



Statement on Behalf of UnitedHealthcare

to the

State All Payer Claims Databases Advisory Committee

May 19, 2021

UnitedHealthcare (UHC) is pleased to provide recommendations to the State All Payer Claims Databases Advisory Committee regarding the development of a model form for the voluntary reporting by group health plans of medical claims, pharmacy claims, dental claims, and eligibility and provider files to State All Payer Claims Databases (APCDs). We support the work of the Advisory Committee in advising the Secretary of Labor on the creation and maintenance of a voluntary reporting form and guidance to states on the collection of data from group health plans in a standardized format.

We believe the Advisory Committee should develop a reporting form and process that allows group health plans to voluntarily report information to state APCDs in a seamless and cost-effective manner. In making its recommendations, the Advisory Committee should also consider the current reporting obligations imposed by state APCDs on health insurers and ways health insurers can share data consistent with the voluntary reporting by group health plans.

UnitedHealthcare is dedicated to helping people live healthier lives and making the health system work better for everyone by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. In the United States, UnitedHealthcare offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries, and contracts directly with more than 1.3 million physicians and care professionals, and 6,500 hospitals and other care facilities nationwide.

Background on State APCD Requirements

Currently 19 states require data reporting by health insurer to an APCD.¹ Several of these states allow voluntary reporting by self-funded group health plans. Based on UHC's experience health insurers may incur costs of around \$1 million to establish a state APCD data sharing platform and continuing annual expenditures of several hundred thousand dollars per state APCD depending on the amount of data and frequency of reporting.

Unfortunately, each state APCD requires different data requirements, report formats, and reporting cycles. The failure of states to adopt uniform data sharing standards results in operational complexity and higher operating costs.

¹ Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Vermont, Virginia, and Washington.

This complexity is further increased by data reporting requirements seeking information that insurers do not routinely gather from health care providers on claims or other health care transactions or maintain on claim systems – to provide a few examples:

- Federal Information Processing Standard (FIPS) County Codes – the FIPS County Codes are unique five-digit codes used to identify United States counties and county equivalents. This information is not included on standard claims submitted by health care providers.
- Medicaid AID Category – relates to the type of Medicaid assistance received by a beneficiary. Medicaid beneficiary status information is not determined or tracked by health insurers but rather is determined by state Medicaid and Children’s Health Insurance programs.
- Employment status – other than the primary subscriber covered by a group health plan, health insurers are not aware of the employment status of the covered member. The CDL asks reporting insurers to designate whether employed individuals are “on leave,” “pending,” or a “retiree” which is information an insurer would not typically maintain.
- Member PCP Effective Date – generally, health insurers do not maintain data regarding when a member first started using a specific health care provider.
- Claim Version number – many claim payment platforms do not create a unique claim version number nor incrementally restate an entire claim, as a required field on claims transactions.

There are on-going efforts to develop uniform reporting requirements. The University of New Hampshire in collaboration with the National Association of Health Data Organizations has developed a standard reporting format – the Common Data Layout (CDL) v2.0² We note that the CDL is a suggested format, but has not been developed by a standards setting organization and is not used by most state APCDs.

Recommendations for Voluntary Reporting by Group Health Plans

UHC supports a uniform, national standard for the reporting of all APCD data by health insurers and voluntary reporting by group health plans. We believe the reporting recommendations adopted by the Advisory Committee should encourage voluntary reporting by group health plans and promote more uniform data sharing by health insurers with state APCDs. In many cases, self-funded employers choosing to report data to state APCDs will ask a service provider such as a health insurer to provide the information. As a result, having consistent reporting standards for both insured and self-funded coverage and across all states will provide more robust data at a lower cost. We suggest the Advisory Committee consider the following with respect to the development of recommendations for data reporting to state APCDs.

Recognize Other Available Data Resources

Beginning in 2022, health insurers and group health plans will be required to produce three machine readable files with information on the negotiated rates and historical costs for covered items, services, and prescription drugs:

² See: APCD Council, *Common Data Layout*, [Common Data Layout | APCD Council](#)

- In-network provider negotiated rates for covered items and services.
- Out-of-network historical allowed amounts for covered items, services, and prescription drugs
- Negotiated rates and historical allowed amounts for covered in-network prescription drugs

This information must be publicly available, without charge, and updated monthly.³ The Centers for Medicare & Medicaid Services (CMS) has released draft data elements for the three machine readable files.⁴

The negotiated rates and historical claim data are associated with each health care provider or facility and each specific health insurer or group health plan coverage option. The files will allow data users to identify the negotiated rates and out-of-network allowed amounts for covered health care items, services, and prescription drugs for all health care providers and facilities for a specified coverage option. We appreciate that state APCDs collect a variety of data that is used for different purposes and the data in the Machine Readable Files may not satisfy all those needs. However, to the extent that existing sources of information are available, health insurers and group health plans should not be required to report the same information multiple times.

Adopt Standard Data Sharing Formats Used by Healthcare Payers and Providers

The healthcare community is migrating to use of the Fast Healthcare Information Resources (FHIR) standard for sharing clinical and claims information. Use of this standard is already required for Medicare and Medicaid programs and Qualified Health Plan issuers on the Federally Facilitated Exchange platforms to make claims, encounter, and clinical data available to beneficiaries and members through open Application Programming Interfaces (APIs).⁵ The standard has also been adopted by CMS as part of the long-standing Medicare Fee-for-Service Blue Button initiative.⁶

The FHIR standard was developed by Health Level 7 International (HL7) and provides a set of resources allowing end-users to securely request datasets from a health insurer, health care provider or other data platform. Depending on the system structure, the data can be obtained on an agreed timeframe. This functionality eliminates the requirement to package and send an entire dataset and gives the end user the flexibility to only request data as needed to fulfill a specific inquiry.

HL7 has created the FHIR Bulk Dataset (Flat FHIR) allowing access to large datasets for a group of individuals.⁷ This methodology would further support the FHIR Blue Button Implementation Guides by allowing for retrieval of multiple claims information datasets.

³ Departments of Health and Human Services, Labor, and the Treasury, *Transparency in Coverage Rule*, 85 FR 75128 (November 12, 2020).

⁴ Centers for Medicare & Medicaid Services, *Information Collection Request (CMS-10715)*, 85 FR 86567 (December 30, 2020). The three draft machine readable file data formats are available at: [CMS-10715 | CMS](#)

⁵ Centers for Medicare & Medicaid Services, *Interoperability and Patient Access Rule*, 84 FR 7610 (March 4, 2019).

⁶ See: CMS Blue Button 2.0 available at: [CMS Blue Button 2.0](#)

⁷ See: HL7, *FHIR Bulk Data Access (Flat FHIR) v1* available at: [FHIR Bulk Data Access \(Flat FHIR\) : / \(hl7.org\)](#)

UHC asks the Advisory Committee to consider the usefulness of the FHIR standards – or other similar standards used by the health care community – as a uniform process to make data available to state APCDs.

Focus Data Collection on Information Shared by Payer and Providers

As noted, some data elements required by state APCDs are not included in health care transactions such as claims. We believe the voluntary reporting by group health plans should be based on data available in the standards created by the Accredited Standards Committee X12 and the National Council on Prescription Drug Programs standards development organizations as part of the HIPAA electronic healthcare data transactions. The data elements in these transactions are included in the FHIR Bulk Data standards referenced above and represent information that a health insurer or group health plan would have available to share with a state APCD.

UHC asks the Advisory Committee to develop reporting processes for group health plans that rely on data available to the plan and not create requirements to gather or generate information not maintained by the plan.

Consider Partnerships with Standards Development Organizations

We believe standards development organizations (SDOs) – such as HL7 – are best positioned to create and maintain standards for data sharing by health insurers and group health plans with state APCDs. SDOs play a vital role in facilitating the electronic transmittal of health information through a standards-based, industry accepted, non-political process. An SDO that agrees to take on this responsibility could ensure the standards meet the needs of state APCDs and the health care community, promote seamless and secure data exchanges, and provide cost-effective data sharing. Housing the standards with an SDO also allows updating as necessary with input from stakeholders..

UHC appreciates the opportunity to provide these recommendations to the Advisory Committee and we look forward to continuing our collaboration on this issue.