Healthcare Payments Data Program Review Committee

August 15, 2019

Office of Statewide Health Planning and Development

2020 W. El Camino Avenue, Sacramento, CA, 95833

Conference Room 1237

OSHPD
Office of Statewide Health Planning and Development

Welcome and Meeting Minutes

Ken Stuart, Chair, Review Committee

Deputy Director's Report

Scott Christman,

Deputy Director and Chief Information Officer,

OSHPD

Proposed Changes to Review Committee Dates

- Third Thursday of January and February
  - January 16,2020
  - February 20,2020
- November meeting to be used as Overflow Month
  - Additional topics including uninsured, RBOs, ASCs
- Shift Governance and Sustainability one month down
  - Expanded OSHPD Healthcare Data Governance Model

Review Committee Meeting Topics

August

Data Quality

- Roles and responsibilities in ensuring data quality throughout its lifecycle
- Effective collaborations with submitters to ensure data quality
- Documentation processes for data quality

September

Data Governance and Privacy

- California privacy landscape
- Privacy considerations for data collection, use and dissemination

October

Technology Alternatives

- Technology options to receive, store, and structure data
- Technology options to incorporate other data sets for research
- Technology options to analyze data and publish reports

November

Overflow Month

- Opportunity to catch up on topics not captured in past months

December

Governance: Administrative Plan for Operating the Database

- Considerations for effectively governing a data management system
- Opportunities to leverage existing data governance structures

Review Committee Meeting Topics

January

Sustainability

- Discussion on associated costs of the database
- Role of fees for data usage or data submission
- Recommended business plan elements to fund the operations of the database

February

Close Out

- Review of final Review Committee recommendations
- Next Steps

Continuation from July 18 Agenda Topic: Mandatory Submitters

Data Submitters

August 15, 2019

Topics – Data Submitters

JULY

1. Who is responsible for submitting data?

   Mandatory Submitters: Types of organizations required to submit data to HPD

2a-c. What lines of business must be submitted to HPD?

   Lines of Business – required and excluded;

   Coordination of submission – mandatory submitter is responsible for completeness of data, including for subcontracted pharmacy and behavioral health services

AUGUST

2d. What is the enrollment threshold below which a plan is exempt?

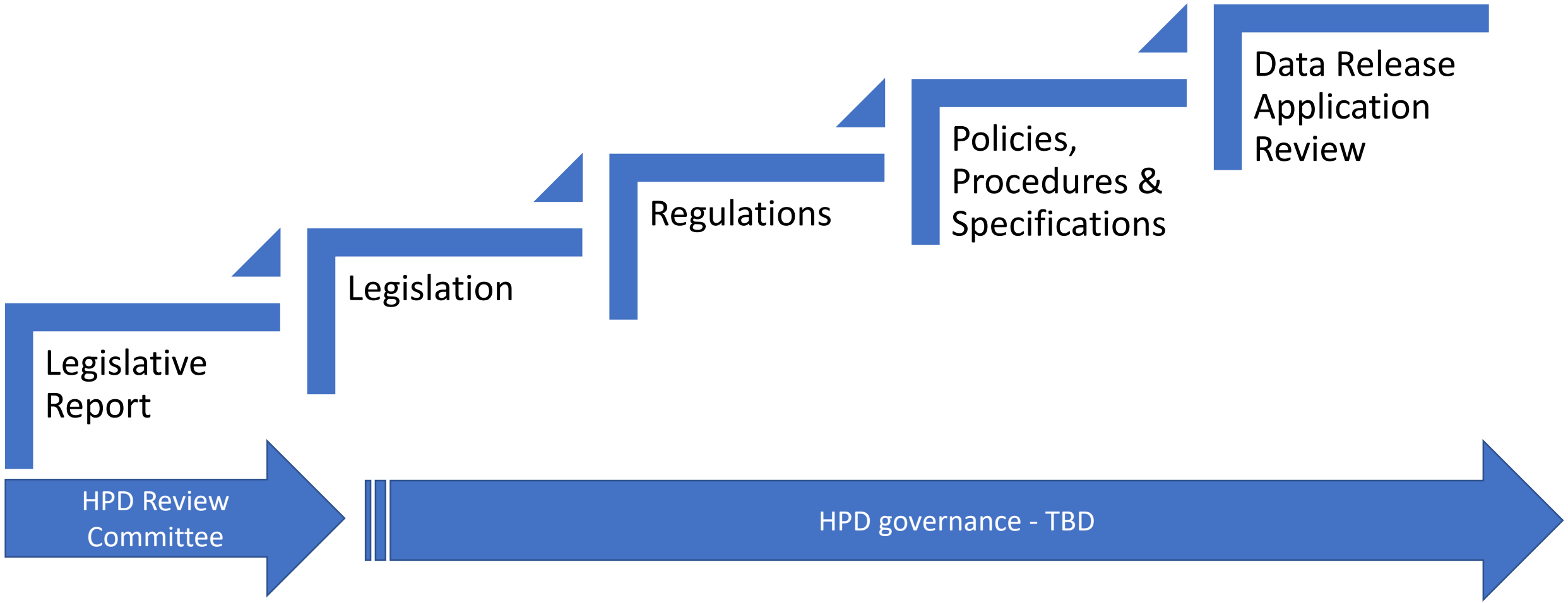
3. How often must data be submitted? On what population?

   Population and frequency of data submission

4. How can non-mandatory submitters contribute data to HPD?

   Provisions to encourage submission of data from voluntary submitters

Design and Implementation Guidance



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Recommendation:

1. **Mandatory Submitters**

APPROVED

1. The Review Committee recommends that definitions for the types of organizations required to submit data as previously defined to the HPD ("mandatory submitters") should be based on federal and existing California laws and definitions, and initially include:
    a. Health care service plans and health insurers
    b. The California Department of Health Care Services, for Medi-Cal managed care plan and fee for service data
    c. Self-insured entities not subject to ERISA
    d. Third party administrators of plans (not otherwise preempted by ERISA)
    e. Dental plans and insurers

Recommendation:

2a. Required Lines of Business

APPROVED

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

a. Required lines of business:

1. Commercial: individual, small group, large group, Medicare Advantage
2. Self-insured plans not subject to ERISA
3. Dental
4. Medi-Cal

Recommendation:

2b. Coordination of Submission

APPROVED

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

b. Coordination of submission: The mandatory submitters are responsible for submitting complete and accurate data directly and facilitating data submissions from appropriate data owners, including data feeds from pharmacy benefit management companies, behavioral health organizations, subsidiaries, and other services carved out to a subcontracting organization.

Recommendation:

2c. Excluded Lines of Business

APPROVED

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

c. Excluded lines of business: all those listed in Insurance Code section 106b as excluded from the definition of health insurance, plus the following:

- Supplemental insurance (including Medicare supplemental)
- Stop-loss plans
- Student health insurance
- Chiropractic-only, discount, and vision-only insurance

Exemptions from Mandatory Submission

Recommendation:

2d. Exemption for Plan Size

AS AMENDED AND TABLED

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

d. Plan Size: Exemption for plans below a threshold to be defined, between 10,000 and 50,000 covered lives for:

1. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
2. Dental

Any threshold with respect to Medi-Cal or Medicare Advantage will be recommended by OSHPD

Exemptions: State APCD Plan Size Thresholds

Threshold below which plans are exempt:	State
Covered Lives	
>1,000 covered lives	CO, DE, MD, MA
>2,000 covered lives	AR
>2,500 covered lives	UT
>3,000 covered lives	CT, RI
>5,000 covered lives	OR
>10,000 covered lives	NH
Other Measures	
>$3M in medical or $300k in pharmacy claims/yr	MN
>$5M in medical or $1M in pharmacy claims/yr	TN
>$2M in adjusted premiums or claims paid/yr	ME
>1% market share	KS

Scenarios for Exemption from Mandatory Reporting to HPD

	Submitting			Exempt	
Threshold – Covered Lives (Commercial/Medicare Adv)	# of plans	# enrollees	% enrollees	# of plans	# of enrollees
>100,000	11	15,929,210	95.9	58	679,332
>75,000	12	16,014,582	96.4	57	593,960
>50,000	14	16,133,763	97.1	55	474,779
>25,000	21	16,367,728	98.6	48	240,814
>10,000	31	16,538,304	99.6	38	70,238
TOTAL	69	16,608,542	100	0	0

Source: California Health Insurers Almanac, 2019: Data File, California Health Care Foundation

Exemption Thresholds for Medicare Advantage

- Medicare Advantage data will be submitted to HPD by the health plans along with commercial lines of business
  - Obtaining the MA data from CMS would take substantially longer
  - Discussed and approved at prior Review Committee meetings
- Without a plan size exemption, small plans would be burdened with data submission requirements and the HPD would incur the cost of additional data feeds with few covered lives (as few as 16)
  - While MA plans submit encounter data to CMS, it is not in the CDL format; so plans cannot simply send the same file to HPD that they send to CMS

Exemption Thresholds for Medi-Cal

- Exemption threshold not relevant for Medi-Cal
  - Medi-Cal data will flow through the Department of Health Care Services, which already collects data from participating plans
- Recommendation previously approved by the Review Committee:
  - The HPD System should pursue the collection of Medi-Cal data directly from DHCS.

Exemption Thresholds for Qualified Health Plans

- To maximize the value of the HPD, it is important to ensure inclusion of data for all health plans participating in Covered California.
  - Use cases include monitoring movement between Medi-Cal and Covered California, monitoring movement between Covered California and the individual market, and evaluation of delivery system and payment changes on outcomes for enrollees
- For current year, based on Covered California enrollment:
  - If exemption at 50,000 covered lives, 4 plans exempt
  - If exemption at 25k, 2 plans exempt
  - If exemption at 10k, zero plans exempt
- Exemption threshold for QHPs should be set to zero to ensure all plans participating in Covered California submit data to HPD.

Scenarios for Exemption from Mandatory Reporting to HPD –Dental

	Submitting			Exempt	
Threshold – Covered Lives (Dental)	# of plans	# of enrollees	% of enrollees	# of plans	# of enrollees
>100,000	22	9,322,252	92.8	35	723,287
>75,000	24	9,482,189	94.4	33	563,350
>50,000	29	9,794,479	97.5	28	251,060
>25,000	32	9,876,919	98.3	26	168,620
>10,000	38	9,990,615	99.5	19	54,924
TOTAL	57	**10,045,539**	**100**	0	**0**

Source: Calculations based on 2017 data from DMHC and CDI websites.

Vote on Recommendation 2d

Recommendation:

2d. Exemption for Plan Size

AS REVISED FOR CONSIDERATION (MARKUP SHOWN)

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

d. Plan Size:

1. Exemption for plans below a threshold to be defined, between 10,000 and 50,000 covered lives for:
   a. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
   b. Dental
2. Given that DHCS will be submitting Medi-Cal data, there is no plan size threshold for Medi-Cal.
3. All Qualified Health Plans (plans participating in Covered California) are required to submit.

[2 and 3 in green text = added]

[DELETED: Any threshold with respect to Medi-Cal or Medicare Advantage will be recommended by OSHPD]

Recommendation:

2d. Exemption for Plan Size

AS REVISED FOR CONSIDERATION

2. The Review Committee recommends that standards for mandatory submission should be broadly specified in statute and clearly defined in regulations, with initial guidance as follows:

d. Plan Size:

1. Exemption for plans below a threshold to be defined, between 10,000 and 50,000 covered lives for:
   a. Combined Medicare Advantage, commercial, and self-insured plans not subject to ERISA
   b. Dental
2. Given that DHCS will be submitting Medi-Cal data, there is no plan size threshold for Medi-Cal.
3. All Qualified Health Plans (plans participating in Covered California) are required to submit.

Data Submission Frequency and Population to Be Reported

Frequency of Data Submission

- Other state APCDs vary for core data, most often monthly or quarterly
- All state APCDs that collect non-claims data do so on an annual basis
- California's scale will result in transmission of very large files, necessitating monthly submission for core data
  - Monthly submission will also enable earlier detection and resolution of any quality and completeness problems with files.
  - A process for requesting an exception to monthly submission requirements will accommodate small plans/lines of business or unusual circumstances
- For supplemental data such as non-claims payment, annual submission balances the burden of submission with timely access to the data

Defining the Population for Data Submission

- Objective: balance comprehensiveness with cost and burden of data submission and collection
- All state APCDs collect data about state residents
- Some APCDs add other populations
  - Public sector retirees
  - Out of state residents covered by a plan issued in the state
- For CA, defining population as **state residents** is straightforward and accomplishes the legislative intent for claims data collection

Recommendation:

3a. Frequency

3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows:

a. <u>Frequency</u>:

- monthly for all core data (claims, encounters, eligibility, and provider files)
- annually for non-claims-payments data files

Recommendation:
3b. Population

3. The Review Committee recommends that the specific requirements associated with submission should be broadly defined in statute and clearly defined in regulation, with initial guidance as follows:

b. **Population:** residents of California

Vote on Recommendation 3

Voluntary Data Submission

ERISA Preemption of Self-funded Data Collection

- *Gobeille v. Liberty Mutual:* states cannot require self-funded employers to submit data to a state APCD because ERISA pre-empts state authority
- Applies to approximately 4.8M Californians:
  - ERISA Self-funded plans
  - Taft-Hartley trusts (collectively bargained)
- Plans that cover public employees are exempt from ERISA so ruling does not apply
  - CalPERS
  - State/county/municipal; public school teachers/retirees; state university and colleges

Voluntary Data Collection in Other APCDs

- Make clear that submission is not prohibited
- Inform self-insured employers and Taft-Hartley plans that they may submit data to the state APCD for plans subject to ERISA
  - State may conduct own outreach (RI, UT, CO NH)
  - State may require health plans, TPAs, and other administrators to notify clients that they can opt into the APCD (UT)
- Require health plans, TPAs and other plan administrators to submit data to the state APCD when requested by the self-insured client (WA)

Recommendation:

4. Voluntary Submitters

4. The Review Committee recommends that:

- HPD should be statutorily authorized to receive data from voluntary submitters.
- HPD shall develop an appropriate process to encourage voluntary data submission.

Vote on Recommendation 4

BREAK

OSHPD Patient-Level Data Quality Management:

How the Patient Data Section of OSHPD currently manages the data quality process for patient-level data.

Presented by, Anthony Tapney, MBA, SSM I, Patient Data Section

for Healthcare Payments Database Review Committee Meeting

August 15, 2019

Agenda

- Overview of data processing
- Approval criteria (Error Tolerance Level)
- Automated edit programs and tools
- Analyst interaction and intervention (customer service, verification, analytical review, special studies)
- Statistics on number of flags on first submission vs. final approval
- Modifications and edit overrides (data flagged but verified as accurate)

2019 Patient-Level Data Elements

Common
- Date of Birth
- Diagnoses and
  - Principal
  - Other(s)
- Disposition of Patient
- External Causes of
- Patient Social Security Number
- Preferred Language Spoken
- Procedures
  - Principal
  - Other(s)
- Race(s)
- Sex
- Total Charges
- ZIP Code

Plus: Facility ID Number, and optional Abstract Record Number

Inpatient only
- Discharge Date
- Pre-hospital Care and Resuscitation (DNR – Do Not Resuscitate)
- Present on Admission Indicators
  - Diagnoses
  - External Causes
- Procedure Dates
- Source of Admission
- Type of Admission
- Type of Care

Differs between IP vs. ED & AS
- Admission Date (Service Date)
- Expected Source of Payment

Patient Level Data Processing

- Online submission of data (files or record entry)
- Transmittal Testing Feature
- Unlimited report validation before formal submission (testing)
- ~1,000 automated edits
- Report tools available for facility to review data
- Making corrections
- Automatic notification for formal submissions

Patient Level Data Approval Criteria

- The approval criteria are specified by regulation
- The data must be at or below the Error Tolerance Level (2%)
- The data must be consistent with the reporting facility's trends and comparisons
  - Trend Edits (allowable % difference based on historical data)
  - Comparative Edits (% error threshold based number of records)

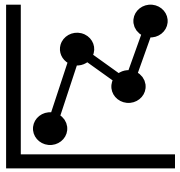
Patient Level Data Automated Edit Programs and Tools

- **Validation Efforts:** A complete description of each edit can be found in the Edit Flag Description Guides: Inpatient and ED & AS
- The system applies over 600 automated validation edits (over 1,000 with Coding Edits)
  - Transmittal
  - Licensing
  - Standard Edits
  - Readmission (inpatient only)
  - Trend Edits
  - Comparative Edits
  - Coding Edits (under revision)
- Additional Desk Audits

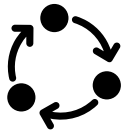
Edit Descriptions

Program	Description
Transmittal Validation 	Checks for proper file format and compares the "Expected" (based on the Transmittal Page information) to "Actual" data submitted. • Virus infected file • No data in file • Multiple files in a Zip file • Incorrect file format • Discrepancy in the number of records submitted vs. the number entered on the Transmittal screen. • One (1) or more records are reported with a Discharge Date that is blank, invalid, or outside the Report Period. • Incorrect Facility ID Number on one or more records • MIRCal Database errors.
Licensing Check 	Checks to make sure your data includes all the types of care and services for which your facility is licensed. For example, if your facility is licensed for Acute care, but no records are reported as Acute type of care, then your data will fail this program. NOTE: This program does not check for records that include a type of care for which your facility is not licensed. The Standard Edit program identifies this type of error.

Edit Descriptions Continued

Trend Edit (T flag) 	Compares the data in the current report period to the facility's historical data to identify uncharacteristic increases or decreases in percentages reported for certain data elements/categories. EXAMPLE: In the Current Report Period, your facility reported 65% Non-Hispanic patients, but in the previous two (2) report periods, you reported only 20% Non-Hispanic patients. If this percentage difference between report periods is outside the "Allowable Difference", then either a Critical or Non-Critical Trend flag is generated. Non-Critical flags will not cause your data to fail this program, but one or more Critical flags will.
Comparative Edit (C flag) 	Based on the TOTAL records reported, checks for reasonable distribution of categories within each data element for the Current Report Period. EXAMPLE: If 100% of your records are reported with Patient Disposition-Home, this program will generate a Comparative Edit flag and your data will fail.

Edit Descriptions Continued

Records with a Blank or Invalid Principal Diagnosis 	This program identifies records with a Principal Diagnosis that is blank, invalid, reported with an "old" diagnosis code after the effective End Date; or reported with a "new" diagnosis code before the effective Begin Date. The erroneous Principal Diagnosis code will receive a critical S-flag.
Standard Edit (S flag) 	Checks for data entry errors and inconsistencies of data reported within each record. EXAMPLE: Admit Date is AFTER the Discharge Date.
Readmission Edit (K flag) 	Groups records that contain identical Social Security Numbers (SSNs), and then checks for inconsistencies between the records. EXAMPLE: Two records with the same SSN cannot have different Dates of Birth; either the SSN or the Date of Birth is incorrect.

Patient Level Data Analyst Interaction and Intervention

- Customer service
- Verification
- Analytical review
- Special studies

Quality Management – Measuring Effectiveness

First vs. final submission*:

- 99% of first submissions failed at least one standard edit
  - 53% of records had 1 or more flags (86% corrected)

- 85% of first submissions failed at least one comparative edit
  - 634 critical edits were applied
  - 60% of all critical edits corrected

- 71% of first submissions failed at least one trend edit
  - 672 critical trend edits were applied
  - 75% of all critical edits corrected

* Inpatient 2nd half 2018 submissions

Quality Management – What about the rest?

- Error Tolerance Level 2%
- Modifications to reporting requirements
- Edit overrides (verified as accurate)

Wrap Up

- Questions?

References

- **Website link:**
  https://oshpd.ca.gov/data-and-reports/submit-data/patient-data/

- **Program Contacts for further information**:
  - Data submission questions:

    Robyn Strong, Patient Data Section Manager Robyn.Strong@oshpd.ca.gov

    Anthony Tapney, Patient Data Section Asst. Mgr. Anthony.Tapney@oshpd.ca.gov

    Rob Fox, Patient Data Section Asst. Mgr. Rob.Fox@oshpd.ca.gov

    MIRCal@oshpd.ca.gov

  - Data requests: dataandreports@oshpd.ca.gov

~Thank you~

HPD Data Quality and Improvement

HPD Review Committee Meeting

Jonathan Mathieu

August 15, 2019

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Office of Statewide Health Planning and Development

Today's Topics

- Why are we talking about Data Quality and Improvement?
- What are the essential Data Quality processes?
- How do APCDs build stakeholder confidence?

Our "ask:"

- Provide guidance from a "big picture" perspective
- Address details in regulation, policy development and implementation

Purpose

- GOAL: Establish and maintain the accuracy and credibility of the HPD database to support its intended use
- Create a shared understanding that Data Quality and Improvement:
  - Requires multiple methods, tools, and processes
  - Some automation is possible, human involvement required
  - Collaborative effort between OSHPD and HPD stakeholders
  - Ongoing, all stages of the data life-cycle
  - Critical to the credibility and sustainability of HPD

Why is this Important?

- Secondary Use of Data – Claims/encounter data are not produced or intended to support APCD uses
- Data Chain of Custody:
  - Service Provider – Billing Office – Payer Processing – HPD Data Extract – OSHPD Processing – Analysis, Reporting, and Release
  - Lots of “room for error”
- Encounter data – no payment incentive to encourage reporting
- Unaddressed data quality problems will damage HPD credibility and threaten sustainability
- Documentation and Transparency are the “best medicine”

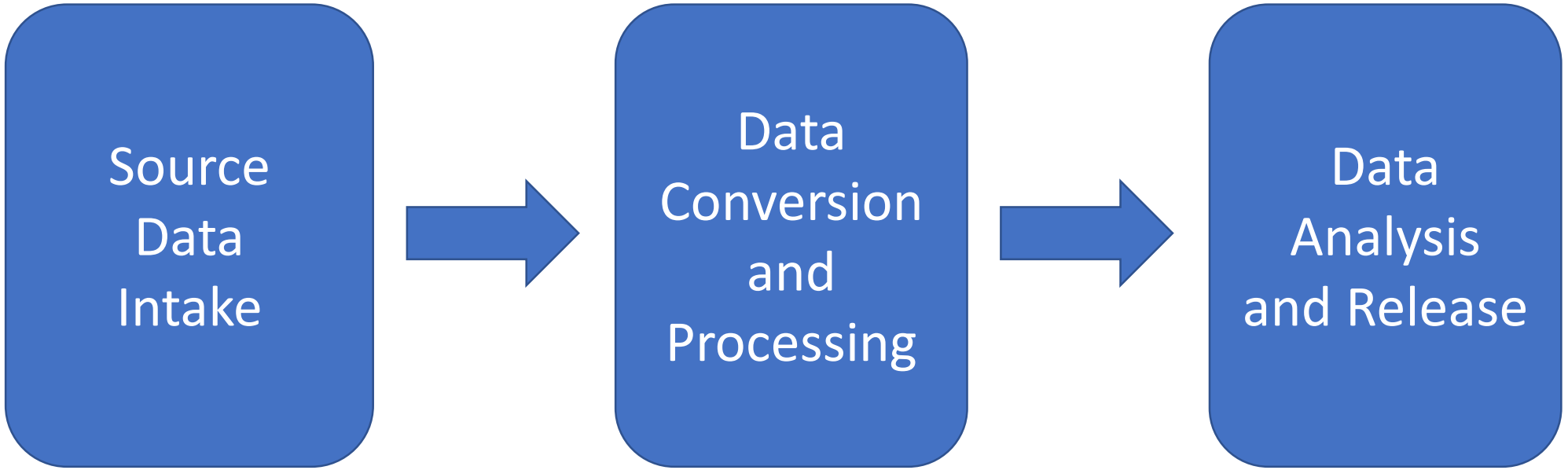
Recognition of Encounter Data Challenges

- DMHC Undertakings
  - 2016 Centene/Health Net merger required $50 million for multi-year, multi-phased approach to improve encounter data
  - 2018 Aetna/CVS merger required $6 million for encounter data improvement
- Medi-Cal
  - Established an Encounter Data Quality Unit
  - Implemented an encounter data collection system
  - Created comprehensive set of data quality metrics encompassing data completeness, accuracy, reasonability, and timeliness
  - Established contract provisions and incentives around data quality
- Centers for Medicare and Medicaid Services (CMS)
  - Federal regulations (CFR § 438.242) define “complete and accurate” and impose requirements on state Medicaid programs
  - Medicare Advantage Plans required to send detailed encounter records to CMS

Data Quality and Improvement

- Methods, tools, and processes for complete and accurate data
- Establish fitness of data to support Use Cases:
  - Data will never be perfect, must be “good enough”
  - Differs by Use Case – population health, disease prevalence, condition specific studies, standards of care, comparative cost/utilization/quality, etc.
  - Cannot validate database *per se,* only fitness for specific uses
- Transparency and Understanding are key:
  - Submitters – data intake requirements
  - Stakeholders – appropriate data uses

Data Quality throughout the Life Cycle

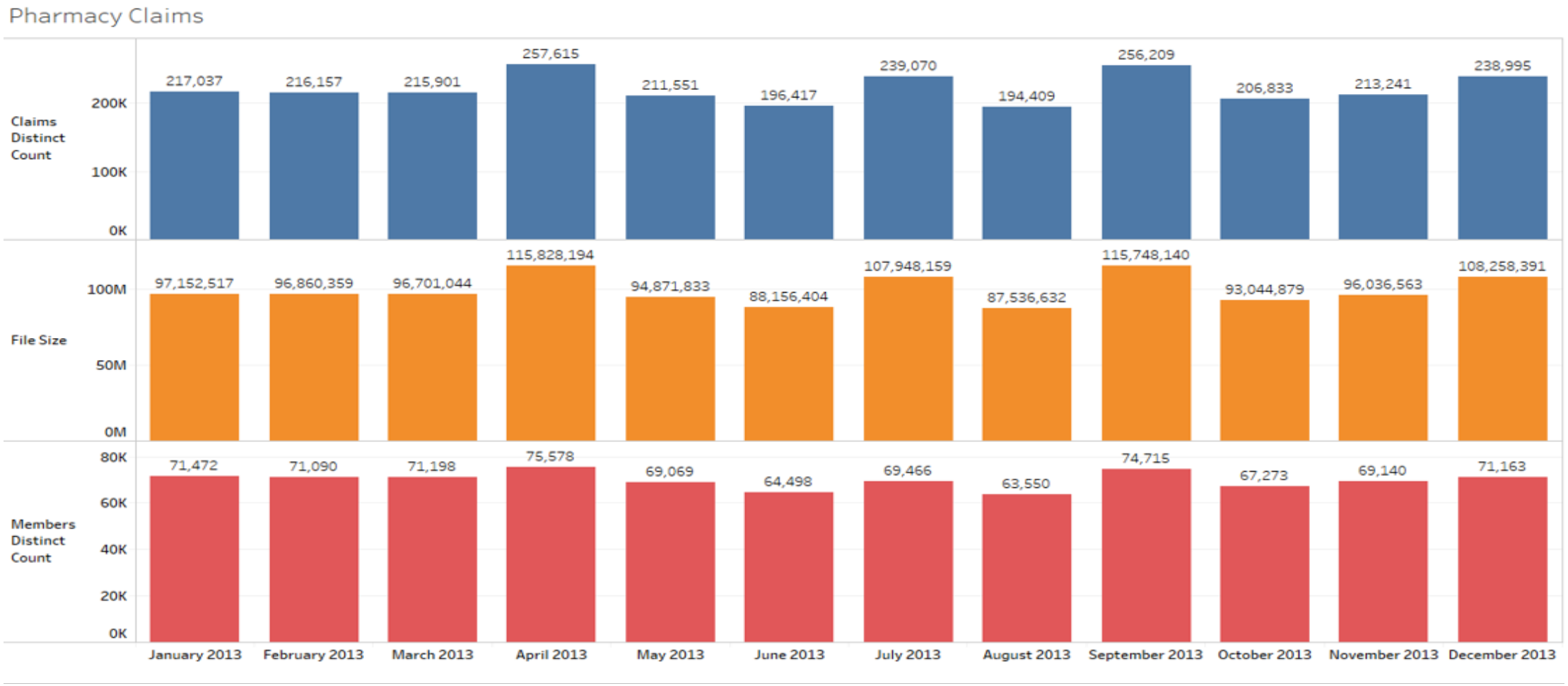


Source Data Intake

- Automated data quality checks/edits:
  - Typically, hundreds of checks/edits
  - Summary reports delivered within hours
  - Informs data acceptance decisions
- Additional HPD Responsibilities:
  - Establish processes to validate submissions
  - Maintain raw files in case of downstream issues
  - Establish clear expectations and timelines for error correction/resubmission

- APCDs develop these processes with data managers
- This requires close collaboration with data submitters

Pharmacy Claims and Members



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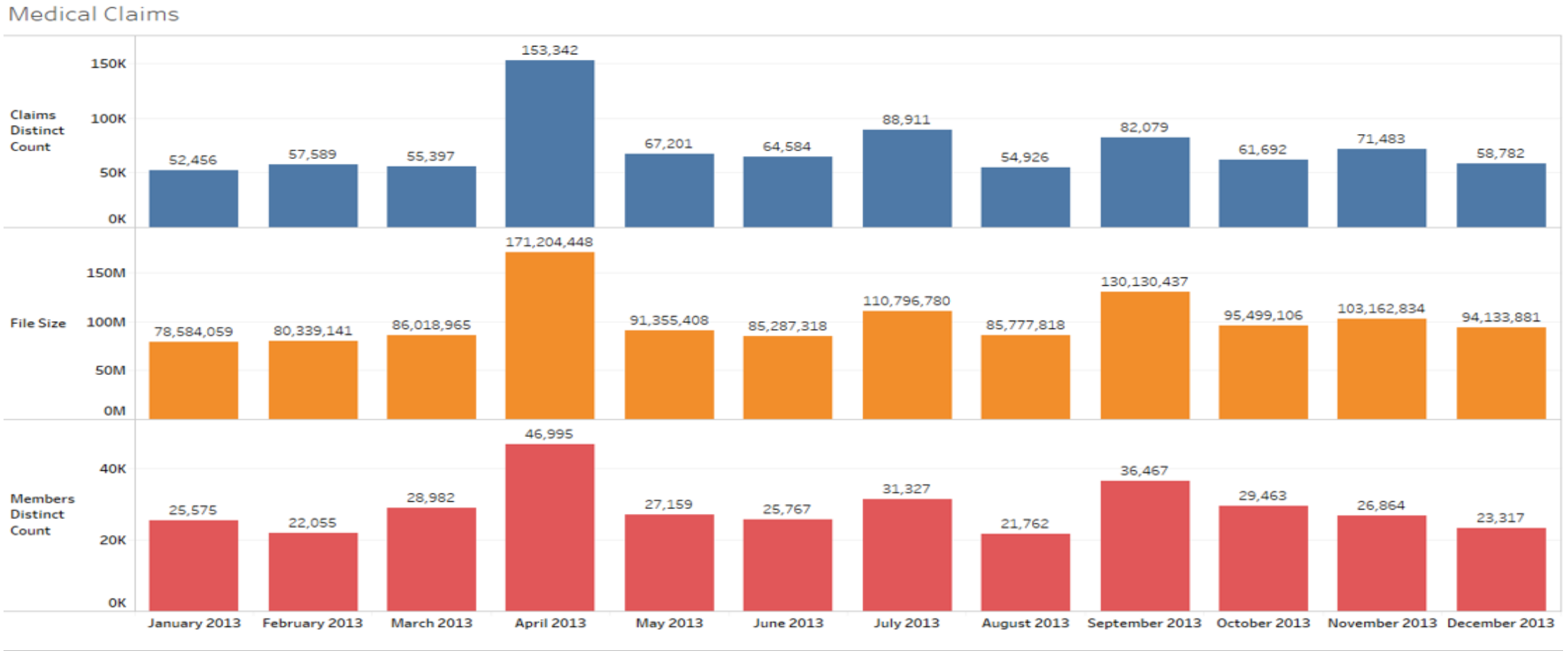
FFS Medical Claims and Members

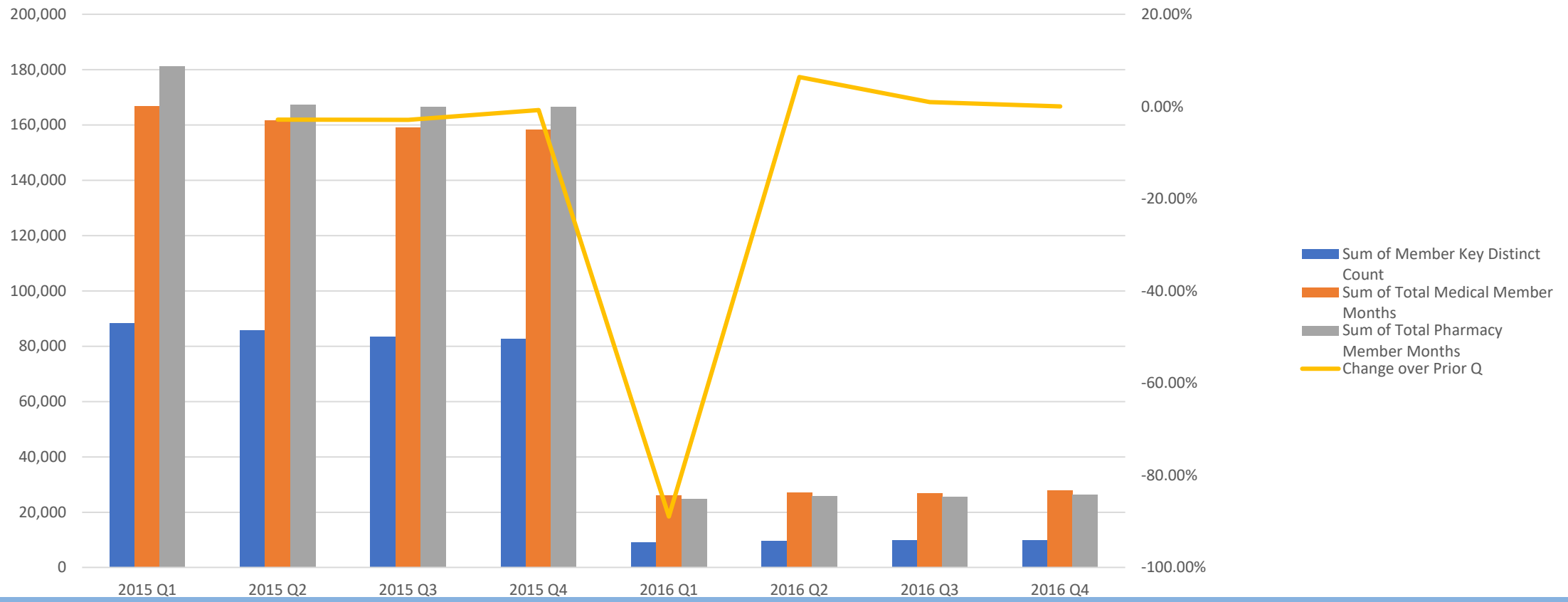


Data Conversion and Processing

- Automated Reports/Dashboards
  - Compare current data to previous months
  - HPD staff review, investigate anomalies, identify solutions
  - Quarantine suspect data until issues resolved
- Processing Quality Control – final checks before data is available for Use
- Look for stability in:
  - Member and Provider counts
  - Service category volume– IP, OP, ED, Prof, Rx
  - Procedure counts, DRGs, CPT, E&M

- APCDs develop these processes with data managers
- Requires close collaboration with data managers and "two sets of eyes"

Member Counts and Months for Commercially Insured Adults 19 – 64



Data Analysis and Release

- HPD Output Quality Control:
  - Validate against other sources
  - Preview results with stakeholders
  - Correction and Appeals process – CMS requirement
  - Document and share data quality reports
- Use of HPD data will improve quality

APCD Experience:

- Credibility is hard won, easily lost and difficult to regain
- Data quality and improvement are the best medicine

How to Build Confidence

- Ask about stakeholder pain points/needs – address these
- Emphasize what HPD *can* do
- Documentation and transparency

Recommendation:

1. Establish HPD Data Quality and Improvement Processes

1. The Review Committee recommends that the HPD Program develop transparent data quality and improvement processes

Recommendation:

2. Multi-Phase Data Quality and Improvement Processes

2. The Review Committee recommends that data quality processes should be applied to each major phase of the HPD data life-cycle, including:

   a) Source data intake

   b) Data conversion and processing

   c) Data analysis, reporting, and release

Recommendation:

3. Resubmission Requirements

3. The Review Committee recommends that the HPD Program have authority to require resubmissions if data fail to meet established data quality standards

Recommendation:

4. Stakeholder Data Quality Information

4. The Review Committee recommends that the HPD Program provide stakeholders with accessible information on data quality, including:

   a) Descriptions of processes and methodologies

   b) Periodic updates on known issues and their implications

Upcoming Review Committee Meeting : September 19, 2019

Appendix

Self-Insured Public Entities and Third Party Administrators

Mandatory Submission: Health Plans/Insurers

- Mandatory submission of data from health plans and health insurers would cover much of the commercial enrollment in California, including:
  - Fully-insured enrollment above the threshold for exemption
  - Administrative services only (ASO) enrollment provided by health plans and health insurers for public self-insured entities not subject to ERISA
- Mandatory submission does not include ASO enrollment for private self-insured entities subject to ERISA due to the Supreme Court *Gobeille* decision
- Data on public vs. private self-insured ASO enrollment not available; estimated at 0.9M public and 4.8M private (see note in table)

Plan	ASO Enrollment	Market Share
Anthem	2,784,723	49%
UnitedHealth	794,412	14%
Blue Shield	705,676	12%
Aetna	695,959	12%
CIGNA	581,158	10%
Kaiser	141,604	2%
All Others	14,044	<1%
Total	5,717,576	100%

Source: CHCF California Health Insurers Almanac, 2017 data, February 2019: Data File.
Note: Self-insured ERISA vs. non-ERISA estimates are based on 2016 bulletin from the Census Bureau; according to Table 3A, 84% of self-insured employer-sponsored coverage in California in CY 2015 was private (assume ERISA) and 16% was public (assume non-ERISA). Apply those percentages to 5.7M Administrative Services Only (ASO) enrollment.

CalPERS Enrollment: 72% Fully Insured

Plan	Covered Lives	Market Share
Fully-insured	1,053,932	72%
Self-insured PERS Plans	377,064	26%
Self-insured Association Plans	32,904	2%
Total	1,463,900	100%

Sources: CalPERS Health Program Enrollment Report, September 1, 2018; Pension and Health Benefits Committee Agenda Item 5c, 6/28/2019

Mandatory Submission: Self-Insured Public Entities and Third-Party Administrators

- Public employers and trusts often offer a mix of fully-insured and self-insured offerings, just as CalPERS does
- As with CalPERS, fully-insured enrollment and enrollment that is self-insured and administered by a plan/insurer will be covered by mandatory submission from those entities
- To maximize data available to the HPD, mandatory submission should also include both:
  - Self-insured employers and trusts not subject to ERISA administering their own benefit programs, e.g. direct contract with a PBM for pharmacy services
  - Third party administrators providing services to self-insured employers and trusts not subject to ERISA

Third Party Administrators

- Provide an array of services to self-insured employers and trusts, including claims administration, provider network management, utilization review, eligibility, billing, and COBRA administration.
- Operate in workers compensation, retirement, life, and other industries as well as health benefits.
- Are required to register with the California Department of Insurance (CA Insurance Code Section 740).

Examples: Public Plans and Administrators

Plan	Description	Administrator
CalPERS: PERS Select, Choice, Care	PPO options for CalPERS members	Anthem
University of California: UC Care and UC Savings Plan	PPO options available to those eligible for UC coverage	Anthem
California Schools Voluntary Employees Benefits Association (VEBA)	Covers education, municipal, and public agency employees in Southern California	McGregor & Associates/Arthur J. Gallagher & Co
Regional Employer/Employee Partnership for Benefits (Joint Powers Authority)	Serving school districts in Southern California	Keenan