If I had $50 million and unlimited technical expertise … I'd convince Congress to create a federal All-Payer Claims Database

By Jenny Gladieux, PhD Candidate in Health Services Research, George Mason University

With *Gobeille v. Liberty Mutual*,[1] the US Supreme Court decided by a 6 to 2 margin that the Employee Retirement Income Security Act of 1974 (ERISA) preempts Vermont's all-payer claims database (APCD) statute[2] as it applies to employer-sponsored health plans. Given that self-funded employer health plans provide benefits to 93 million Americans[3] (almost a third of the US population), Vermont's attempt at creating a robust APCD in order to rein in health care costs while promoting population health essentially became a bust with the decision.

So what? What is an APCD and why is it important, you may ask. An APCD systematically gathers together information from clinical and claims sources across a variety of organizations including insurers, pharmacy benefit managers, and health care providers themselves – hospitals, doctors, nursing homes, and others. The goal is to aggregate health care information, utilize it to improve care quality, and disseminate it for consumer choice and better population health. At least 17 states have laws that enable the collection of health care claims data to build an APCD, but there is no standardization among these states for the information that is collected or used.[4] For instance, some of the states collect price and clinical information in addition to claims information, and some do not.[5]

You may also ask why other approaches don't do population health as well as an APCD? Doesn't interoperability of electronic health records along with regional health information exchanges (HIEs) allow for population health? Two reasons exist for why electronic health records in and of themselves are not sufficient for population health. First is timing. Interoperability appears to be a long way off given the blocking certain health IT vendors have put in place to protect the proprietary nature of their platforms.[6] Second, HIEs don't tell physicians what other providers out there have delivered services to the presenting patient. In other words, physicians would need to go on a fishing expedition to all other providers to see if their patient had medical services at other offices or hospitals or paid for by payers who don't contract with the physician. A database, by its very nature, allows for the organization of

---

[1] Slip Opinion 14-181 (3/1/16) available at http://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf. For further analysis of ERISA preemption and the *Gobeille* decision, see Nicole B. Gage, *Revisiting ERISA Preemption in* Gobeille v. Liberty Mutual, 11 DUKE J. CONST. L & PUB. POL'Y SIDEBAR 195 (2016).

[2] Vt. STAT. ANN., TIT. 18, §9410(a)(1) (2015 Cum. Supp.) (V. S. A.).

[3] See ERISA Industry Committee's Amicus Curie brief at page 4 available at http://www.eric.org/uploads/doc/legal/Alfred%20Gobeille%20v_%20Liberty%20Mutual%20Insurance%20Company%20-%20102115.pdf. *See also* Kaiser Family Foundation, *2015 Employee Health Benefits Survey* (Sept. 22, 2015), available at http://kff.org/healthcosts/report/2015-employer-health-benefits-survey/.

[4] See the state legislation listed at the APCD Council's webpage at https://www.apcdcouncil.org/apcd-legislation-state.

[5] *Id*. Compare Colorado and Rhode Island which require price transparency with Virginia which treats price information as proprietary.

[6] *See* Senator Cassidy's comments at the Senate HELP Committee hearing on "Achieving the Promise of Health Information Technology," (October 1, 2015), available at http://www.help.senate.gov/hearings/achieving-the-promise-of-health-information-technology.

data, and perhaps more importantly, permits queries for the retrieval of required specific information without flailing around hoping all information is up-to-date and complete.

Given these reasons – ERISA preemption, the lack of standardization across state APCDs, and the potential for moving health care to quality and value through better population health – if I could, I would waive a magic wand, and with $50 million and unlimited technical expertise, create a federal APCD. This ACPD would be federal law that trumps ERISA preemption, creates a one stop shop for clinical and claims information no matter where the provider or payer is located, and allows our health system to evolve toward population health management where partners across many sectors—including public health, health care organizations, community organizations, and businesses—are able to integrate investments and policies across all social determinants of health.[7]

Creation of a federal APCD is not the last step in population health however. As John Morrissey notes in his paper "Data Driven," one key to true population health is having a sufficient number of professionals who have an understanding of both clinical and claims data and how they work together with other external data to put together a comprehensive health picture.[8] Data analytics (not just information management), and the technical expert staff to produce it, are critical to achieving population health. Analytics is a process whereby raw clinical and claims data is taken, flipped into actionable medical reports using evidence-based guidelines, and then pushed back out to health care organizations who then deliver the reports to front line clinicians.

Implementing a federal APCD will not be simple. Many operational problems exist; choices will need to be made including:

- What part of the federal government should run it (The US Department of Labor, the US Department of Health and Human Services, an independent entity such as the Patient Centered Outcomes Research Institute, or another body);
- Who must submit information and how to incorporate Medicare, Medicaid, and other payers such as the VA and Indian Health Service;
- What information must be submitted (claims, clinical, price, and/or quality metrics);
- How frequently must information be submitted (real-time, monthly, quarterly, or annually) and how frequently can information be fed back to clinicians;
- How to integrate all the information and what to do with existing state APCDs; and
- Privacy concerns (e.g., what to do about substance abuse records that have extra federal privacy protection?)

[7] For a discussion of population health management and achieving the triple aim of better health, better health care, and at lower cost, see David Kindig, *What Are We Talking About When We Talk About Population Health?* in HealthAffaris Blog (April 6, 2015), available at http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/.

[8] In Hospitals & Health Networks at 26 (February 2013).

Actually bringing a federal APCD to its potential fruition will likely take time and cost more than $50 million. This dilemma could possibly be solved/offset by instituting user fees. This is another choice that will need to be decided.

In the end, $50 million and unlimited technical expertise for data analytics may not be enough. A federal APCD will likely require Congress to take action and answer some of the above issues by passing legislation. Given the ERISA preemption decision in *Gobeille v. Liberty Mutual*, an act of Congress is almost guaranteed to be necessary in order to force employer-sponsored plans to submit data. The current political environment in Washington doesn't have a clear appetite to take on a federal APCD however. As an alternative, some have suggested that the President could facilitate the de facto creation of a federal APCD by having the Department of Labor issue standards for a database and encouraging ERISA plans to voluntarily submit information,[9] but with a pending change in Administration, this scenario also seems unlikely. Perhaps the best use of at least part of the $50 million is to stage an advocacy campaign for Congress to pass legislation establishing a federal APCD.

[9] See Erin Fuse Brown and Jaime King, *The Consequences of* Gobeille v. Liberty Mutual *For Health Care Cost Control* (March 10, 2016) in HealthAffairs Blog, available at http://healthaffairs.org/blog/2016/03/10/the-consequences-of-gobeille-v-liberty-mutual-for-health-care-cost-control/. See also *Comment Letter on new Schedule J for self-insured plans* by the National Academy of State Health Policy (October 4, 2016), available at http://nashp.org/wp-content/uploads/2016/10/CA_-Final_-NASHP-Comments-and-Proposal-to-DOL.pdf.