All-payer claims databases: a work in progress

By **Tara Bannow**

Despite being the country's smallest state, Rhode Island is home to a whole lot of activity aimed at getting healthcare costs under control.

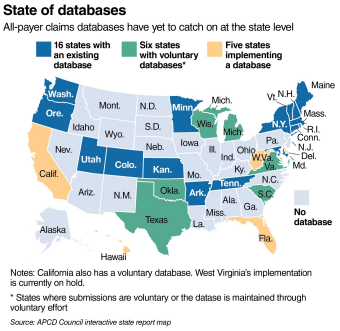
Brown University in Providence is putting $550,000 from a New York not-for-profit organization to work, drilling into the state's all-payer claims database to measure healthcare performance and try to figure out how to make the information useful to consumers, payers and providers.

Parallel to that effort, a governor-appointed steering committee recently began meeting with the goal of setting a healthcare cost growth target by the end of the year.

Rhode Island was chosen for the grant because there's so much momentum in the state to lower healthcare costs, said Dr. Jay Want, executive director of the Peterson Center on Healthcare, which awarded the grant. It's one of the few states that places an annual cap on how much insurance companies can increase their prices in contracts with hospitals.

The work in Rhode Island is mirrored by that of other states, many of which are working feverishly to harness the wealth of information that has been accumulating for years in their all-payer claims databases, electronic portals that collect all of the private and public insurance claims their rules allow. Like in Rhode Island, the work is often aided by grants from the private sector.

The real challenge, then, becomes building actionable tools, such as easy-to-use websites, that can help chip away at the problem of ballooning healthcare costs by helping individuals and payers choose where to get less expensive and higher quality care.



Even though 16 states had all-payer claims databases up and running as of earlier this year and another two had plans in place to do so, the National Conference of State Legislatures says it's still too early to say whether they've helped states control costs for patients or payers.

“We haven't seen the kind of shift in consumer demands associated with that information being really usable,” Want said.**Playing the long game**

It's a long, complicated process, and experts on the front lines caution that databases alone don't lower healthcare costs. What they can do, though, is yield reliable numbers that put better focus on the

problem of healthcare costs.

“You need to have the data to inform those conversations, so people understand where the pain points are,” said Jonathan Mathieu, vice president of data and delivery for the Center for Improving Value in Health Care, the not-for-profit organization that administers Colorado's all-payer claims database. “Once you understand where the pain points are, you can start to have more informed conversations, and that contributes to political will to do something about unwarranted variation.”

Advocates caution that even once such databases have advanced to become more consumer-friendly and aggregate procedure-level cost data, it won't be possible to draw a causal line between all-payer claims databases and lower healthcare costs, because there are so many other factors at play, including quality improvement initiatives and high-deductible health plans, said Suzanne Delbanco, executive director of the Catalyst for Payment Reform.

“I see the data being produced by an all-payer claims database as an enabler,” she said. “It's something that could help a provider understand how they compare to their peers and where they need to get better.”

Rhode Island's governor back in 2015 requested money in her budget proposal to study setting a cost-growth target. But a state deficit prevented that funding, which is now coming from the Peterson Center on Healthcare.

Even with the funding secured, it's controversial work, said Rhode Island Health Insurance Commissioner Marie Ganim. “When you're talking about reducing costs, you're talking about potentially people's jobs,” she said. “You're talking about changing systems that are in some ways intractable. So you really need to have credible, reliable information on which you're making decisions.”

Rhode Island is no stranger to uncharted waters in the healthcare space. It is one of two states that places annual caps on price increases negotiated between hospitals and insurers, and the only state to do so by regulation, Ganim said. In the other state, Maryland, that requirement is embedded in state law. Vermont goes a step further by regulating hospital budgets.

That means despite rapid consolidation occurring within the state's hospital sector, commercially insured patients are largely protected from higher prices. Boston's Partners HealthCare has **proposed acquiring** Providence-based Care New England Health System, for example, a deal that still needs state and federal regulatory approval. Three-hospital health system Lifespan, also based in Providence, has **joined the merger talks**.

“We have a built-in safeguard,” Ganim said.**Run the gamut**

Each all-payer claims database is unique. Those established under state law have specific parameters that govern what they can report and who they can release the data to.

In Colorado, the products and reports produced using its database reach a broad audience, including consumers, employers, payers, researchers, state agencies and lawmakers, said Ana English, executive director of the Center for Improving Value in Health Care.

In July, the center rolled out a new **“Shop for Care”** tool on its website that shows prices paid for 13 common imaging procedures at Colorado providers by ZIP code. Users can search by facility name, distance, price or patient experience.

An example from the Colorado All Payer Claims Database (2016)

Over the next 12 to 18 months, the center plans to add an array of prices for inpatient and outpatient procedures based on a bundled-payment methodology, English said.

It's difficult for states to take action on healthcare costs or pricing without having reliable information to back up those decisions, she said.

English said she's feeling hopeful about the momentum

that's building in her state. “Really what's driving it now is that the industry needs to take action or it is going to be done for them,” she said. “I think that the realization is that change is coming. Either you're a part of it or it happens to you.”

All-payer claims databases have been used to compile important analyses, such as a report on inadequate treatment for hepatitis C patients in Colorado, a study in Arkansas that examined what conditions people are using medical marijuana for, and countless studies on opioid prescribing, said Josephine Porter, co-chair of the APCD Council and director of the University of New Hampshire's Institute for Health Policy and Practice.

“I think there are a lot of examples of ways these data have been used to inform important conversations on health transparency and cost controls,” she said.

Denise Love, fellow co-chair of the APCD Council and executive director of the National Association of Health Data Organizations, cautioned there are a lot of barriers to transparency making it more difficult for those striving to build all-payer claims databases.

A major setback was the 2016 U.S. Supreme Court ruling that self-insured plans don't have to turn over their claims information to such databases. And there's been some examples on the pharmaceutical side of companies invoking intellectual property and gag clauses to generally prevent the release of price data, she said.

“We just have to keep overcoming those barriers,” she said.**Will patients use them?**

But even if price transparency tools are improved, there's still the question of whether people will use them—and some research has found they don't. A **2017 study** in the journal Inquiry found that only 11% of more than 70,000 families offered the Truven Treatment Cost Calculator used the tool at least once.

Researchers concluded that employers and payers need to pursue strategies to increase engagement with healthcare price information, particularly among those with higher healthcare spending. Another **study last year** in Health Affairs found only 13% of Americans who had some out-of-pocket spending in their last healthcare visit had asked about their expected spending before receiving care.

Despite the rise in high-deductible health plans, the majority of Americans still are “very insulated” from the actual cost of healthcare, Delbanco said. That's one thing that dampens the use of the tools resulting from all-payer claims databases.

“For those of us who have PPO plans or HMOs, there's not going to be a lot of motivation to look at price information because you know what your copay is or you have a pretty reasonable deductible or coinsurance,” she said.

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