



## **All-Payer Claims Database**

In recent years, several states have established databases that collect health insurance claims information from all healthcare payers into a statewide information repository. Known as “all-payer claims databases,” they are designed to inform cost containment and quality improvement efforts. Payers typically include commercial health insurers, Medicaid and Medicare. There are currently anywhere from 15 to 20 states that have established or are in the process of developing all-payer claims databases.<sup>1</sup>

The databases contain eligibility and claims data (medical, pharmacy and dental) and include cost, use and quality information. The data consist of service-level information based on valid claims processed by health payers. Service-level information includes charges and payments, the providers receiving payment, clinical diagnosis and procedure codes and patient demographics. To mask the identity of patients and ensure privacy, states usually encrypt, aggregate and suppress patient identifiers.

By collecting all claims into one data system, states gain a complete picture of what care costs, how much providers receive from different payers for the same or similar services, the resources used to treat patients and variations across the state and among providers in the total cost to treat an illness or medical event. In turn, businesses, consumers, providers and policymakers can use the information to make better-informed decisions about cost-effective care. The databases vary state by state according to location of the database (some states authorize the state agency or health data authority to collect and manage data, either internally or through contracts with external vendors) and the types of payers that report the data (commercial payers, government payers, self-insured, uninsured data or some combination thereof).

New Jersey currently has a database within the Department of Health (DOH) that collects data for inpatient, same-day medical, same-day surgical and ED visits for all payers. Hospitals submit this data via a national universal billing (UB) form. However, this database does not collect data on actual payments to providers, nor is there data collected from outpatient services or pharmaceuticals. There is pending legislation A-1834, sponsored by Assemblyman Herb Conaway (D-Delran) that would establish a claims database within the Department of Banking and Insurance that would collect only commercial claims.

As a result of prolonged discussions surrounding out-of-network payments, some provider groups have expressed interest in having an independent database to analyze provider claims. Furthermore, as insurance companies begin to roll out cost-estimators for consumers, providers

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<sup>1</sup>Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, Louisiana, Washington, New York, Pennsylvania and Wisconsin.

are limited in their opportunities to control or object to arbitrary data sets produced by insurance companies. NJHA has produced this research brief to determine if it would be in the best interest of the industry to pursue a version of an all-payer claims database in New Jersey.

### **Potential Benefits**

- **Increased Efficiencies / Reduced Costs** - The transparency of information in the APCDs can lead to efficiencies in reducing healthcare costs within the entire healthcare system. In Maine, a study based on data from its APCD concluded that, if potentially avoidable inpatient use and high-cost, high-variation outpatient use were reduced by 50 percent, medical spending by commercial health payers could be reduced by 11.5 percent, and Medicaid spending could be reduced by 5.7 percent. Researchers estimated healthcare payers in Maine could save \$115 million annually by reducing avoidable emergency department use.<sup>2</sup>

In New Hampshire, one report found that Medicaid members who received primary care in 2006 incurred \$4.1 million for emergency department visits for conditions more appropriately treated in a primary care setting. A second, related report found that Medicaid patients who were frequently treated in the emergency department often were seen for conditions that probably could have been treated in a primary care office or clinic. An estimated \$2.1 million could have been saved if each frequent emergency department user had made just one less outpatient emergency room visit during 2006.<sup>3</sup>

Hospitals and health systems could also gain from having access to paid claims information. The Pennsylvania Health Care Cost Containment Council (PHC4) produces annual reports regarding hospital performance and hospital financials, as well as some targeted reports on cardiac surgery, hip and knee replacements, etc. The Hospital and Health System Association of Pennsylvania (HAP) used the data one year to oppose the administration's proposal to limit Medicaid inpatient payments to two visits per year as part of the state budget process. HAP was able to analyze the PHC4 claims data to ascertain the diagnoses and age of Medicaid patients who were hospitalized more than once and successfully defeat that budget proposal.

- **Out-of-Network Payments and Cost Estimators** - Health insurance companies already are beginning to roll out transparency tools that utilize their own data sets to inform consumers about their payment rates to providers and their members' cost-sharing obligations. A third-party data set would standardize this data aggregation and prevent health insurance companies from manipulating their data to achieve certain payment reductions.

### **Potential Concerns**

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<sup>2</sup> Collecting Health Data: All-Payer Claims Database. [NCSL Briefs for State Legislators](#) May 2010.

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- **Publication of Proprietary Information** - Although the increase in transparency can lead to cost savings within the system, the gathering and potential publication of once proprietary information could be problematic for some hospitals. In Tennessee, both the payers and the providers were instrumental in limiting access to the data because of concern over how the state might use the data, especially because of the lack of understanding of the actual claims data.
- **Use of Data to Cut Funds to Hospitals** - There is also a threat that data sets would be used improperly to cut rates to providers, or provide an improper picture of healthcare costs in a hospital. In New Hampshire, a cost index report generated by the N.H. Department of Insurance on inpatient and outpatient utilization impacted the cost indices they generated for comparative purposes.<sup>4</sup> According to reports by the Commonwealth Fund and the National Conference of State Legislatures, most of the cost savings were generated from reducing utilization in the emergency departments. This could lead to revenue reductions for hospitals.

### Lessons Learned from Other States

- **Establishment / Governance of the APCD** – A few state hospital associations stressed the need for the hospital industry to be involved in the creation of the APCD, as well as be involved in the continued evolution of the database. According to HAP, “If set up by the state, hospital associations need to be in on the ground floor to enable ease and cost effectiveness of data collection; development of reports that are useful and useable for public policymakers, clinicians, purchasers, and consumers; and to ensure ongoing public accountability of the state agency itself.” Hospitals have two representatives on the PHC4 in Pennsylvania. In Wisconsin, the president of the Wisconsin Hospital Association is the current chair of the multi-stakeholder board that governs the repository.
- **Access, Verification and Usage of Data** – There is a great amount of variation among the states on how the data is used. Some states employ complete transparency methods and will publish provider-specific information on a Web site; other states require the information to be confidential and limit the access to government entities. According to the Minnesota Hospital Association, “The use of Minnesota’s database is too narrow – it can only be used by the state Department of Health for ‘provider peer grouping,’ which is an effort to rate hospitals and providers on both cost and quality. If hospitals and health systems had access, the APCD could be very useful in operational improvement efforts, especially being able to look at entire episodes of care or at populations with chronic conditions.”

In Massachusetts, the data is completely controlled by the Massachusetts Division of Healthcare Finance and Policy with regulations that will make it very difficult for anyone outside of DHCFP to access the data if it is determined that the use of the data doesn’t meet all of DHCFP criteria as promulgated by regulation. According to the Massachusetts Hospital Association, “As we move towards integrated care systems and ACOs, access to this data is critical for understanding the population that one is managing. So in retrospect,

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<sup>4</sup> <http://www.nhhealthcost.org/>

an important lesson learned is that access to the data (within the parameters of privacy regulations of course) without jumping through numerous hoops...is very important to pursue.”

Some states also have expressed the need for the databases to allow providers to verify the data before any publication. According to the Minnesota Hospital Association, “We would also suggest that you fight for a mechanism for your members to verify the data that’s being reported about them, preferably at the record level. Because these are patients that were treated by the hospital or health system, and you can argue that this is part of ‘health care operations,’ there should not be an issue with HIPAA. Without this ability to verify, you basically trust the health plans’ data and the Department of Health’s analysis without an ability to rebut the results.” Massachusetts also warns, “Just beware of accuracy of the data before it is made public by the state agency and make sure that providers have reasonable access to the data.”

- **Multiple Vendors** - The state should seek bids from multiple vendors when reporting quality data.<sup>5</sup> In Tennessee, the primary staff at the state working to establish the database had almost no understanding of the claims data but contracted with OnPoint to do the collection and processing of the data. Because of the cost of the OnPoint contract Tennessee is planning to bring the database in-house and lacks the personnel to process and edit the data.
- **The Data Should be Inclusive of All Payers / All Services** – There was nearly uniform consensus from hospital associations across the country that for the data to be useful in its objectives, the data set needs to be comprehensive. This includes data from commercial payers, as well as government and self-insured payers. It also includes services beyond the hospital walls such as labs and pharmaceuticals.
- **Individual Hospitals and Other Healthcare Providers Should Remain Confidential** – Many states, but not all that were surveyed, expressed concerns with hospital information being made public. In New Hampshire, the state law makes payer-specific names and individual physicians confidential, but hospitals and other healthcare providers can be reported by name. However, the data within the Tennessee all-payer claims database is available only to authorized persons working for the state of Tennessee and its designated entities. The data is not released to the public nor deemed a public record. Additionally, the database may be used for analyzing and public reporting at the statistical population level, not the individual level. This is something that NJHA must fully consider during its policy discussion of the establishment of an APCD.

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<sup>5</sup> *Pennsylvania* - The biggest issue from the very beginning was the mandate in the legislation that allowed one vendor to report the quality data that was used in risk adjustment. While at the beginning of PHC4 this was something the hospital community accepted, over time this became problematic as it did not allow hospitals to choose vendors and was viewed as a costly mandate. The lesson learned was not to allow mandates in legislation for specific technologies or vendors.