April 17, 2019

Mr. Ted Calvert
California Office of Statewide Health Planning and Development (OSHPD)
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Dear Ted,

On Covered California's behalf, I am pleased to submit the attached suggested use cases for the Healthcare Cost Transparency Database, often referenced as an All Payer Claims Database or APCD. We expect that OSHPD's APCD implementation will provide great value to stakeholders and Californians in general, and we anticipate a substantive and ongoing partnership with you during your effort.

These use cases from Covered California are grounded in our role as a public entity interested in past, current, and future enrollees' access to and utilization of high quality, cost-effective medical care. Nonetheless, almost all our proposed use cases apply broadly to most insurance markets, not just individual and small group. We expect these use cases to have similar applications for a variety of other purchasers and market-organizers broadly (both public and private) who share our commitment to find opportunities to help health care markets deliver increasingly higher-value care.

Like OSHPD, we observe strict requirements emphasizing protection of individuals' data privacy. Our suggested use cases' data analyses rely on the prerequisite guarantee of protecting patient confidentiality and information security at all times.

Critical Data Attributes: In addition to providing the attached use cases, Covered California suggests that the OSHPD APCD adopt the following among its foundational data elements:

- **Allowed cost** information comprised of the insurer / payer paid amount and the consumer cost share amounts. Given the California market, a fee-for-service equivalent amount for capitated services also is essential.

- **Provider identification** accomplished via the individual practitioner National Provider Identifier (NPI); a comprehensive facility identifier (e.g., OSHPD

identifier) encompassing inpatient hospitals, outpatient diagnostic / treatment centers, and ambulatory surgery centers; the one-to-many roll-up of practitioners to medical practices; and the organization of facility and practitioner identifiers to show the composition of delivery system entities like Accountable Care Organizations (ACOs). To provide detailed analysis in patterns in care, it is essential to identify the individual (rendering) provider, and not rely only the tax ID, for example. California is fortunate to have the statewide provider directory utility, Symphony (being deployed by IHA), that can provide the foundation for claims data submission standards and APCD data augmentation to support these provider identification needs.

- **Product identification** distinguishing each carrier's products and, as appropriate, networks. The goal here should also be to distinguish each product type in single carrier, multiple product arrangements (e.g., carrier provides a client with HDHP, PPO, EPO, and HMO products). For example, Covered California currently accomplishes this via the combination of carrier, plan type, metal tier, metal tier variant, and Health Insurance Oversight System (HIOS) ID. Regardless, HIOS ID is a necessary product identification component in all individual and small group health insurance markets.

- **Alternative Payment Model (APM)** non-claims financial payments and penalty amounts. APM data templates are available from several other state APCDs that include this APM data.

- **Premium amounts and benefit coverage information** are also essential data for the commercial market. One approach to capture benefits information would be to collect the full HIOS ID for every product in the individual and small group markets – on and off-Exchange -- along with each product's assigned actuarial value (AV), or even additional plan design details from SERFF filings. Capturing the AV for the large group market (with a standardized methodology, such as with the CMS Actuarial Value Calculator) may be the only possible approach to capture a benefits coverage proxy in the near term given the myriad benefit designs in the experience-rated market.

- **Payer and provider identifiable records** are essential to perform a wide range of expected analyses, but will require data use safeguards to ensure that the identities of the payer and provider are not disclosed in ways that reveal a contracted fee between the two parties except for special, permitted data uses.

Longer term, the following data elements will enable additional functionality, and the APCD data model should accommodate them:

- **Social determinants of health** beginning with demographic data including age, gender, race, ethnicity, language, income, and location (e.g., street address); expanding to include education, physical environment, etc., as such data become available. Where applicable, OSHPD's APCD should also consider the inclusion of data / algorithms to construct social determinants' proxies.

- **Clinical and patient-reported outcomes data**, which are used for performance accountability, as it becomes available through Health Information Exchanges, government/public sponsored registries, Qualified Clinical Data Registries etc.

Analytic Enhancements: OSHPD should also equip its APCD with a core set of data / analytic capabilities, including:

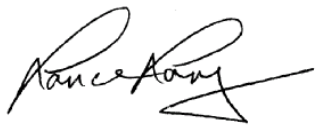
- A patient severity of illness / risk adjustment system;
- Mapping of claims to medical services categories (e.g., imaging, lab, preventive care, specialty office visits, etc.);
- A measures engine to produce standard cost and quality measures;
- Episode groupers to organize services into acute and chronic episodes of care;
- Master Patient Index to allow for longitudinal analysis of the same individual across coverage sources (and claims feeds);
- Wasteful / inefficient care measures; and
- ZIP Code to census tract mapping.

Data Governance Considerations: Covered California recognizes that various entities, public and private, are likely to be either contributors and consumers of OSHPD APCD data , or both at the same time. We encourage the committee to consider a tiered data user framework with appropriate controls to balance data suppliers' data sensitivities and the importance of making data available to the public. The use cases attached consider 4 kinds of possible users/audiences (government users, issuers & providers, public use, and researchers) as examples only. Each would require a different level of access and degree of detail in available data. For example, as a prospective data supplier, Covered California will want assurances that submitting data to the APCD will not in any way hamper its ability to certify Qualified Health Plans, consistent with its statutory obligations. Similarly, as a prospective APCD data consumer, we certainly anticipate that the APCD governance will accommodate direct access to APCD data for our own analyses. For both sides of this equation to work, the APCD will need both a

clear user approval and data governance framework, and a rock-solid process to safeguard information security and the privacy of all Californians. If the data safeguards are not clear, data suppliers will resist participation, while if the data access is too limited, users will not be able to derive actionable results.

Thank you again for presenting us with this opportunity to help inform and support your efforts. If you have any questions or issues regarding our submission, please do contact me. All of us on the Covered California team look forward to opportunities to assist you regarding the Healthcare Cost Transparency Database.

Sincerely,



Dr. Lance Lang
Chief Medical Officer

Enclosure

Covered California Candidate Use Cases for California All Payer Claims Database

Much of Covered California's candidate APCD use cases focus on the commercial market. A number of these same use cases can be extended to address similar issues in the Medi-Cal and Medicare Advantage markets.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
Market Structure & Competition							
UC01 – Market Structure, Stability, and Opportunity for Improvement	Compare claims costs and population health status among insurance markets and enrollees. To inform policy, use results to assess: i) each market's enrollment and risk pool changes over time, ii) cost trends, iii) consumer affordability metrics, iv) gaps in coverage, adverse selection, and migration within/among markets, and v) over/under use of services.	Insurance market-specific, product type level cost per member per month (PMPM), utilization rates & population risk scores. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• HIOS ID & metal tier • Grandfathered products ID • Actuarial value (AV) / other benefits level indicator • Master Patient Index (MPI) • Enrollee Severity of Illness (SOI) /risk classification	• *Government and Public Users:* Public and private policy makers and regulators designing market subsidies and market stabilization policies	• *Public:* Consumer advocates seeking better understanding of the consumer experience with coverage, care and costs across markets. • *Public:* Issuers and provider groups seeking understanding of how their market position and competitiveness relates to state averages and trends.	• *Public:* Market enrollment & cost trends reporting (e.g. annual HCCI outputs) • *Public:* Analysis of population health status, costs and value by market segments. • *Approved User:* Raw extracts for analytics	• Create market rules to ensure consumer affordability and market stability.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC02 – Market Competition: Premium Trends	Evaluate premium and claims cost trends in the individual and small group markets: i) average premium amounts & changes, ii) medical loss ratios, iii) age & area factors, and iv) claims costs changes by medical service categories. Use results to: i) model future premiums and marketplace fees, and ii) assess & negotiate carrier premium rate increases.	Qualified Health Plan (QHP) carrier-specific individual and small group product level premiums and total claims cost. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• Enrollee-level premiums & subsidy amounts • HIOS ID & metal tier • Grandfathered products ID • AV / other benefits level indicator • Standard medical service categories	• *Government Users:* Covered California, Department of Managed Health Care, and Department of Insurance	• *Approved Users:* Researchers analyzing opportunities to improve market efficiency.	• *Approved User:* Detailed premium and cost trends report and analysis, by rating region, product, and payor.	• Equip the State with evidence-base to guide its health reform policy-making.
UC03 – Program & Carrier Value Performance Dashboard	Report California healthcare value performance to the general public. Produce market and carrier-specific cost and quality results for various insurance markets. Use results for: i) government accountability reporting to the public, ii) preparing public and private purchasers for negotiations with carriers, and iii) consumer health insurance decision support services.	Insurance market and carrier-specific cost and quality measure results. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• Measures engine: cost and quality metrics • Clinical/other non-claims-based quality measures	• *Public:* Consumer advocates, public policy leaders, media, and others working on behalf of the public • *Public:* Consumer end-users who are choosing insurance products & provider networks.	• *Government User:* detailed analysis of healthcare value (cost and quality) by issuer & market • *Health Plans:* benchmark data for carrier performance improvement	• *Public:* dashboard and atlas-type website with summary performance metrics	• Be accountable to all Californians for healthcare cost and quality

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC04 – Market Competition: Provider Pricing	Evaluate extent to which providers' pricing is determined by factors such as market share, geographic region, facility / institution type (e.g., academic, training, public), and patient payment mix. By geographic area/medical service type, assess prices by provider and price variation among providers. Use results for: i) policy re: market structure & competitive practices, ii) healthcare services supply needs, and iii) payment reform.	Provider-specific (facility, medical group, IPA) utilization and unit prices for target services. Allowed costs (Y) Provider-identifiable (Y) Payer-identifiable (N) Enrollee-identifiable (N)	• Enrollee attribution to primary care/ provider sys • Diagnosis/service grouper • Provider parent-to-child linkage • Medical service market areas • Enrollee SOI/risk classification	• *Government Users:* Regulators oversight of market structure and proposed ownership changes. • *Government Users:* Analysis of provider supply & payment reform policies to ensure access to care in all California geographies.	• *Researcher:* Analysis of the relationship between provider supply/market structure and health care costs. • *Issuers & Providers:* Evaluate own performance compared to benchmarks to identify provider supply & payment reform opportunities.	• *Pubic:* Provider-level reporting on costs. • *Approved user:* Extracts to perform quantitative evaluations (eventually made public) of payment reform initiatives. • *Approved user:* Analysis of the relationship between provider supply and market structure and cost of health care	• Guide policy and practitioners to advance payment reform, access to care and other initiatives informed by the impact of market forces on price competition

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
Cost & Quality Management							
UC05 – Benefit Design Modeling	Generate PMPM cost & services utilization to model benefit design changes and actuarial value impact. Use results to evaluate likely candidates for benefit design changes, for example value-based insurance design (VBID) that incents consumers to utilize alternative care settings (telehealth, e-Consults, retail visits, etc.).	Commercial market, all carriers' benefit design information summarized by metal tier, service type-specific utilization and cost PMPM Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (N) Enrollee-identifiable (N)	• HIOS ID and metal tier • Enrollee income level • AV / other benefits level indicator (ideally HPD already links to attributes of the plan design through available regulatory filings (SERFF).) • Standard medical service categories • CPT Category II Codes & HCPCS alpha codes (e.g. G-codes)	• *Government Users:* Covered California benefit design work is enhanced using the broader commercial market population utilization/cost experience. • *Public:* Consumer advocates seeking to provide input on the impact of benefit design changes on consumer welfare.	• *Researcher:* Analyze impacts of benefit design on access, utilization and costs • *Issuers & Providers:* Own performance compared to benchmarks and potential alignment of specific benefit design approaches such as VBID.	• *Public:* Market trends report on benefit design approaches • *Approved User:* Raw extracts for analytics, including core attributes of plan design linked to claims (e.g. linkage to SERFF filings for Individual/Small Group products)	• Advance innovative ways to provide cost-effective care (e.g. telehealth, VBID, etc.)

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC06 – Marketplace Medical / Drug Cost Drivers	Identify medical/Rx cost drivers by differentiating unit price and intensity of utilization for target services. Profile each carrier's cost and utilization drivers to identify most-to-least efficient programs. Compare to reference non-Marketplace populations. Use results to identify options to dampen escalating costs per price/utilization drivers.	Carrier and metal tier level cost PMPM and utilization rates (inlcuding measures of utilization intensity). Summarized, non-Marketplace individual/small group population cost PMPM and utilization rates. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• HIOS ID & metal tier • AV / other benefits level indicator • Enrollee SOI/risk classification • Standard medical service categories	• *Government Users:* CalPERS, Covered California - issuer contracting terms informed by cost drivers evidence. • *Issuers & Providers:* Issuer own performance compared to benchmarks to advance their value strategies	• *Researcher:* Analyze health care spending and disaggregate by medical service categories. Track and trend drivers contributing to growth in health care spending.	• *Public:* Market trends report (e.g. annual HCCI outputs) • *Public:* Analysis of relative value and cost drivers across population and market segments. • *Approved User:* Raw extracts for research	Distill costs into price and utilization components (with measures of utilization intensity) to create actionable information on the intensity and price of services
UC07 – Complex, High Cost and Variation Services: Savings and Quality Opportunity	ID target enrollee cohorts and/or services (e.g., multiple chronic conditions, cancer, ESRD, etc.). Identify the cost, utilization, and quality variation among carriers. Use results to: i) establish performance benchmarks to measure and monitor, ii) adopt care management processes, and iii) for Center of Excellence (COE) programs, evaluate vendors/services.	Carrier product-specific, populations defined by condition or treatment; organize enrollees by SOI/risk groups. Distill costs/utilization by target service categories (e.g., diagnostics, prescriptions, procedures, etc.). Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• Diagnosis/service grouper • Enrollee SOI/risk classification • Standard medical service categories • Centers of Excellence ID • Measures engine: cost and quality metrics	• *Issuers: Evaluate & improve complex care programs working with providers, COE, etc.* • *Government Users:* Covered California has benchmarks for accountability requirements in issuer contracting	*Researcher:* Analyze impacts of complex patient identification and care management processes.	*Public:* Population care trends report *Approved User:* Raw extracts for research	Aggregate multi-payer data to create reliable information on a number of vulnerable population cohorts.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC08 – Document Wasteful, Inefficient Care	Apply measures of unnecessary and harmful care (e.g., Milliman Waste Calculator, Choosing Wisely, PBGH Wasteful Drugs, and brand name drugs with generic equivalents). Use results to: i) establish benchmarks to measure and monitor, and ii) inform providers and enhance point-of-care BI tools	Insurance market-specific and carrier-specific service level utilization and total costs. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• Wasteful services classification	• *Issuers:* Compare the cost and utilization of wasteful services against a benchmark and identify improvement opportunities. • *Government Users:* Data insights to consider policies to mitigate wasteful spending and potentially harmful services.	• *Researcher:* Analyze impacts of identification processes and variation in costs, utilization, and quality of carriers delivering care management for chronic conditions. • *Public:* Market trends report that raises consumer awareness about potentially harmful care.	• *Public:* Public reporting of trends • *Public:* Alert consumers to wasteful care that can harm you. • *Approved User:* Raw extracts for research	• Dampen premium cost increases and pay for innovation by eliminating inappropriate, harmful services.
Delivery System Reform							
UC09 – Alternative Payment Model Evaluation	Assess the value of alternative payment model (APM) products/networks. Evaluate claims costs and quality metrics. Use results to: i) evaluate value-based purchasing (VBP) savings & deficits by APM model type; ii) evaluate VBP benefit designs, and iii) VBP designation for consumer shopping/plan choice.	Carrier-specific APM product / network cost PMPM and quality. Allowed costs (Y) Provider-identifiable (Y)* Payer-identifiable (Y) Enrollee-identifiable (N) *Provider care system IDs to include ACOs, PCMH, and/or designated medical practices	• ID “APM types” (e.g. shared risk) • APM non-claims transaction payments & penalties • Provider care systems ID (e.g. PCMH, ACOs, etc.)	*Issuers and Providers:* Compare the cost and quality of competing APM models. *Government Users*: Conduct oversight to safeguard against APM unintended consequences and to promote successful models.	*Researcher:* Evaluate the factors that are influencing APM model successes and failures.	• *Public:* Market trends report • *Public:* inform consumers APM benefits and assure them that quality is not sacrificed • *Approved User:* Raw extracts for research	• Oversee and refine Alternative Payment Model initiatives in their launch/early stages

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UC10 – Select Network Performance and Network Access	Evaluate EPO/select network product performance re: cost, access, and other quality attributes. Special access analytics to document enrollee locus of care, distance/time to care received, and variation in provider availability by geographic area by major service categories. Use results for: i) network adequacy determinations, and ii) product performance designation and/or remediation actions.	Carrier-specific product and/or provider networks' cost PMPM, quality, and access metrics Allowed costs (Y) Provider-identifiable (Y)* Payer-identifiable (Y) Enrollee-identifiable (N) *Select network products are identified at carrier product level (e.g., HIOS); other products may be comprised of multiple networks that are identified at provider system level	• HIOS ID • Network ID for sub-products (linked or linkable to standardized provider directories, ideally with geospatial keys for providers) • Carrier product network size classification • Enrollee attribution to primary care/ provider sys • Census tract assignment • Geospatial analytics options related to both providers and enrollees (e.g. travel time) • Measures engine: cost and quality metrics	• *Government Users*: DMHC, and CDI for ensuring network adequacy and developing measures for network breadth, Covered California for assessing network quality. • *Issuers:* Compare network breadth against other issuers or product types.	• *Researcher:* Evaluate cost and quality performance of issuer network strategies. • *Public:* inform consumers about network adequacy and care convenience to support their insurance choices	• *Public:* Public reporting on provider availability and access. • *Approved User:* Raw extracts for research with geospatial lens.	*See that all populations – across insurance markets and products – have access to quality care.*

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC11 – Advanced Primary Care	Evaluate the cost and quality performance of primary care practices to assess the characteristics of advanced primary care (APM) systems (e.g., PCMH, HIE-enabled, care teams) Use results to: i) target practices for APM contracting, and ii) establish performance benchmarks.	Medical practice/group level, subset by commercial and Medi-Cal populations. Allowed costs (Y) Provider-identifiable (Y)* Payer-identifiable (N) Enrollee-identifiable (N) *Provider care system IDs to include ACOs, PCMH, and/or designated medical practices	• Provider care systems ID (e.g. PCMH, ACOs, etc.) • Enrollee attribution to primary care/ provider sys • Clinical/other non-claims-based quality measures (e.g. lab results)	• *Government Users*: model ROI per alternative primary care investment strategies. • Providers: evaluate and benchmark progress using all-payer data aggregated by provider entity.	• *Researcher*: Evaluate cost and quality performance of advanced vs. traditional primary care practices, including characteristics of successful models. •	• *Public:* Population care trends report • *Approved User:* Raw extracts for research	Determine the most compelling approaches to reallocate healthcare dollars to primary care.

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UC12 – Accountable Care Organizations (ACOs)	Evaluate the cost and quality performance of ACOs and other integrated delivery systems to assess these products/networks and the related characteristics of successful programs. Use results to: i) select and advance proven products, and ii) document evidence re successful ACO program elements.	Carrier-specific ACO products and/or provider networks' cost PMPM, quality, and access metrics Allowed costs (Y) Provider-identifiable (Y)* Payer-identifiable (Y) Enrollee-identifiable (N) *ACOs are identified at carrier product level or may be networks within products that are identified at provider system level	• Provider care systems ID (e.g. PCMH, ACOs, etc.) • Enrollee attribution to primary care/ provider sys • Clinical/other non-claims-based quality measures (e.g. lab results) •	• *Researcher:* Evaluate access, cost and quality performance of ACOs and integrated delivery systems, including characteristics of successful models. • *Government Users:* Data insights for contracting with specific models of ACOs and integrated delivery systems and promoting characteristics of successful models. • *Health systems are a key audience…*	• *Issuers:* Issuers would be able to compare the access, cost and quality performance of their ACOs to others.	• *Public:* Population care trends report • *Approved User:* Raw extracts for research	Assemble the evidence to advance new integrated delivery and financing models.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC13 – Integrated Behavioral Health	Evaluate innovations to integrate behavioral and physical health care delivery. Identify best practices and associated cost and quality metrics. Use results to: i) determine coverage & payment for telehealth, care coordinators / CHWs, etc., and ii) designate high performing behavioral health care systems.	Medical practice/group-specific PMPM cost, utilization of services and quality metrics. Allowed costs (Y) Provider-identifiable (Y) Payer-identifiable (N) Enrollee-identifiable (N)	• Enrollee attribution to primary care/ provider sys • Provider directory: ID medical practice/ group members, assign practice IDs • Clinical and patient reported outcomes (PRO) measures	• *Issuers and Providers:* Aggregate all-payer data by provider entity to evaluate integrated behavioral health care system pilots. *Government Users:* Data insights for identifying characteristics of successful models and promoting coverage and payment policies.	• *Researcher:* Evaluate cost, utilization, and quality performance of practices that integrate behavioral health services.	• *Public:* Population care trends report • *Approved User:* Raw extracts for research	Create care systems to serve the vulnerable population of people with mental and behavioral disorders.
UC14 – Value Benchmarks Construction	Compute cost and utilization benchmarks across all California payers. Use results to set industry-standard value metrics to measure & monitor health reform initiatives.	Insurance market-specific, product type level (HMO, ACO, EPO/Select Network) cost PMPM and utilization of services rates. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (N) Enrollee-identifiable (N)	• Provider care systems ID (e.g. ACOs) • Risk/severity adjustments to make valid comparisons across diverse populations	• *Government Users:* Data insights for measuring baselines and identifying benchmarks. • *Government Users:* State and federal policymakers can set appropriate cost and utilization benchmarks for health reform initiatives (e.g., cost containment)	• *Researcher:* Evaluate cost and utilization trends across market segments and identify opportunities for savings.	• *Public:* Market trends report • *Public:* Analysis of health reform initiatives in meeting benchmarks for reducing costs and utilization. • *Approved User:* Raw extracts for research	• Provide analytic resources, including performance benchmarks, as a public good to support health reform.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC15 – Health Disparities Evaluation	Evaluate population cohorts defined by socioeconomic status (SES) attributes (e.g., income, location, race/ethnicity); assess disparities in care access, resources consumed and quality by SES cohort. Use this evidence-base to set and monitor insurance market and carrier health equity performance targets.	Insurance market-specific and carrier-specific cost PMPM, service utilization rates, and quality scores aggregated by SES population cohorts. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• SES proxies (e.g. AHRQ SES Index) • SES data capture • Census tracts with zip codes and full census FIPS identifiers for linkage to other census and spatial SES datasets mapped • Measures engine: AHRQ PQIs and other quality metrics • Enrollee SOI/risk classification	• Issuers and Providers: Access heretofore unavailable data to identify & care for underserved populations • *Government Users:* Data insights for measuring baselines and identifying performance targets for reducing health disparities.	• *Public:* Data insights for consumer advocates promoting policies reducing health disparities.	• *Public:* Health equity report card, documenting utilization and quality experience by key SES categories. • *Approved User:* Raw extracts for research, prepped for ready linkage with additional data sources (ZTCAs, census tracts, etc)	• Establish and advance statewide data infrastructure strategies to identify and eliminate health disparities.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
Consumer Services							
UC16 – Enrollee Decision Support: Out of Pocket Costs	Produce medical and prescription claims cost distributions to create: i) medical/drug service utilization by low-high usage groups and average per unit allowed amounts, ii) distribution of claims cost by household member, and iii) claims cost differences by age, gender and geography. Use results to: i) assist consumers in choosing health insurance products, ii) guide high deductible health plan (HDHP) enrollees re: budgeting for health savings accounts (HSAs), and iii) consumer price shopping services.	Commercial market, all-carrier product-level cost PMPM, cost per service, and per person service utilization. Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (N) Enrollee-identifiable (Y)	• Metal tier • AV / other benefits level indicator • Standard medical service categories	*Government Users:* Data insights for Covered California in designing consumer decision support tools for plan selection and the algorithms for displaying choices. Public: equip consumers and advocates with better decision support services	• *Researcher:* Evaluate whether consumers made optimal plan choices given their claims experience • *Public:* Analysis of effective characteristics of decision support tools	• *Public:* Policy reports on distribution of costs and usage of health care. • *Approved User:* Raw extracts for research	Foster more efficient markets by equipping consumers with information to make healthcare choices.

Use Case Title	Use Case Summary	Data Aggregation Level Needed for Analysis	Data Implications/ Augmentation	Primary Audience	Secondary Audience	Output Examples	User Value
UC17 – Balance Billing Impact	Evaluate extent to which enrollees are subject to out-of-pocket costs for services rendered by out-of-network professional providers at in-network facilities and/or for urgent/emergent services. Use results to inform policy and regulations for: i) out of network hold harmless terms, ii) provider maximum allowed amounts for out-of-network services, and iii) provider notice/communication to patient obligations.	Commercial market, carrier product-specific, by metal tier, provider-type (facility and professional) utilization and allowed costs for target provider types (e.g., anesthesiology, radiology, pathology, surgery and hospital inpatient, outpatient, emergency dept., etc.) Allowed costs (Y) Provider-identifiable (N) Payer-identifiable (Y) Enrollee-identifiable (N)	• HIOS ID and metal tier • Validated out-of-network claims flag • Standard medical service categories	• *Government Users:* Data insights for state and federal policymakers to set policies on balanced billing. Regulators have insight into the extent of the issue and monitor for trends. • *Public:* Data insights for consumer advocates promoting fairer insurance coverage.	*Researcher:* Study balanced billing for directional relationship with issuer, provider, or service characteristics.	• *Approved User:* Raw extracts for research	Protect consumers against surprise costs at time of service and ensure that providers are fairly compensated when rendering out-of-network services.

Glossary

(Health) Insurance Markets
Includes all commercial markets – individual, small group, and large group including self-funded accounts that are participating in APCD, whether public or private sponsored coverage; Medi-Cal, Medicare Advantage, and Medicare fee-for-service if CMS is a participating APCD data contributor. The individual and small group markets are comprised of all on-Exchange and off-Exchange products. Most of Covered California's proposed APCD use cases apply broadly to multiple purchasers / stakeholders.
Qualified Health Plan (QHP)
Entails entire individual insurance market, both on- and off-Exchange.