The Value of All-Payer Claims Databases for Employers

What are All-Payer Claims Databases (APCDs)?

APCDs are databases, typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. Data are submitted directly from health insurers, third-party administrators, and pharmacy benefit managers.

Why have APCDs been developed?

States have established state-sponsored APCD systems to fill critical information gaps needed to make effective health policy decisions, to support health care and payment reform initiatives, and to address the need for transparency in health care. States with APCDs are responding to a need for comprehensive, multi-payer data that allows a variety of health care stakeholders – including employers – to understand the cost, quality, and utilization of health care.

Why are APCDs important for employers?

The health of employees is of paramount importance for employers; helping employees stay healthy is a goal for wellness and productivity in the workplace. In addition, one of the most important issues for employers is controlling health care costs. A recent article from Castlight Health summarized the issue this way:

> "Rising healthcare costs place a huge strain on business. According to a new Harris Poll, which consisted of more than 100 CFOs at large self-insured U.S. companies, **80%** say they feel powerless when it comes to managing their company's healthcare spending. Even more so, **90%** agree that if their company's healthcare costs were lower, they could afford to invest more in their businesses."[1]

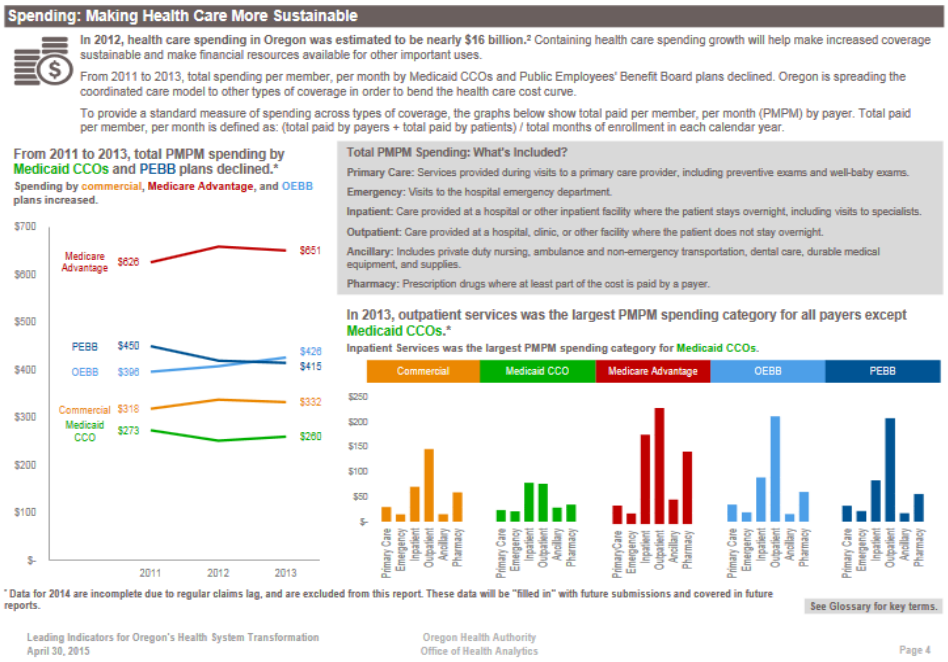
Health system performance improvement requires the availability of comprehensive local data. Employers often seek more information to understand the quality of care their employees receive, how much variation there is in health care costs, and what opportunities exist to improve the health and health care of their employees. Given the importance of health, health care, health insurance, and health policy to business, many employers are interested in making data-driven decisions for themselves and in the states in which they do business. APCDs can serve this purpose.

The examples below illustrate the ways state APCD data are used to support needs of importance to employers.

State and Regional Benchmarking

Employers contribute significant amounts of money, often over $10,000 per employee, in premiums for health insurance[2]. Given this level of investment, employers are actively engaged in understanding health care cost and utilization. While some employers have access to data about the health and health care of their own employees through their insurance companies, third party administrators, or other contractors, many businesses lack any information to which they can compare, or benchmark, their own experience. Many state APCDs have state and regional reporting that provide analysis across payers, providing comparisons that employers often lack. Examples include:

The Oregon Health Authority published a report that provides comparisons of Per-Member Per-Month costs, by service category, for commercially insured, public employees, and public payers.[3] Employers can use this report to compare their own experience in costs for common types of health care services.



Spending: Making Health Care More Sustainable

In 2012, health care spending in Oregon was estimated to be nearly $16 billion.² Containing health care spending growth will help make increased coverage sustainable and make financial resources available for other important uses.

From 2011 to 2013, total spending per member, per month by Medicaid CCOs and Public Employees' Benefit Board plans declined. Oregon is spreading the coordinated care model to other types of coverage in order to bend the health care cost curve.

To provide a standard measure of spending across types of coverage, the graphs below show total paid per member, per month (PMPM) by payer. Total paid per member, per month is defined as: (total paid by payers + total paid by patients) / total months of enrollment in each calendar year.

From 2011 to 2013, total PMPM spending by Medicaid CCOs and PEBB plans declined.*

Spending by commercial, Medicare Advantage, and OEBB plans increased.

Total PMPM Spending: What's Included?

Primary Care: Services provided during visits to a primary care provider, including preventive exams and well-baby exams.

Emergency: Visits to the hospital emergency department.

Inpatient: Care provided at a hospital or other inpatient facility where the patient stays overnight, including visits to specialists.

Outpatient: Care provided at a hospital, clinic, or other facility where the patient does not stay overnight.

Ancillary: Includes private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies.

Pharmacy: Prescription drugs where at least part of the cost is paid by a payer.

In 2013, outpatient services was the largest PMPM spending category for all payers except Medicaid CCOs.*

Inpatient Services was the largest PMPM spending category for Medicaid CCOs.

* Data for 2014 are incomplete due to regular claims lag, and are excluded from this report. These data will be "filled in" with future submissions and covered in future reports.

See Glossary for key terms.

Leading Indicators for Oregon's Health System Transformation
April 30, 2015

Oregon Health Authority
Office of Health Analytics

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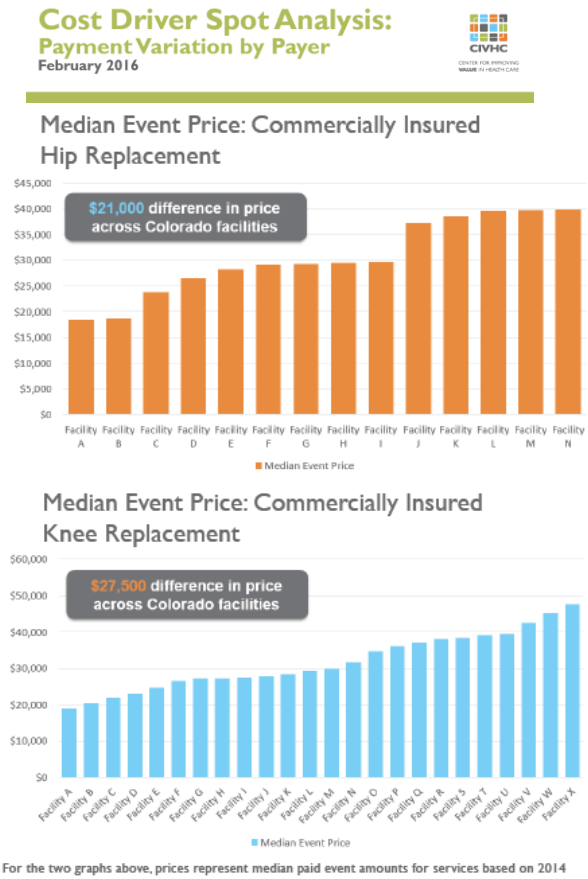
In Colorado, the Center for Improving Value in Health Care is using their APCD to identify variation in costs for common procedures among facilities across Colorado[4]. Variations in costs for the same procedure in health care facilities is often of interest to employers, as they try to understand how and where health care dollars are spent.



Cost Driver Spot Analysis:
Payment Variation by Payer
February 2016

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Median Event Price: Commercially Insured Hip Replacement

Median Event Price: Commercially Insured Knee Replacement

For the two graphs above, prices represent median paid event amounts for services based on 2014 commercial claims data from the CO All Payer Claims Database, www.comedprice.org. Estimates include insurance payments and patient responsibility (copay, deductible,etc.).

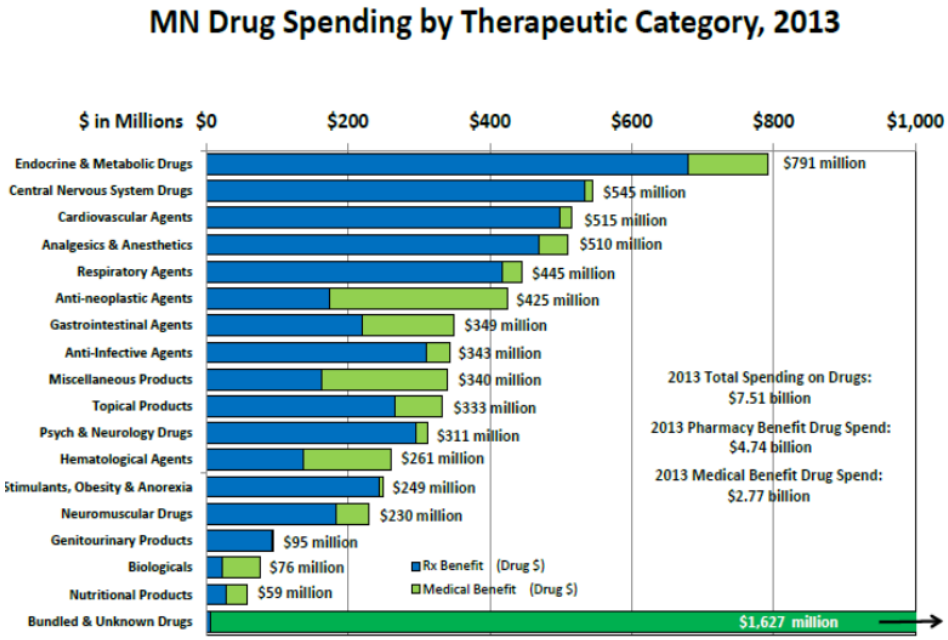
Analysis of Key Cost Drivers

Employers often focus attention on specific key drivers of cost for their own plans. Understanding the impacts of these cost drivers statewide and regionally can be beneficial for employers as they consider possible opportunities for improvement in their own populations. Examples of APCD analysis that can be of value for employers as they try to understand key issues include:

Pharmacy: Pharmacy costs are a major focus of review with many employers, as pharmacy costs often rise at a greater rate than other health care expenses, as described in a recent Business Insurance article:

> "'Cost increases for pharmaceuticals are growing faster than for medical costs, so some employers are putting their focus there to manage spending,' Ms. Ageloff said. 'Pharmacy is the component of employee benefit plans that has the highest rate of increase right now,' Ms. Ageloff said of drug costs that today can account for at least 20% to 25% of employers' total medical spending versus the historical 15%."[5]

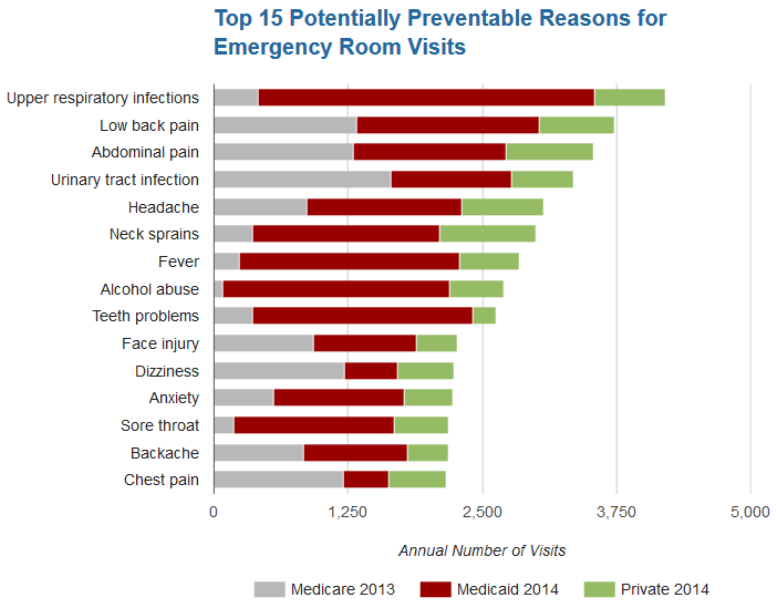
The State of Minnesota recently presented an analysis of trends in pharmacy costs using statewide APCD data[6]. This analysis provides a state-level review of costs by drug category, which can be used by employers to understand if their trends mirror local use statewide. It distinguished between office-administered drugs and drugs obtained as pharmacy benefits, to highlight the price pressure from drugs prescribed in medical settings.



Source: Analysis by the PRIME Institute, University of Minnesota using the Minnesota All Payer Claims Database (MN APCD) data from 2009 to 2013.

Avoidable Care*:* Health care cost and utilization review for employers often focuses on potentially avoidable care. The goal of these types of analyses are to identify opportunities to prevent unnecessary care.

The State of Rhode Island released online reporting[7] that reviews potentially avoidable emergency room visits and quantifies the costs associated with those visits. This type of analysis can be used by employers to understand where they have opportunities to educate their employees about opportunities for preventing avoidable care.



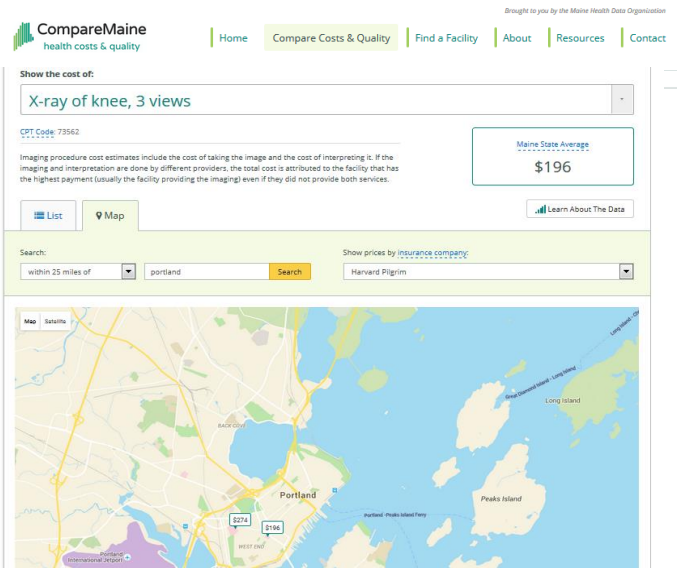
Tools to Support Health Care Consumerism

There has been a trend towards more employee contribution to health insurance costs for many years.[8] Given this trend, there is a need to support active health care consumerism and greater price transparency in order to assist individuals with their health care decision-making. As summarized in the Health Research Institutes 2015 Medical Cost Trend Report[9]:

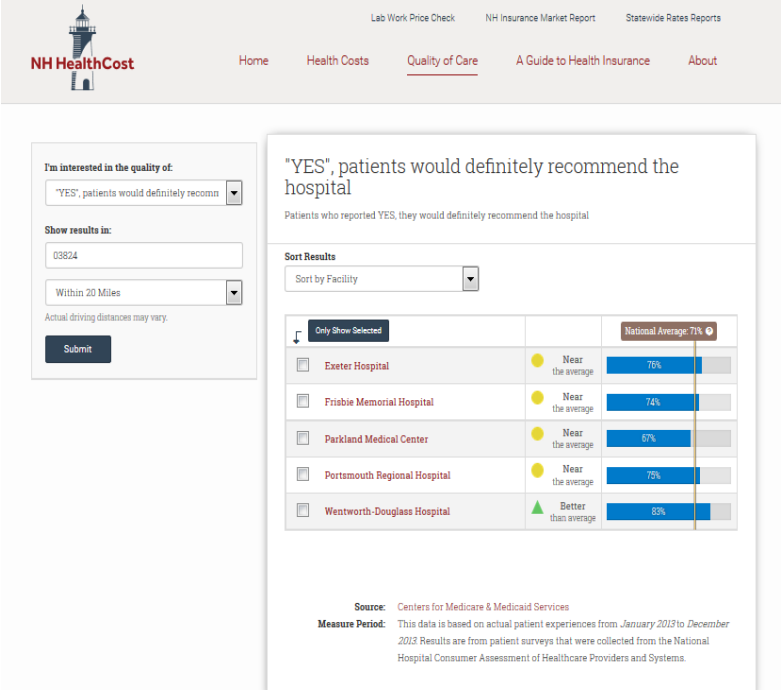
> "As employers continue to shift financial responsibilities to their employees, the cost-conscious consumer will exert greater influence in the new health economy."

Individuals need tools to support understanding of price and quality variation. States are using APCD data to create those tools. Examples include:

Compare Maine[10]: The Maine Health Data Organization uses the Maine APCD to drive a consumer-focused website in which individuals can search for the average price of common procedures, by facility and by payer, to support active decision making of where to seek care, particularly for health care services that allow consumer choice (e.g., knee X-ray or lipid screening).



New Hampshire HealthCost: In 2015, New Hampshire was the only state in the United States to receive an "A" in the Catalyst for Payment Reform's Price Transparency Report Card. [11] One reason for this grade was the website from the New Hampshire Insurance Department, NH HealthCost.[12] This site provides cost information, by payer and by provider, as well as quality outcomes to support heath care shopping.



Why should employers support data submission to an APCD?

Given the capacity of APCD data to provide better information to businesses, support employees' health care decision-making, and inform important state health policy decisions that directly impact employers, there is clear value to employers including their data in a state APCD. This assures that the state data are representative of the commercially-insured population in a state, including the employer's own experience. Thus, the information generated by the APCD will be relevant to employers' business needs in the context of the health care market in which the insurance is purchased and care is provided. As self-funded employers are faced with the choice to opt-out of APCDs, they should consider the benefits to the employer, their employees, and the state health care delivery system by choosing to include their own data in the data system. The Health Research Institutes 2015 Medical Cost Trend Report[13] advises that:

> "Employers must pursue strategies that not only strengthen their bottom line but better equip workers to make informed health decisions—or they will likely pay a high cost in the long run."[14]

APCDs can support the strategic thinking of employers and the broader, statewide health care context. Analysis of APCD data provides better understanding of the burden of chronic conditions, health issues of aging populations, and other population health issues that impact healthy communities for employers and their employees.

Data are securely submitted to APCDs in encrypted files in order to protect the privacy of any health care information. All data is maintained by law as confidential, in compliance with state and federal health privacy laws. Therefore, APCDs are a safe solution for system-wide data that can be beneficial to employers, and many other health and health care stakeholders.

How can employers find out more?

Information about each state APCD can be found at the APCD Council website: www.apcdcouncil.org. Many states have advisory committees and/or councils that can present a formal opportunity for employers to stay involved in APCD activity.

For more information about the varied uses of APCD data, see www.apcdshowcase.org.

[1] http://www.castlighthealth.com/blog/cfos-feel-powerless-when-it-comes-to-managing-healthcare-costs-new-poll-finds/

[2] http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

[3] http://www.oregon.gov/oha/OHPR/RSCH/docs/All_Payer_all_Claims/Leading_Indicators_April_2015.pdf

[4] http://www.civhc.org/getmedia/118a37cb-2fc0-4896-abe2-1ffd251fcbc3/2.2016_spot_analysis_paymentvariationbypayer.aspx/

[5] http://www.businessinsurance.com/article/20151122/NEWS03/151129955

[6] Minnesota Department of Health presentation, Personal Communication. Not yet posted online.

[7] http://health.ri.gov/data/potentiallypreventableemergencyroomvisits/

[8] http://kff.org/report-section/ehbs-2015-summary-of-findings/

[9] *Medical Cost Trend: Behind the Numbers, 2015*. PwC Health Research Institute, June 2014. Available at: https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/pwc-hri-medical-cost-trend-2015.pdf

[10] http://www.comparemaine.org/

[11] http://catalyzepaymentreform.org/images/documents/2015_Report_PriceTransLaws_06.pdf

[12] http://nhhealthcost.nh.gov/

[13] *Medical Cost Trend: Behind the Numbers, 2015*. PwC Health Research Institute, June 2014. Available at: https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/pwc-hri-medical-cost-trend-2015.pdf

[14] http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-medical-cost-trend-2016.pdf