HCCI HEALTH CARE COST INSTITUTE

Necessary versus sufficient claims data

An assessment of health care price research implications following the Gobeille v. Liberty Mutual Insurance Co Supreme Court decision

This data brief compares the membership and prices of national samples of self-funded and fully insured employer-sponsored insurance (ESI) claims data for the years 2010 through 2014. Differences between these two populations has become more relevant following the Supreme Court decision in Gobeille v. Liberty Mutual Insurance Co, 577 U.S. (2016), which upheld an appellate court ruling that under the Employee Retirement Income Security Act (ERISA) of 1974, states cannot require self-insured employers or the administrators of their claims to submit data to all-payer claims databases (APCDs).

Self-insured employers typically finance the insurance plan but contract with another organization to provide services such as provider network negotiations and claims processing. These organizations are often referred to as third party administrators (TPAs). In contrast, employers with fully insured plans purchase insurance plans for their employees from insurers with administrative services included. Insurance plans sold to fully insured employers are subject to the federal and state insurance regulations. Self-funded employers, however, are subject to insurance regulations through ERISA.

In this analysis, self-funded insurance plan status is used as a proxy for ERISA plans and fully insured status as a proxy for non-ERISA. Differences in the ERISA and non-ERISA populations may be driven by prices and/or utilization. This data brief focuses on comparisons of prices. The analysis population was limited to individuals under 65 years of age enrolled in a large group, commercial health plan with health maintenance organizations (HMO), preferred provider organizations (PPO), or point of service (POS) plan types.

Member demographics were similar for HMO and POS plans, which comprise the largest portion of the ERISA and non-ERISA populations

In both the ERISA and non-ERISA populations, the largest percentage of membership was in POS plans. In the ERISA population, POS plans accounted for over 80% of membership in every year. In the non-ERISA population the total percentage of POS membership increased from 40% in 2010 to 51% in 2014 (Figure 1).

The non-ERISA population had nearly the same percentage of the population enrolled in HMO plans as POS plans in 2010, 38% versus 40%, respectively. The proportion of non-ERISA HMO enrollment declined from 38% in 2010 to 27% in 2014. ERISA HMO membership was always substantially lower than other plan types but also decreased from 4% in 2010 to 2% by 2014. The proportion of PPO membership was consistent over time in both the ERISA and non-ERISA populations.

Data Brief #4

July 2016

KEY FINDINGS

The majority of both ERISA and non-ERISA membership was in point of service (POS) plans

In 2014, 85% of the ERISA population and 51% of non-ERISA population were covered by point of service (POS) plans.

Non-ERISA prices were similar to ERISA prices on average

On average, non-ERISA prices were within 5% of ERISA prices for inpatient, outpatient, and professional service categories.

Figure 2 presents the distribution of age groups by population and plan type from 2014. Between the two populations, the distribution of membership within plan types was similar for HMO and POS plans. However, there were larger percentages of younger members (ages 18 – 24 and 25 – 34) enrolled in non-ERISA PPOs compared to ERISA PPOs.

Over the study period, the gender distribution in the ERISA and non-ERISA population was similar. On average, membership was 49% male/51% female across all plan types (data not shown).

On average, non-ERISA prices were within 5% of ERISA prices for most plan types and medical service categories

A price index, controlling for utilization, was calculated to compare the average non-ERISA price to the average ERISA price (see Data and Methods). An index value of 1.00 indicates that the average non-ERISA price is equal to the average ERISA price. Thus, the difference between the price ratio and 1.00 can be interpreted as the percentage differ-

ence in price of the non-ERISA population relative to the ERISA population. For example, a price index of 1.05 implies non-ERISA prices were 5% higher than ERISA prices.

The price indices for each year-plan type-medical services combination are shown in Table 1. Non-ERISA HMO prices were, 2%-4% higher from 2010 through 2012, but by 2014 were 1%-2% lower. Non-ERISA POS prices were consistently 1%-5% less than ERISA POS prices. Non-ERISA PPO prices were the most different ranging from 3% to 13% higher than comparable ERISA prices.

Among the service categories, the HMO and POS average inpatient prices were the most similar differing by 1% or 2% in most years. The PPO inpatient price index increased from 1.06 in 2010 to 1.13 in 2012. The index value, however, did decrease in the remaining years of the study period to 1.07 in 2014.

Within outpatient services, the non-ERISA POS prices were 4% less than the ERISA POS prices in every year of the study. Although both HMO and PPO non-ERISA prices were generally higher than the respective ERISA prices, the average difference for HMO plans was 1%. Among PPO plans the average difference was 8% and in 2011 non-ERISA PPO outpatient prices were 10% higher.

Similar to the other service categories, non-ERISA POS professional services were lower than ERISA POS prices in the study period. Among PPO plans, the non-ERISA prices fluctuated between 3% and 6% higher than ERISA prices. For HMO plan types, however, there was a steady decline in the price ratio from 1.04 in 2010 to 0.98 in 2014. There was also a decline in the price ratio for POS plans over the study period, from 0.98 in 2010 to 0.95 in 2014.

The average price for a specific service may differ between ERISA and non-ERISA populations

It is possible to compare the prices for particular services. Although it is not possible to compare every price for every service, as a descriptive example Table 2 reports ratios of non-ERISA to ERISA prices for the ten most prevalent inpatient diagnosis-related group (DRG) services in the ERISA population in 2014. These ten DRGs account for approximately 43% of admissions and over 20% of inpatient spending in both populations. Consistent with the inpatient average the non-ERISA DRG-level prices were most comparable to the ERISA prices for POS plan types. The widest variation in prices was among PPO prices.

Policy Implications

The differences between the ERISA and non-ERISA populations in plan type distributions and demographics suggest that there may also be utilization differences between the two populations. However, the price indices described above show how the overall average prices compare, assuming the same mix of services are used in both populations. Generally, prices for HMO and POS plan types tended to be similar between the ERISA and non-ERISA populations. In PPO plan types non-ERISA prices appeared to be higher.

Although the HCCI data includes approximately 27% of the under 65 ESI population in the US in a given year, the data is a convenience sample and may not be representative of the full commercially insured population. As such the results of this study may not be generalizable to APCDs in all states. However, the results suggest that non-ERISA data may be applicable for many policy relevant analyses, even when ERISA data is not available.

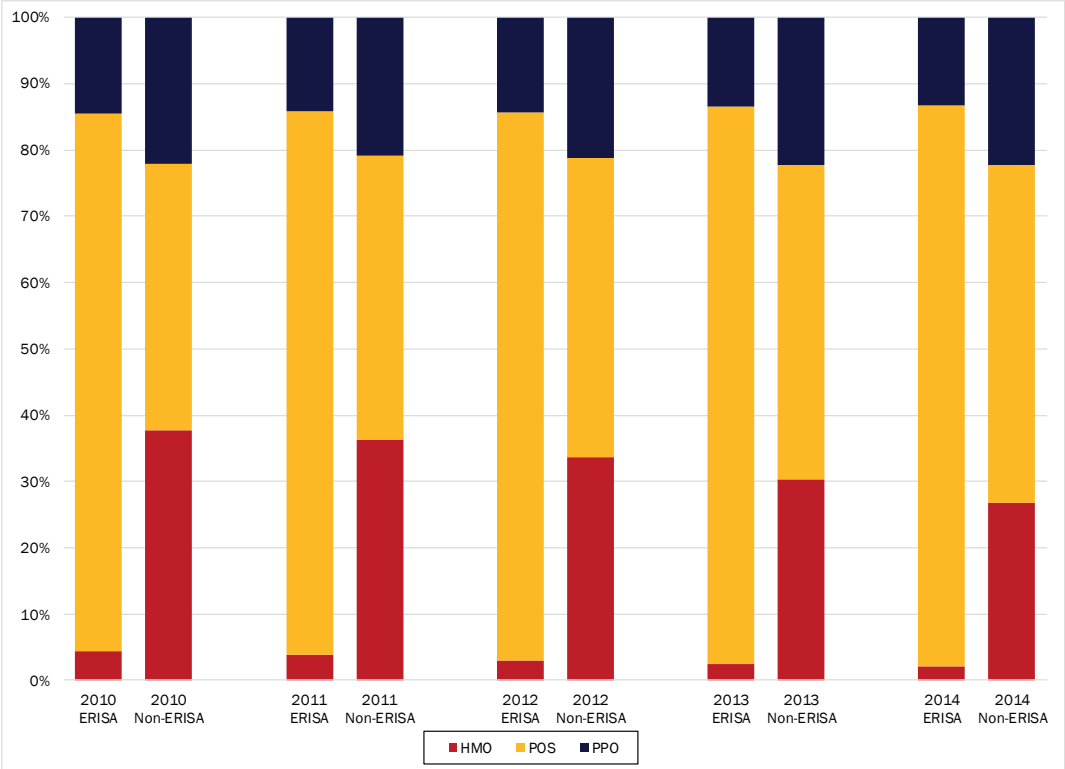
Finally, this study compared prices while attempting to control for utilization differences. The dynamics of the differences between the two populations are likely much more complicated. This study does not attempt to account for differences between ERISA and non-ERISA populations due to member preferences or health plan benefit structures, which may influence plan choice, utilization of services, and ultimately impact the price of services.

Data and Methods

To ensure reliable comparisons, the analyses were limited to the ESI large group market, under age 65 who were covered by health maintenance organizations (HMO), preferred provider organizations (PPO), or point of service (POS) plan type. The resulting average annual membership accounts for approximately 22% of the national under 65 ESI population each year.

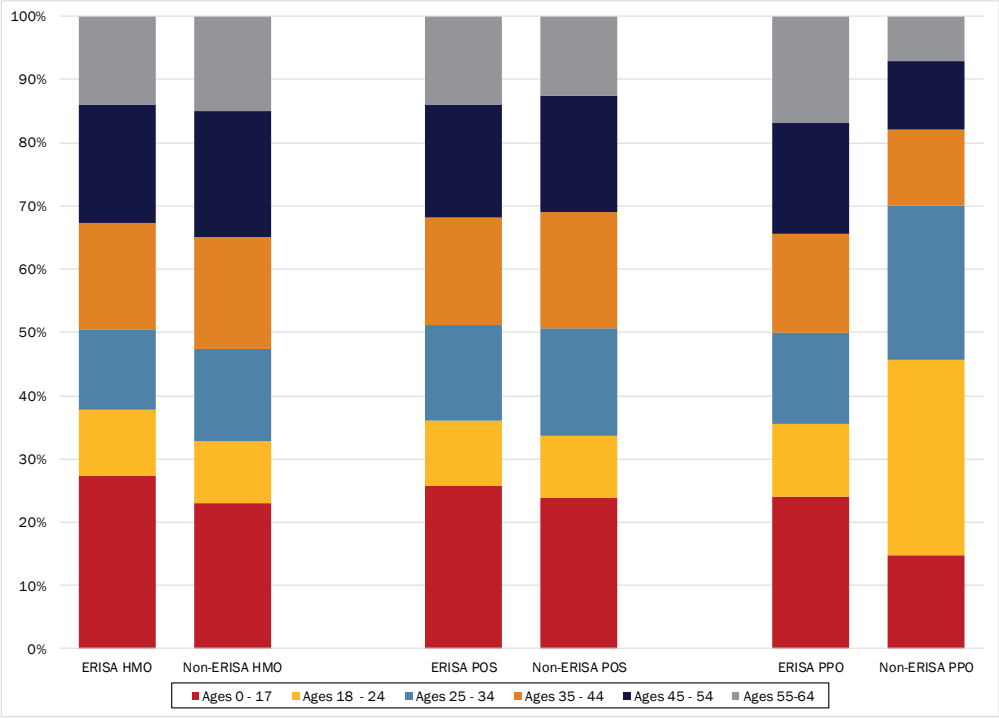
To control for differences in utilization between populations, a price index was calculated, which held the service mix for each plan type and time period fixed. This was accomplished by applying the ERISA populations' proportion of services to the non-ERISA population of the same plan type and time period and calculating a weighted average price for each population. The index value was calculated as the ratio of non-ERISA to ERISA total weighted average prices. Indices were calculated for combinations of plan type and major medical service category. Medical service categories were inpatient, outpatient, and professional services (e.g., doctors, nurses, or other non-facility prices).

Figure 1. Membership by plan type



Source: HCCI, 2016.

Figure 2. Membership by age (2014)



Source: HCCI, 2016.

Table 1. Price indices by plan type and medical service category

	HMO plans			POS plans			PPO plans		
	Inpatient	Outpatient	Professional	Inpatient	Outpatient	Professional	Inpatient	Outpatient	Professional
2010	1.03	1.02	1.04	0.99	0.96	0.98	1.06	1.08	1.05
2011	1.01	1.01	1.04	0.96	0.96	0.98	1.12	1.10	1.06
2012	1.01	1.03	1.02	0.98	0.96	0.98	1.13	1.07	1.03
2013	0.99	1.01	1.01	0.99	0.96	0.97	1.11	1.07	1.04
2014	0.99	1.00	0.98	0.98	0.96	0.95	1.07	1.08	1.03
Average	1.01	1.01	1.02	0.98	0.96	0.97	1.10	1.08	1.04

Source: HCCI, 2016.
Note: The price ratio is calculated as non-ERISA weighted average price divided by ERISA weighted average price.

Table 2. Price ratios for top ten DRGs (2014)

DRG	DRG description	HMO	POS	PPO
775	Vaginal delivery without complicating diagnoses	0.86	0.99	1.17
795	Normal newborn	0.88	1.00	1.10
766	Cesarean section without CC/MCC*	0.85	0.98	1.22
885	Psychoses	0.83	0.94	1.10
470	Major joint replacement or reattachment of lower extremity without MCC*	0.93	1.00	1.10
897	Alcohol/drug abuse or dependence without rehabilitation therapy without MCC*	0.99	0.86	0.99
765	Cesarean section with CC/MCC*	0.85	0.98	1.27
794	Neonate with other significant problems	0.99	1.05	1.09
392	Esophagitis, gastroenteritis, and miscellaneous digestive disorders without MCC*	1.00	1.00	0.89
774	Vaginal delivery complicating diagnoses	0.88	0.98	1.12
Average price ratio of top ten DRGs		0.91	0.98	1.11

Source: HCCI, 2016.
Notes:
1. The DRGs listed are the ten most frequent in the overall ERISA population in 2014. The rows are ordered by descending volume. In 2014, the same ten DRGs were also the most frequent with the same rank order among the overall non-ERISA population.
2. The price ratio is calculated as non-ERISA average price divided by ERISA average price.
3. MCC denotes a Major Comorbid or Complicating Condition as defined by CMS. CC denotes a Complicating or Comorbid Condition as defined by CMS.

Authors
Eric Barrette and Katharine McGraves-Lloyd
ebarrette@healthcostinstitute.org
571-257-1584

Health Care Cost Institute, Inc.
1100 G Street NW, Suite 600
Washington, DC 20005
202-803-5200