

# Updated Issue Brief: All Payer Claims Databases

## Introduction: What is an All-Payer Claims Database?

An All-Payer Claims Database (“APCD”) is an electronic system that aggregates claims and administrative data from public and private payers. APCDs allow states to monitor utilization and healthcare charges across all payers, and, as such, are key tools for policymakers to identify and respond to systematic trends among (nearly) all delivery settings.

According to the [APCD Council](#) (a collaboration between the University of New Hampshire and the National Association of Health Data Organizations), 18 states have existing APCDs.[\[1\]](#) Further research by the Source indicates that, as of December 2015, 4 additional states have existing APCDs.[\[2\]](#) The Source has catalogued state and private efforts to investigate the feasibility of enacting an APCD – please refer to the Source [APCD map](#).

## Data Sources:

An APCD collects from payers claims data that arise out of transactions between covered patients and healthcare providers. For the purposes of data collection, a “[potential payer](#)” is defined as a commercial insurance carrier, third-party administrator (with respect to employer sponsored plans), pharmacy and dental benefit administrator, state Medicaid, the Centers for Medicare and Medicaid Services (“CMS”), the Federal Employees Health Benefit Program, or TRICARE administrator (military). Due to unavailability of claims data, self-payers and uninsured patients are not typically included in APCDs and are not subject to the reporting statute.

## What Data and How is it Collected:

Although there is no uniform nationwide data collection standard with respect to the submission of [claims data](#) under an APCD program, the following data is generally responsive: (1) patient social security number or member ID|(2) type of care plan and contract|(3) patient demographics|(4) diagnosis/treatment code or drug code|(5) service provider information|member payment responsibility|(6) type and date of bill paid|(7) facility type|(8) revenue codes|and (9) services dates.

The majority of APCDs are currently mandated by statute, with rules requiring the submission of claims data to a collection agency. Under those rules, failure to provide the mandated data can result in penalties to the reporting entity. APCD data collection can also be voluntary. For example, [The California Healthcare Performance Information System](#) (CHPI), a public benefit corporation, administers a voluntary APCD that consists of claims from Medicare fee-for-service, Anthem Blue Cross, Blue Shield of California, and United Healthcare.

### **Potential Uses for an APCD:**

APCDs can be used in a number of ways to benefit consumers. First, they can be cost comparison tools for patients that present information about the prices of medical procedures by facility or practice (derived from claims data and adjusted for severity of illness). For example, [Massachusetts](#) mandates the creation of a [consumer website](#) to facilitate price shopping (see also [Maine](#), [New Hampshire](#), and [Colorado](#)). Efforts to create price transparency websites for consumers from payer data mirror certain voluntary efforts by hospital systems to encourage shopping among their member hospitals by posting price data directly (e.g. [Wyoming](#)), or collaborations between the state and hospital associations to do the same (e.g. [Iowa](#), [Minnesota](#)). [Employers](#) can benefit from APCDs by comparing claims data across coalitions or against other payers to track the performance of their plans.

Recently, a voluntary collaborative of major health payers (currently, Aetna, Assurant Health, Humana, and UnitedHealthCare) agreed to provide the Health Care Cost Institute with health insurance claims data to create [guroo.com](http://guroo.com), a multi-state price comparison tool for over 70 common health services based on actual amounts paid to providers. The Guroo tool is novel because it allows consumers to make state-by-state comparisons, and to compare their health costs against the national averages.

Second, APCDs can be used to determine the effectiveness of healthcare cost reduction strategies and delivery reform. For example, [New Hampshire](#) is using claims data from its APCD to monitor the effect of accountable care projects. [Vermont](#) is using its APCD to study patient centered medical homes, which are an integrated form of primary care delivery intended to increase quality and reduce waste.

Third, researchers can benefit from APCD data in tracking population health and utilization. Some states are [reportedly](#) working towards linking clinical data from provider health information exchanges and benefit/plan design from health insurance exchanges to study the potential correlations between clinical outcomes and plan design on spending.

Colorado has made significant strides towards realizing the potential of APCD resources for researchers. Colorado's APCD permits organizations to promulgate customized data requests that further the state's Triple Aim in healthcare: improved health outcomes, lower costs, and better care. Colorado launched a [showcase](#) of ways other organizations (predominantly non-profits and state government) are using customized data sets in the areas of health coverage and rate setting, outcome/cost improvement, and payment reform. Projects of note include: a [study by Project Angel Heart](#), a non-profit, to determine whether home-delivered meals to chronically ill patients will reduce overall healthcare expenditures|a [study by the Colorado Health Institute](#) to assess the impact of the

ACA provisions requiring no cost-sharing for preventive health services on utilization|and a [study by an orthopedic care provider](#) to investigate opportunities to implement bundled payments as an alternative for fee-for-service.

### **Studies on the Impact of APCDs:**

As APCDs are a fairly recent invention (Maine's being the first in 2003), their specific contribution on healthcare pricing and quality has not been comprehensively determined. To the extent that APCDs facilitate price shopping when used as consumer price comparison websites, there is [evidence](#) that transparency regulations can drive down prices for common, uncomplicated elective procedures. Nevertheless, there is [concern](#) that weak provider competition may blunt the impact of transparency initiatives, and that consumers may not be sensitive to price changes where carriers are responsible for the lion's share of payments. The [increased adoption](#) of high-deductible health care plans under the ACA may spur increased consumer price sensitivity, however.

Ambivalence towards the effectiveness of price transparency initiatives notwithstanding, various APCD programs are already beginning to generate valuable research respecting trends in cost, quality, and utilization. To date, the APCD Council has compiled a [list](#) of over 40 of such studies.

### **Challenges to APCD Implementation and Design:**

There are several implementation and design challenges facing the establishment of an APCD, including (1) privacy/security, (2) accuracy and integrity, (3) comprehensiveness, (4) antitrust violations, (5) claims of trade secret, and (6) cost.

#### *Privacy/Security:*

[Data privacy and security](#) are central to ensuring a viable data-sharing regime. The recent large scale data breach at

Anthem underscores the risk of maintaining a comprehensive electronic health resource with potentially sensitive patient data.

#### *Accuracy and Integrity:*

Providers may be concerned as to whether reports and consumer websites based on APCD data will accurately reflect prices and quality|to wit, whether they will account for variation in the complexity of cases and the subjectivity within quality of care. Assessments of “quality” are often conflicting, and there is marked [lack of agreement](#) over ratings methods and appropriate measures of performance with respect to healthcare facilities.

#### *Comprehensiveness:*

A comprehensive APCD with data from 100 percent of payers may be difficult to obtain. Data from employer sponsored plans can be hard to capture unless there is a third party administrator, and some administrators have [litigated](#) whether state APCD reporting mandates are preempted by ERISA. As noted above, data respecting self-payers and the uninsured are not typically included in APCDs.

#### *Antitrust Violations:*

State agencies and APCD operators may be concerned that the release of negotiated price information could lead to collusion in violation of state and federal antitrust laws.

#### *Trade Secrets/Gag Clauses:*

Some insurance carriers and providers are [likely to object](#) to the collection and public release of negotiated rates, claiming the information is confidential per “gag clauses” in contracts or subject to trade secret protection.

#### *Cost:*

Multi-state Insurance carriers may be concerned with the administrative cost to comply with multiple APCD database data collection formats, which may be alleviated by [harmonization efforts](#). Data collection standardization could facilitate the creation of a nationwide APCD.

The cost of establishing and maintaining an APCD may also be a significant impediment towards their universal adoption. For example, in 2013, the New Jersey Department of Banking and Insurance [declined to apply for a grant from the federal government to create an all-payer claims database](#), citing the annual cost of maintaining the database as the primary factor. A [report](#) by the Rutgers Centers for State Health Policy indicated other states pay between \$200,000 and \$1.5 million annually to maintain, operate, and analyze information arising out of an APCD.

### ***Gobeille v. Liberty Mutual Insurance Company:***

The reach of APCD legislation is currently being tested in *Gobeille v. Liberty Mutual*, which is presently before the U.S. Supreme Court. The case stems from Liberty Mutual Insurance Company's refusal to comply with Vermont's reporting requirements under the state's APCD statute, which the insurer argues is preempted by The Employee Retirement Income Security Act of 1974 (ERISA)—a notoriously broad statute that preempts any state law that “relates to” an self-insured plan. The U.S. Court of Appeals for the Second Circuit sided with Liberty Mutual, finding that ERISA did preempt Vermont's reporting requirement as it applied to Liberty Mutual's plan, and Alfred J. Gobeille, in his official capacity as Chair of Vermont's Green Mountain Board, appealed. The issue before the Supreme Court is whether the Court of Appeals erred in holding that ERISA preempts Vermont's APCD as applied to a third-party insurance administrator for self-funded ERISA plans. The Court heard arguments on December 2, 2015 and will be expected to render a decision by the end of June 2016.

## APCD In Your State:

For up-to-date information on state implementation efforts, please check the Source [APCD map](#). Additional information for each state can be found in their respective state pages under [Legislation/Regulation](#) or by navigating through the “States” tab.

[\[1\]](#) According to ACPD Council, 12 states have existing APCDs (Washington, Utah, Colorado, Kansas, Tennessee, Minnesota, Maryland, Delaware, Massachusetts, Vermont, New Hampshire, and Maine)|5 states are in the process of implementing an APCD (Washington, Arkansas, West Virginia, New York, and Connecticut)|1 state has an existing APCD with voluntary submission (Virginia), 4 have existing voluntary efforts (California, Oklahoma, Wisconsin, and Michigan)|21 states have a strong interest in an APCD (Alaska, Hawaii, Idaho, Montana, Wyoming, Nebraska, Arizona, New Mexico, Texas, Louisiana, Iowa, Illinois, Kentucky, Alabama, Florida, South Carolina, North Carolina, Ohio, Pennsylvania, Delaware, and New Jersey)|and there is no current activity in the remaining 7 states (Nevada, North Dakota, South Dakota, Indiana, Mississippi, and Georgia).

[\[2\]](#) See Illinois [Executive Order 14-01](#) (passed Jan. 17, 2014), Nebraska [LB 76](#) (passed Feb. 13, 2014), Louisiana [H.B. 498](#) (passed Jun. 29, 2015), and Hawaii’s [Healthcare Innovation Plan](#).

According to the Source, 26 states have functional ACPDs or are in the process of implementing an APCD (Washington, Oregon, California, Hawaii, Utah, Colorado, Nebraska, Kansas, Oklahoma, Minnesota, Arkansas, Louisiana, Wisconsin, Illinois, Tennessee, Virginia, West Virginia, Maryland, Pennsylvania, New York, Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire, and Maine)|17 are investigating an APCD option (Alaska, Idaho, Montana, Wyoming, Arizona, New Mexico, Texas, Iowa, Kentucky, Alabama, North Carolina, South Carolina,

Florida, Michigan, Ohio, Delaware, and New Jersey)|and there is no information on the remaining 7 states (Nevada, North Dakota, South Dakota, Missouri, Indiana, Mississippi, and Georgia).