Low Value Services Report- Overall

Low Value Measure Rule	Total Services Measured	Percentage of all Services Measured	Number of Individuals who Received Services	Total Low Value (Likely Low & Low Value Combined)							Quality Index	Low Value Index
				Number of Low Value Services	Number of Individuals who Received a Low Value Service	% of Distinct Members with Services	Total Proxy Cost of Low Value Services	Average Proxy Cost per Service	Per Member Per Month	% of Overall Low Value Spending		
Totals	5,554,680	100%	3,043,745	2,045,867	1,573,514	41%	$786,504,384.30	$345.32	$11.13	100%	63%	37%
Common Treatments	359,160	6%	279,744	356,799	277,701	99%	$6,162,886.00	$17.27	$0.18	1%	1%	99%
Don't order antibiotics for adenoviral conjunctivitis (pink eye).	540	0%	538	480	478	89%	$5,922.32	$12.34	$0.00	0%	11%	89%
Don't prescribe oral antibiotics for uncomplicated acute tympanostomy tube otorrhea.	298	0%	281	108	101	36%	$2,955.33	$27.88	$0.00	0%	64%	36%
Don't prescribe or recommend cough and cold medicines for respiratory illnesses in children under four years of age.	40,546	1%	30,544	40,546	30,544	100%	$268,622.82	$6.63	$0.00	0%	0%	100%
Don't prescribe oral antibiotics for members with upper URI or ear infection (acute sinusitis, URI, viral respiratory illness or acute otitis externa)	317,776	6%	258,381	315,667	256,578	99%	$5,885,425.51	$18.64	$0.00	1%	1%	99%
Diagnostic Testing	996,175	16%	660,846	533,766	351,888	53%	$273,515,373.11	$512.43	$4.31	38%	49%	60%
Don't do imaging for low back pain within the first six weeks, unless red flags are present.	41,304	1%	41,234	31,670	31,606	77%	$8,202,688.03	$259.01	$0.13	1%	23%	77%
Don't do imaging for uncomplicated headache.	26,173	0%	24,793	9,888	9,451	38%	$11,439,690.03	$1,157.16	$0.18	2%	62%	38%
Don't obtain brain imaging studies (CT or MRI) in the evaluation of simple syncope and a normal neurological examination.	2,977	0%	2,936	2,121	2,084	71%	$3,414,086.31	$1,609.66	$0.05	0%	29%	71%
Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy.	14,027	0%	13,444	8,390	8,017	60%	$1,913,514.47	$228.07	$0.03	0%	40%	60%
Don't routinely do diagnostic testing in patients with chronic urticaria.	428	0%	428	332	332	78%	$188,522.85	$567.84	$0.00	0%	22%	78%
Don't perform electroencephalography (EEG) for headaches.	3,789	0%	3,671	2,183	2,127	58%	$2,802,109.56	$1,283.60	$0.04	0%	42%	58%
Don't perform imaging of the carotid arteries for simple syncope without other neurologic symptoms.	5,997	0%	5,828	2,239	2,171	37%	$3,915,017.14	$1,748.56	$0.06	1%	63%	37%
Don't order computed tomography (CT) scan of the head/brain for sudden hearing loss.	2,923	0%	2,777	1,348	1,312	47%	$7,205,972.67	$5,345.68	$0.11	1%	54%	46%
Don't routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis.	10,784	0%	10,567	6,252	6,149	58%	$17,002,263.94	$2,719.49	$0.27	2%	42%	58%
Don't use coronary artery calcium scoring for patients with known coronary artery disease (including stents and bypass grafts).	74	0%	74	74	74	100%	$14,145.24	$191.15	$0.00	0%	0%	100%
Don't perform routine head CT scans for emergency room visits for severe dizziness.	21,675	0%	20,925	14,680	14,234	68%	$25,429,370.27	$1,732.25	$0.40	4%	32%	68%
Don't perform advanced sperm function testing, such as sperm penetration or hemizona assays, in the initial evaluation of the infertile couple.	30	0%	25	30	25	100%	$3,718.01	$123.93	$0.00	0%	0%	100%
Don't perform a postcoital test (PCT) for the evaluation of infertility.	12	0%	12	12	12	100%	$690.97	$57.58	$0.00	0%	0%	100%
Don't order CT scans of the abdomen and pelvis in young otherwise healthy emergency department patients (age <50) with known histories of kidney stones, or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic.	2,857	0%	2,393	2,101	1,681	70%	$2,748,229.60	$1,308.06	$0.04	0%	26%	74%
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	650,667	12%	424,332	429,523	250,468	59%	$171,182,133.15	$398.54	$2.70	24%	34%	66%
Don't order computed tomography (CT) head imaging in children 1 month to 17 years of age unless indicated.	8,012	0%	7,789	6,863	6,787	87%	$6,869,221.14	$863.71	$0.11	1%	13%	87%
Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.	104,359	2%	99,531	15,941	15,360	15%	$11,183,768.06	$701.57	$0.18	2%	85%	15%
Disease Approach	98,303	2%	71,930	56,442	44,604	63%	$92,151,075.46	$1,632.67	$1.45	13%	43%	57%
Don't prescribe nonsteroidal anti-inflammatory drugs (NSAIDS) in individuals with hypertension or heart failure or CKD of all causes, including diabetes.	53,878	1%	41,068	43,580	33,571	82%	$1,879,096.32	$43.12	$0.03	0%	19%	81%
Don't schedule elective, non medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age.	16,722	0%	13,950	0	0	0%	$0.00	$0.00	$0.00	0%	100%	0%
Don't perform an arthroscopic knee surgery for knee osteoarthritis.	372	0%	369	372	369	100%	$851,619.97	$2,289.30	$0.01	0%	0%	100%
Don't prescribe antidepressants as monotherapy in patients with bipolar I disorder.	15,164	0%	8,560	2,563	1,817	21%	$138,630.53	$54.08	$0.00	0%	83%	17%
Don't perform Computed tomography (CT) scans in the routine evaluation of abdominal pain.	4,949	0%	4,791	3,642	3,522	74%	$6,759,704.01	$1,856.04	$0.11	1%	26%	74%
Don't perform revascularization without prior medical mangement for renal artery stenosis.	2,114	0%	1,822	2,102	1,812	99%	$14,280,476.05	$6,794.24	$0.22	2%	1%	99%
Don't perform vertebroplasty for osteoporotic vertebral fractures.	1,255	0%	1,089	1,206	1,043	96%	$14,713,454.91	$12,200.21	$0.23	2%	4%	96%
Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology.	3,530	0%	3,261	2,866	2,659	81%	$53,102,305.08	$18,528.37	$0.84	8%	19%	81%

Focuses on identifying potentially unnecessary medical services using the MedInsight Health Waste Calculator methodology.

Explores:

- Average and total costs of common low value services
- Comparison of overall low value spending by service

Consumer Price Transparency Tool: NH

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Providers | Lab Work Price Check | NH Insurance Market Report | Statewide Rates Reports

NH HealthCost

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Compare Health Costs & Quality of Care in New Hampshire

NH HealthCost was developed by the New Hampshire Insurance Department to improve the price transparency of health care services in New Hampshire.

Know What You Might Pay

Compare health care costs in the state of New Hampshire by insurance plan.

COMPARE COSTS

Know The Care You Can Expect to Receive

See how different facilities in New Hampshire perform.

COMPARE QUALITY

Guide to Health Insurance

Empower yourself with answers to questions you may not think to ask

FIND ANSWERS

Employer Toolkit

Analyze and understand NH health insurance information and download tools

FIND RESOURCES

Focuses on providing cost estimates for common medical and dental procedures by medical provider or facility in New Hampshire.

Explores:

- Costs of procedures based on insurance provider
- Comparison of provider or facility quality of care

Research on Pharmacy Spending: MN

APCD All-Payer Claims Database COUNCIL

MN APCD
All Payer Claims Database

ISSUE BRIEF | NOVEMBER, 2016

Pharmaceutical Spending and Use in Minnesota: 2009-2013

Introduction

Prescription drugs offer important treatment options to providers and patients for addressing acute and chronic conditions. And, although many innovative prescription drugs confer substantial clinical and economic benefits to patients, the steady increase in prescription drug spending has resulted in greater interest by policy makers and other stakeholders in Minnesota and nationwide to better understand the underlying trend in the market for prescriptions.

As they consider key policy questions related to prescription drug coverage and purchasing strategies, stakeholders – including legislators, public and private purchasers, employers, pharmacy benefit managers, and consumers – historically have had limited information on Minnesota-specific spending trends and cost drivers across the entire spectrum of drug spending. Given the complexity of the prescription drug market and the overall scarcity of detailed data about it, prescription drug spending reports are often limited to assessments of spending in retail pharmacy settings, with little detail available on spending for prescription drugs in medical settings such as physicians' offices, hospital outpatient clinics, and other health care facilities.[1] Drug spending and use in these medical settings has been increasing substantially in recent years, contributing to growth in overall health care spending. Yet details about this trend, particularly at the state level, are not generally available.

This issue brief is the first in a series of policy briefs

Future issue briefs will further explore spending for and use of prescription drugs in Minnesota by:

- Groupings of drugs by their functions (therapeutic category);
- Whether they are brand, generic, or specialty drugs;
- Channels of distribution and payment;
- Groupings of type of prescribing providers; and
- Variations in spending, use, and cost by geographic location.

Key Findings

- Spending in 2013 on all prescription drugs for Minnesotans with insurance coverage captured in the MN APCD was about $7.4 billion.
- Prescription drugs spending in pharmacy and medical claims accounted for approximately 20 percent of total health care consumption that year.
- Between 2009 and 2013, prescription drug spending rose 20.6 percent, with medical claims accounting for more than one-half (55.1 percent) of this growth.
- The greater role of medical claims in drug spending, relative to pharmacy claims, is due to higher cost-

Focuses on understanding prescription drug spending for Minnesotans with insurance coverage

Explores:

– The role of medical claims and how they intersect with drug spending and pharmacy claims

Research on Costs of Potentially Preventable Emergency Room Visits: RI

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State of Rhode Island
Department of Health

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HealthFacts RI

HealthFacts RI, Rhode Island's All-Payer Claims Database, is a new powerful dataset that can be used to examine the use, quality, and cost of healthcare provided to Rhode Islanders. HealthFacts RI is jointly managed by the Executive Office of Health and Human Services, the Department of Health, the Office of the Health Insurance Commissioner, and HealthSource RI.

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Data table

Potentially Preventable Emergency Room Visits

Introduction

A potentially preventable emergency room visit is when a patient goes to an emergency room for a health condition that could have been treated in a non-emergency setting or prevented by keeping them healthier earlier on. Treatment in an emergency room is generally more expensive than a primary care visit. When people have fewer barriers to good health in their communities, and when they can easily access high quality primary care and follow-up, they are less likely to end up in the emergency room. (Patients experiencing a medical emergency should always seek emergency care.)

Key Findings

In Rhode Island, we could potentially save $90 million annually by preventing non-emergency visits to emergency rooms.

Chest pain is one of the top reasons for potentially preventable emergency room visits, and the most expensive. Better access to primary care and disease management could help prevent these visits.

Upper respiratory infections, low back, and abdominal pain are common, potentially preventable, reasons Rhode Islanders go to the emergency room.

Discussion

Rate

In Rhode Island in 2014, 46% of Emergency Room visits were potentially preventable for the privately insured population, compared to 70% for people with Medicaid, and 71% for people with Medicare in 2013 (Medicare data is not available for 2014). Compared to rates reported by New York (74%) and Minnesota (65%), Rhode Island had considerably fewer potentially preventable visits among people with private insurance. For the publicly insured population, Rhode Island's performance more closely resembled those reported by Minnesota, New York and Texas.

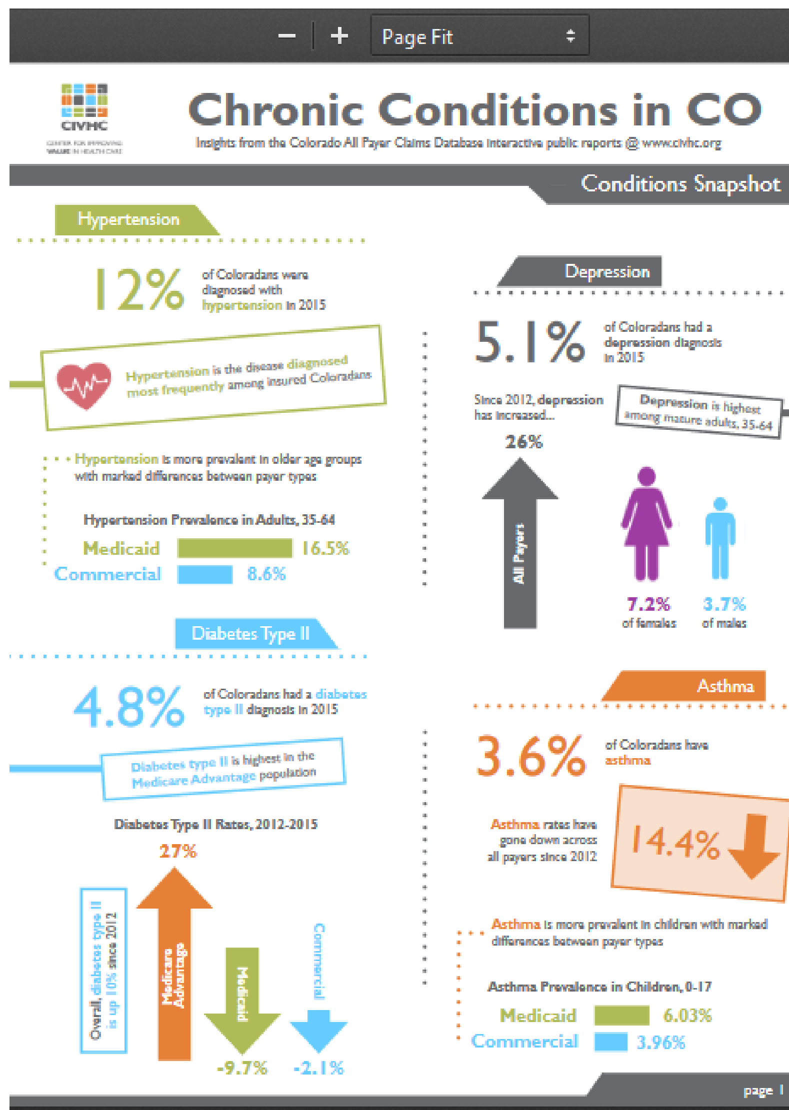
Cost

Focuses on the costs associated with potentially preventable visits to the ER in Rhode Island.

Explores:

- The potential cost savings that could be realized when preventing non-emergency visits to the ER
- The most common reasons for potentially preventable emergency room visits

Research on Chronic Conditions: CO



Focuses on the most commonly diagnosed chronic conditions among insured Coloradans.

Explores:

– Chronic conditions in terms of geography, payer type, gender, and age

State APCDs are Evolving

APCD COUNCIL All-Payer Claims Database

State Collaboration for Solutions

ERISA

https://www.apcdcouncil.org/scotus-gobeille-v-liberty-mutual-insurance-company-decision

All Payer Claims Database-Common Data Layout (APCD-CDL™)

https://www.apcdcouncil.org/common-data-layout

SAMHSA 42 CFR-guidance to states

https://www.nahdo.org/sites/nahdo.org/files/SAMHSA%20Guidance%20FINAL%205%2019%2017.pdf

Non-claims Payments

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Key Regulatory Issues Facing APCD States Post *Gobeille v. Liberty Mutual*

APCD All-Payer Claims Database COUNCIL

- Enforceability: APCD statutes are and remain, for the most part, enforceable.
- Scope: Generally, governmental plans are exempt from ERISA's provisions and are not impacted by the *Gobeille* decision with regard to claims submission.
- Voluntary reporting: Who decides? ERISA does not address this situation. According to state regulators, most TPAs seem to be concluding that the plan sponsor (i.e., the employer) has the right to determine whether the TPA continues to voluntarily submit data.
- HIPAA Privacy: Claims data voluntarily submitted by self-funded ERISA plans would continue to comply with HIPAA privacy requirements notwithstanding the *Gobeille* decision.
- Regulatory authority and APCD 'savings' from preemption: The *Gobeille* decision did not address and does not alter a state's authority to "regulate insurance." The APCD requirements do not have to come from or be administered by the state department of insurance for the savings clause to apply.
- What documentation is required to opt-out of the APCD? States typically have the authority to request documentation or other verification of a plan sponsor's decision to opt-out of (or opt-in to) APCD data submission.

Nothing about ERISA prevents submission of data- it only prevents states requiring submission

These responses are not meant to provide legal advice and should not be relied upon as such. Instead, this is a compilation of opinions and regulatory interpretations that may help guide states as they assess the impact of the SCOTUS decision on APCD efforts.

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APCD-CDL™ Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) is to harmonize the claims collection effort across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs and improve accuracy in claims data collection.

Development process of the APCD-CDL™

- Co-ordinate a state response to Supreme Court decision *in Gobeille v. Liberty Mutual*
- Cross walked state APCD files for consistency and divergence
  - States had made efforts in the past to harmonize https://www.apcdcouncil.org/publication/history-apcd-council-harmonization-efforts
- Weekly calls from May 2016- March 2017 to review every proposed field with states, vendors and payers
  - October 2018 states requested NAHDO/APCD Council make APCD-CDL™ available
  - December 1 2018, APCD-CDL™ available by request https://www.apcdcouncil.org/sites/default/files/media/cdl_request_form_2018_0.pdf
  - APCD-CDL™ advisory committee developing a process for maintenance (Jan 2019-present)

Recommendations for Health Cost Control

APCD All-Payer Claims Database COUNCIL

Letter to The Honorable Lamar Alexander, Chair, HELP Committee

Create pathway to encourage development of APCDs

We recommend that the Department of Labor use its authority to create a standardized process that state APCDs could use to collect data from self-insured plans or that Congress amend ERISA to allow states to move ahead on their own.

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