

The Benefits and Challenges of All-Payer Claims Databases



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All-Payer Claims Databases

Over the past 10 years, a number of states have passed legislation that require commercial health insurers, third party administrators, pharmacy benefit managers, dental benefit administrators and government programs to submit health care claims data to a state agency. The laws generally require information relating to health care costs, quality, and utilization, including data on medical, dental, and pharmacy claims, member eligibility and providers. The state agencies collect and aggregate the data into an electronic database that is often called an “all-payer claims database” or “APCD.”

APCDs are touted as vehicles for increased transparency in the health care system because they permit examinations of costs, quality, utilization and geographical/racial differences among health care services, as well as assessments of the impact of state programs, demonstrations and initiatives. APCDs are also serving as a decision support tool, helping states make health policy decisions and determine, among other things, how much is spent on health care in their state; whether common procedures differ in pricing, depending on the facility; and how the use of health care services has changed over time.

Legislation

At least 18 states have passed legislation requiring the creation of an APCD, including Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington and West Virginia. The statutes generally require the submission of patient social security numbers or member IDs; type of health insurance plan; patient demographics; diagnosis, treatment and or drug codes; service provider information; member payment responsibility; facility type; revenue codes; and dates of service. Examples of the legislation and regulations in Massachusetts, Rhode Island and New York are set forth below.

Massachusetts

The APCD statute in Massachusetts requires the collection of data from commercial payers, third party administrators, self-insured or self-administered plans and public programs. The information is used by health care providers, health plans, researchers, and others to address a wide variety of issues, including price variation, population health and quality measurement.

A primary goal of the Massachusetts APCD is to promote administrative simplification that is beneficial to both insurers and state agencies. Insurers have been faced with complex, overlapping and sometimes contradictory requests for data submissions from upwards of ten state agencies that use health care claims data in their research, regulatory activity and operations in Massachusetts. The APCD will allow submission of data under a single submission specification and the Center for Health Information and Analysis (“CHIA”) is the sole agency responsible for maintaining data infrastructure and processes.

The APCD enabling statute, Chapter 12C of Massachusetts General Laws, requires CHIA to draft regulations to ensure the uniform reporting of information from private and public health care payers. The information enables CHIA to analyze changes over time, in health insurance premium levels; in the benefit and cost-sharing design of plans offered; in measures of plan cost and utilization; and in the type of payment methods implemented and the number of members covered by alternative payment methodologies.

Payers must provide claims-line detail for all health care services provided to Massachusetts residents, whether or not the health care was provided within

Massachusetts, including out-of-state residents of a Massachusetts-based employer or Massachusetts employment site. The data includes information on fully-insured and self-funded accounts and all medical products for all individuals and all group sizes.

The penalty for non-compliance includes \$1,000 per week for each week that a Payer fails to provide the required health care data and information, up to an annual maximum of \$50,000.

Rhode Island

Rhode Island formed its APCD, known as “HealthFacts RI”, after legislation was passed requiring the Director of the Department of Health (the “Director”) to establish and maintain a unified health care quality and value database.

HealthFacts RI’s mission is to provide actionable data to support the study and comparison of health care data; to identify opportunities to improve health care quality and health outcomes and reduce health care costs; and to help Rhode Islanders make informed decisions about their health care.

The purpose of the database is to determine the capacity and distribution of existing resources; identify health care needs and inform health care policy; evaluate the effectiveness of intervention programs on improving patient outcomes; compare costs between various treatment settings and approaches; provide information to consumers and purchasers of health care; improve the quality and affordability of patient health care and health care coverage; strengthen primary care infrastructure; strengthen chronic disease management; and encourage evidence-based practices in health care. R.I. Gen. Laws § 23-17.17(9).

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Insurers, health care providers, health care facilities and governmental agencies must file reports, data, schedules, and statistics or other information, including health insurance claims and enrollment information; information relating to hospital finance; and any other information relating to health care costs, prices, quality, utilization, or resources required by the Director.

The penalties for a failure to comply in Rhode Island include compliance orders issued by the state, fines up to \$300 and possible criminal penalties.

New York

The New York APCD is under development and administered through a new bureau within the New York State Department of Health

Office of Quality and Patient Safety. The APCD will support health care finance policy, population health and health care system comparisons and improvements by providing information about how and where health care dollars are being spent, and will help answer important questions for various stakeholders, including state policy makers, health plans, employers, providers, researchers and consumers.

The collection of data from public and private payers in New York is occurring in phases. A number of health plans began submitting test data in 2014, live medical and pharmacy data in 2015 and large commercial payers are submitting data in 2016.

APCD Benefits

Not only is the data required by APCDs available to the states to inform regulatory and policy decisions, the data is also available as a resource for insurers, employers, providers and other purchasers of health care. Data can enhance the ability of consumers and employers to make informed and cost-effective health care choices.

Given that controlling health care costs is an important issue for employers, many employers want to make data-driven decisions about the health care they offer their employees. Employers can compare or benchmark the information they have about their own employees with the vast amount of information collected in an APCD.



For example, the Oregon APCD allows employers to compare their costs for common health care services by publishing detailed reports on per-member per-month costs, by service category for commercial and public insurance programs in Oregon. Similarly, the Colorado APCD publishes information on the variations in cost for common procedures in health care facilities across the state.

Having access to and understanding this type of information is particularly valuable for employers and employees as premiums and employees' cost sharing for the health care services continue to increase. Access to quality and cost information will assist employers and employees in making decisions about where to receive care.

APCDs can also be used by insurers and providers to determine the effectiveness of health care cost reduction strategies, alternative payment models and delivery reforms. Researchers are using the data to track population health, utilization and costs.

APCD Challenges

Despite the apparent benefits of APCDs, they are faced with some administrative and legal challenges.

Administrative Challenges: Some of the administrative challenges faced by APCDs include the cost to states and data submitters to develop, maintain and comply with the APCD, the need to maintain privacy and security over patient data, as well as to ensure the integrity, comprehensiveness and accuracy of the data.

There are obvious inherent privacy and security risks in maintaining such a comprehensive electronic database of sensitive health care information. It's also difficult to accurately reflect prices and quality through data without accounting for variations in the complexity of cases and the subjectivity within quality of care. Furthermore, there is risk to payers, providers and consumers on various levels due to the release of negotiated price information, some of which may be prohibited from disclosure by contracts between payers and providers. Finally, the collection, submission and analysis of the data is complex and costly for all stakeholders.



Legal Challenges: The State of Vermont's APCD, known as the Vermont Health Care Uniform Reporting and Evaluation System, recently faced a legal challenge in a case that made its way to the Supreme Court of the United States.

In *Gobeille v. Liberty Mutual Insurance Co.*, the Supreme Court determined that the Employee Retirement Income Security Act ("ERISA") preempts the Vermont state law that requires health insurers to report health care data to the State. Under the Vermont law, self-insured employers and third party administrators fall under the definition of health insurers and are therefore required to submit data. Liberty Mutual is a self-insured employer, which means that it pays for the health care services provided to its employees and their dependents who are enrolled in the benefits plans offered by Liberty Mutual. Blue Cross Blue Shield of Massachusetts is Liberty Mutual's third party administrator that processes the health care claims of Liberty Mutual's employees and their dependents.

Instead of complying with Vermont's statute, Liberty Mutual instructed Blue Cross not to submit information about its employees to the State, and filed a claim in the US District Court for the District of Vermont seeking a declaration that ERISA preempts Vermont's statute. The District Court granted summary judgment to Vermont, but the Court of Appeals for the Second Circuit reversed. The Supreme Court of the United States agreed with the Second Circuit and held that ERISA preempts Vermont's statute.

ERISA's preemption clause states that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 USC § 1144(a). Also, ERISA's reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive. There is a requirement in ERISA that welfare benefit plans file an annual report with the Secretary of Labor (the "Secretary") that includes data on paid claims. The Court noted that ERISA permits the Secretary to use that data "for statistical and research purposes, and [to] compile and publish such studies, analyses, reports, and surveys based thereon." 29 USC § 1026(a). The Court held that Vermont's reporting regime interferes with nationally uniform plan administration and "preemption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 945 (U.S. 2016).

Impact of Gobeille: As a result of the Supreme Court's decision in *Gobeille v. Liberty Mutual Insurance Co.*, self-insured plans in Vermont and elsewhere may decide not to allow submission of their employees' claims information to the state. This presents a problem for the completeness and effectiveness of the APCDs because, according to the Kaiser Family Foundation 2015 Employer Health Benefits Survey, nationally, 63% of workers with employer-based health insurance are in self-insured plans.

Further, the Supreme Court's decision holds that ERISA preempts Vermont's statute as applied to ERISA plans (emphasis added). "ERISA plans" are "employee welfare benefit plans" that are subject to ERISA, which includes fully-insured employer sponsored coverage as well. Most state statutes are applicable to the health insurers, as opposed to the employee welfare benefit plan itself, so fully-insured employers may not have standing to challenge an APCD statute, but the possibility exists.

Regardless of whether a state statute is preempted, those who are self-insured and other employers will consider voluntarily complying with the statutes in an effort to capitalize on the benefits offered by a robust and comprehensive APCD, as explained above.

Conclusion

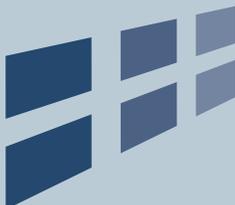
Unless and until additional challenges threaten the enforceability of state APCD statutes, states are moving forward with using big data to make informed decisions. If the triple aim of reducing cost and improving quality and population health is to be achieved, it must be informed and based on comprehensive, accurate data. Given the time and expense expended by various stakeholders across the country on developing and implementing APCDs, hopefully they will fulfill their purpose of assisting with health policy decisions, supporting health care and payment reform initiatives and addressing the need for transparency.



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